# 2014 SURVEY OF ILLINOIS LAW: INSURANCE LAW

MARGARET DOMANSKI* & DAVID J. E. ROE**



---

* Margaret Domanski graduated from The John Marshall Law School in May of 2014. At John Marshall she was the Lead Production Editor of *The John Marshall Journal of Information Technology & Privacy Law* where she was in charge of the production of the journal and worked in collaboration with the Editor in Chief. While at John Marshall, she also competed at the 22nd Annual Duberstein Bankruptcy Moot Court Competition and was on Moot Court Honors Council. Ms. Domanski has a Bachelors Degree in Economic and Political Science from DePaul University.

** David J. E. Roe practices in the area of business liability analysis, liability insurance coverage, casualty and commercial disputes. David provides aggressive and focused representation in insurance coverage matters ranging from general liability, D&O, automobile, to professional liability coverage and toxic tort coverage. He has represented business and insurance clients across the United States ranging from Internet start-up companies to Fortune 100 corporations. He is the author of legal books including "Illinois Automobile Insurance Law" published by Thomson/Reuters and the Illinois Civil Jury Instructions Companion Handbook. He presents Continuing Legal Education seminars for ApexCLE, the Illinois State Bar Association, and others. He is licensed in Illinois and Michigan, admitted in the U.S. Supreme Court and a member of the Michigan Bar Association, author of numerous insurance articles and an award winning winemaker.

## I. INTRODUCTION

This article analyzes significant Illinois opinions relating to insurance law issued over a two year period from October 1, 2011, through September 30, 2013. The purpose of this survey is to highlight the changes, modifications, or extensions of existing law, and not necessarily to present every decision announced during this period. The focus is on significant developments in recent case law in order to present to the practitioner emerging issues and foreshadow potential changes in insurance law.

## II. CONSTRUCTION OF THE INSURANCE POLICY, APPLICATIONS, FORMATION AND MODIFICATION

### A. Construction of the Policy and Duties of the Insurer and Insured

*1.* Standard Mutual Insurance Co. v. Lay

Holding: TCPA is a remedial and not a punitive statute and that the $500 liquidated damages per violation are not punitive damages. Therefore this makes them insurable.[1]

In *Standard Mutual Insurance Co. v. Lay*,[2] the Illinois Supreme Court addressed the issue of whether the federal Telephone Consumer Protection Act ("TCPA") which prescribed damages of $500 per violation constituted punitive damages and therefore not insurable as a matter of Illinois law and not recoverable from the insurer.

Lay was a real estate agency that contacted Business to Business Solutions regarding facsimile message advertising. Business to Business Solutions provided services in which they sent fax advertisements to thousands of fax machines. Lay hired its services and they created an advertisement for the sale of a car wash, which included Lay's contact information. Business to Business Solutions sent the advertisement to 5,000 fax numbers. Unbeknownst to Lay, the people and entities on Business to Business Solutions' fax list did not consent to receive fax advertisement. Locklear was one of the recipients of these unsolicited faxes. Locklear brought a class action against Lay for violations of the TCPA. Lay tendered its defense to its insurer, Standard, which had issued Lay a commercial general liability insurance policy. Standard informed Lay that the insurance policies may not cover the conduct alleged in the class action complaint. According to Standard, the TCPA may constitute a penal statute and the policies excluded coverage for willful violations of penal statutes. Standard agreed to defendant Lay in the underlining action subject to a reservation of rights.

The essence of the TCPA is that it makes it unlawful to send unsolicited advertisement to any fax machine, including those at both businesses and residences, without the recipient's prior permission. The receipt of an unsolicited fax advertisement implicates a person's right of privacy insofar as it violates a person's seclusion, and such a violation is one of the injuries that a TCPA fax-ad claim is intended to vindicate.

The TCPA outlaws four practices. The Act: (1) makes it unlawful to use an automatic telephone dialing system, or an artificial or prerecorded

1. Standard Mutual Insurance Co. v. Lay, 2013 IL 114617.
2. *Id*.

voice message, without the prior express consent of the called party, to call any emergency telephone line, hospital patient, pager, cellular telephone, or other service for which the receiver is charged for the call; (2) forbids using artificial or prerecorded voice messages to call residential telephone lines without prior express consent; (3) proscribes sending unsolicited advertisements to fax machines; and (4) bans using automatic telephone dialing systems to engage simultaneously two or more telephone lines of a business.[3]

Locklear argues that the TCPA is a remedial and not a penal statute and therefore the statutory damages of $500 per violation are not punitive damages. In construing a statute the court may consider the reason for the law, the problem sought to be remedied and the purpose to be achieved. In enacting the TCPA, Congress determined that unrestricted telemarketing was regarded as an intrusive invasion of privacy. The purpose of the TCPA is to protect the privacy interest of residential telephone customers by restricting unsolicited automated telephone calls to the home, and facilitating interstate commerce by restricting certain uses of fax machines and automatic dialers.[4]

*2.* Bona Fide Partnership v. Regent Ins. Co.

Holding: Since the policy limit in this case was $1,850,000 and plaintiff's loss exceeded that policy limit, defendants correctly paid the additional $10,000 for debris removal required by the policy. [5]

In *Bona Fide Partnership v. Regent Ins. Co.*,[6] Bona Fide Partnership owned a building that was insured by Regent Insurance Company. The limit of insurance on the building was $1,850,000. If the loss exceeded the limit of the policy then the policy provided an additional amount for debris removal. At issue in the case is the correct amount of debris removal. On November 7, 2008, a commercial building owned by Bona Fide Partnership was damaged when a neighboring building caught on fire. On December 5, 2008, Bona Fide Partnership's building was formally condemned. In a December 10, 2008 letter, Regent Insurance notified Bona Fide Partnership that the building had sustained fire damage to the extent that complete demolition was required. The letter further acknowledged that demolition bids were being obtained and once bids were reviewed and an agreement was reached in regard to scope and cost then demolition would proceed. Robinett Demolition submitted a successful bid and contracted with Bona Fide Partnership to demolish and remove the building for $246,180. It was agreed

3. *Id*. ¶ 28.
4. *Id*. at ¶ 27.
5. Bona Fide Partnership v. Regent Ins. Co.,2013 IL App (4th) 120988-U (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
6. *Id*.

upon that the physical damage to Bona Fide Partnership's property, not including the cost of debris removal, exceeded the policy limit. Regent Insurance paid the policy limit plus $10,000 for demolition and debris removal. Bona Fide Partnership filed a declaratory judgment against Regent Insurance.

The court addressed the question of whether the language of the policy required payment to Bona Fide Partnership of up to 25% of the amount paid by Regent Insurance for loss or damage to the covered property, plus $10,000 in additional coverage for the debris removal because the loss exceeded the policy limit.

The court determined that the plain language of the policy showed the limits of the policy to be $1,850,000. The parties agreed that the total loss of the building exceeded $1,850,000. Reading the policy as a whole showed an overall limit existed to cap Regent Insurance's total amount of exposure. Here, the total loss exceeded the policy limits so that 25% payment for debris removal was not available because it would further exceed the insurance limit under the policy. Instead Bona Fide Partnership was entitled to just the $10,000 for debris removal. The additional $10,000 when added to the physical loss would have resulted in payments in excess of the policy limit. However, the court held that the plain language of paragraph 4(a) in the policy expressly stated that if the policy limit is exceeded, then Regent Insurance will pay an additional $10,000.[7] Therefore, the $10,000 was intended to be an exception to the "Limits of Insurance." Paragraph 4 also provided the insured with an option to purchase an increased debris removal coverage limit with the following language: "if an increased limit of insurance is purchased, the above $10,000 limit of insurance is replaced by the Debris Removal Limit of Insurance shown in the Declarations."[8] The insured would have little incentive to purchase additional debris removal coverage if the policy language allowed the potential to receive coverage in excess of the policy limit.

*3.* Indiana Insurance Co. v. Royce Realty and Management Inc.

Holding: That (1) the endorsement that limited coverage to losses that arose out of insured's use of the premises and that arose out of operations incidental to those premises, was ambiguous, and had to be construed to encompass accidents that arose out of the insured's use of the premises to conduct its property management activities, despite the fact that the accident at issue arose away from those premises, and (2) designated-premises endorsement did not qualify as an express exclusion that would have put

7. *Id.* at ¶ 23.
8. *Id.*

insured on notice that the fundamental purpose of the CGL policy had changed, and that most of the coverage under the policy was nullified.[9]

In *Indiana Insurance Co. v. Royce Realty and Management Inc.*, the insurer, Indiana Insurance Company, filed a declaratory judgment action seeking a determination as to whether a claim for personal injury suffered by Cathy Stackhouse was covered under the insurance policy that Indiana had issued to Royce Realty and Management Inc.[10]

The questions before the court were whether the scope of the insurance policy covered a personal injury claim. Indiana argued that the plain language of the Endorsement limited coverage to claims that arose out of the "ownership, maintenance or use" of Royce Realty's office, her claim was not covered by the policy. The court stated that in order to ascertain the scope of the coverage under the policy, the court was to look to the intent of the parties and the meaning of the words used in the insurance policy as a whole, which took into account the type of insurance for which the parties had contracted, the risks undertaken and purchased, the subject matter that is insured and the purposes of the entire contract. Further, when construing the scope of coverage courts focus on the type of policy for which the parties have contracted. Here the type of policy that the parties contracted for is a CGL policy. A CGL policy typically protects against claims for injuries or losses arising from the insured's business operations. Royce Realty sought to obtain coverage for its operations on the properties it managed. The policy at issue was labeled as a CGL policy and contained language that insured against liability which arose from Royce Realty's operations.

The court found the meaning of the endorsement ambiguous, in that it limited coverage to losses that arose out of Royce Realty's "use" of the premises and arose out of "operations incidental to those premises" without defining those terms and reasonable people could differ over the meaning of the terms.[11] In reading the endorsement together with the rest of the CGL policy the court determined that a reasonable person would likely understand the terms "use" and "operations incidental to the premises" to encompass business operations conducted from the designated premises, even where those operations involved off-premises activities.

Therefore the court construed the endorsement as encompassing accidents that arose out of Royce Realty's use of the premises to conduct its property management activities, despite the fact that the accident at issue here arose away from those premises.[12] Indiana knew that Royce Realty was in the business of property management services to a variety of commercial properties that included golf courses, townhouses, and shopping centers. The

9. Indiana Insurance Co. v. Royce Realty and Management Inc., 2013 IL App (2d) 121184.
10. *Id*.
11. *Id.* at ¶ 29.
12. *Id*.

potential for accidents that could give rise to lawsuits against such a property manager was obvious. Indeed, the very type of accident experienced by Stackhouse was "a risk likely to be inherent in the insured's business." Nevertheless, Indiana chose to issue Royce Realty a CGL policy—a type of policy intended to protect against risks associated with business operations—but then apparently sought to quietly convert it to a premises liability policy, that would leave such risks without coverage, by simply inserting the Endorsement into the policy.

*4.* American Zurich Insurance Company v. Wilcox

Holding: Under the policy exclusion insurer had no duty to defend law firm or lawyer, as lawyer was working for his liquor licensing business when he obtained liquor license for restaurant/lounge.[13]

In *American Zurich Insurance Company v. Wilcox*,[14] American Zurich Insurance brought a declaration that it had no duty to defend. Zurich issued a lawyers professional liability insurance policy that insured Wilcox & Christopoulos, L.L.C., ("the Wilcox law firm") and Mark Wilcox ("Wilcox"). Zurich alleged that the law firm and lawyer engaged in a civil conspiracy to open and operate a restaurant/lounge by illegal means.

The court addressed the issue of whether the insurer had a duty to defend the action against the insured. The duty of an insurer to defend an insured was determined by the allegations of the underlying complaint.

American Zurich contended that it had no duty to defend Wilcox law firm against an investor's complaint because exclusion E of the policy applied to acts or omissions of "any insured" "for any business entity" in which "any insured" has a "controlling interest." American Zurich asserted that Wilcox was an insured attorney under the policy and therefore any acts by him for a business in which he had a controlling interest are excluded from coverage. Zurich contended that the circuit court found that Wilcox had a controlling interest in Liquor License Solutions, and thereby it triggered exclusion E.

In order to determine whether Zurich as a duty to defend Wilcox law firm the court first addressed whether there was a duty to defend the attorney Wilcox individually. There was no doubt that Wilcox was an insured under the policy since he was listed as a lawyer in the application for the policy on the day the policy was incepted. So then the question becomes whether within the meaning of exclusion E, Wilcox was an insured acting "for" a company in which he had a controlling interest. If Wilcox was acting for Panacea Partners, which he had no controlling interest, then the exclusion does not

13. American Zurich Insurance Company v. Wilcox, 2013 IL App (1st) 120402.
14. *Id*.

apply and Zurich has a duty to defend. If however, Wilcox was acting for Liquor License Solutions, a company he admitted to manage and which he had a controlling interest, then exclusion E applies and American Zurich is not obligated to defend him in the underlying lawsuit. Therefore, the court had to interpret the term "for" in the exclusion and determine whether the term was sufficiently ambiguous so as to require the court to construe the policy against American Zurich as the drafter of the policy. The court took the term "for" and considered it in the context of the entirety of exclusion E. The parties implicitly acknowledge that the term "for" in exclusion E essentially means for the "benefit of," disagreeing only as to whose benefit Wilcox's actions were aimed at. This implicit acknowledgment is supported by the American Heritage Dictionary's definition of the term "for" as: (1) "used to indicate the recipient or beneficiary of an action"; or (2) "on behalf of"; or (3) "in favor of," all of which essentially mean "for the benefit of."[15] Accordingly, in this context, the court failed to see two reasonable interpretations of the term "for." All three of these definitions essentially define "for" as "for the benefit of" and the court therefore found the term unambiguous.[16] Even if Wilcox was acting for the benefit of both, there can be no doubt, nor does the Wilcox law firm attempt to deny, that Wilcox was also acting for the benefit of his company, Liquor License Solutions. So exclusion E of the policy was triggered. American Zurich therefore has no obligation to defend Wilcox under that provision.

The next question is whether American Zurich must defend Wilcox law firm pursuant to exclusion E. The exclusion is applicable to all insureds under the policy based upon the conduct or interest of any one insured. The language of exclusion E explicitly precluded coverage of "alleged acts or omissions by *any* Insured . . . for any business enterprise . . . in which *any* Insured has a Controlling Interest."[17] The court determined that Wilcox is an insured under the policy, since he was listed as a lawyer in the application for the policy on the day the policy was incepted. Accordingly, since, as an insured, Wilcox acted for the benefit of Liquor License Solutions, in which he has a controlling interest, exclusion E also applies to the entire law firm. Therefore, pursuant to exclusion E, American Zurich need not defend the Wilcox law firm.

15. *Id.* at ¶ 40 (citing AMERICAN HERITAGE DICTIONARY, 685 (5th ed. 2011)).
16. *Id.* at ¶ 40.
17. *Id.* at ¶ 22.

B. Duty to Defend

*1.* Lagestee-Mulder Inc. v. Consolidated Insurance Co.

Holding: The Complaint's vague use of term, "damages," did not trigger duty to defend.[18]

In *Lagestee- Mulder Inc. v. Consolidated Insurance Co.,*[19] Lagestee-Mulder Inc. ("LMI") was hired by Crown Centre LLC ("Crown") to construct a multi-story office building in Frankfort, Illinois. LMI then subcontracted the supply and installation of the needed windows and doors to Frontrunner Glass & Metal Inc. Pursuant to the subcontract, Frontrunner was required to purchase and maintain insurance that named LMI as an additional insured. Frontrunner complied with the obligation and purchased an occurrence-based commercial general liability policy from Consolidated Insurance Company. The policy required Consolidated to cover sums that its insureds (Frontrunner as primary policy holder and LMI as an additional insured) became legally obligated to pay because of property damage, caused by an occurrence, taking place within the coverage territory, during the policy period. The Policy also required Consolidated to defend any suit seeking damages for covered property. During the later stages of construction, Crown experienced water infiltration at numerous locations, as well as other construction defects and it prompted Crown to file suit in Illinois state court. LMI tendered the defense of its claim to Consolidated on March 6, 2009 but Consolidated made no coverage decision during the subsequent six months. Consolidated denied coverage for Crown's claim against LMI and rejected LMI's tender of defense. LMI brought instant lawsuit against Consolidated in which it alleged a breach of its duties under the policy.

The questions before the court are whether complaint triggered the insurer's duty to defend under the Policy. Specifically, the court must determine whether the complaint alleged "property damage" covered by the policy. The policy is a standard occurrence based CGL policy which provided coverage for property damage caused by an occurrence during the policy period. In addition to providing coverage, it also required Consolidated to defend any suit seeking damages for covered property.

To determine whether an insurer's duty to defend has been triggered, a court must compare the allegations in the underlining complaint with the language of the insurance policy. However, "[a]n insurer may not justifiably refuse to defend an action against its insured unless it is clear from the face of the underlying complaint that the allegations fail to state facts which bring the case within, or potentially within, the policy's coverage."[20] Because an

18. Lagestee-Mulder Inc. v. Consolidated Insurance Co. 682 F.3d 1054 (7th Cir., 2012.).
19. *Id*.
20. *Id*. at 1056.

insurance company must defend its insured in actions that are even potentially within coverage, its duty to defend was broader than its duty to indemnify.

However, comprehensive general liability policies are intended to protect the insured from liability for injury or damage to the persons or property of others; they are not intended to pay the costs associated with repairing or replacing the insured's defective work and products, which are purely economic losses. Finding coverage for the cost of replacing or repairing defective work would transform the policy into something akin to a performance bond. The underlying complaint did not clarify what explicit damages Crown sustained, nor did it specify whether anything other than the building was damaged. Since the complaint exclusively alleged damage to the structure itself, that in itself was insufficient to trigger Consolidated's duty to defend. Here, the factual allegations of the complaint cannot support LMI's assertion that Crown alleged anything other than defective construction because the complaint was devoid of any facts that would support this construction. Because the complaint only alleged damage to the structure itself, Consolidated's duty to defend was not triggered.

## III. PROFESSIONAL LIABILITY COVERAGE

### A. Duty to Defend

#### *1.* Illinois State Bar Ass. Mut. Ins. v. Frank M. Greenfield and Associates

Holding: A provision in malpractice insurance was against public policy, when it may operate to limit an attorney's disclosure to his clients. Consequently, a voluntary payment clause did not provide a defense to ISBA Mutual.[21]

In *Illinois State Bar Ass. Mut. Ins. v. Frank M. Greenfield and Associates*, the court addressed the issue of whether an admission of error in a legal malpractice claim by a policyholder without his insurance company's approval gave the company the right to deny coverage and not defend the malpractice suit.[22]

Greenfield had a professional liability insurance policy through Illinois State Bar Association Mutual Insurance Company (ISBA Mutual). ISBA Mutual filed a complaint for declaratory judgment in which it alleged that the law firm of Frank M. Greenfield & Associates, P.C., was the named insured on a professional liability insurance policy issued by ISBA Mutual and Greenfield individually. The firm and Greenfield were named in a lawsuit

21. Illinois State Bar Ass. Mut. Ins. v. Frank M. Greenfield and Associates, 2012 IL App (1st) 110337.
22. *Id*.

initiated by the underlying plaintiffs, who sought compensatory damages for Greenfield's omission of a provision in a client's will, which allegedly damaged the underlying plaintiffs upon the client's death. The firm and Greenfield tendered their defense of the suit and ISBA Mutual accepted that tender, subject to a reservation of rights for the reasons underlying its complaint for declaratory judgment.

ISBA Mutual argued that it has no duty to defend the firm and Greenfield in connection with the underlying plaintiffs' complaint because Greenfield admitted liability in a letter dated June 17, 2008. Greenfield represented Leonard and Muriel Perry for estate planning. Leonard executed a will that poured his assets into a trust, Muriel did the same with her assets. However, in preparing the will, Greenfield "failed to include language that Muriel W. Perry was exercising her Power of Appointment from her deceased husband's trust."[23] Approximately a month after Muriel's death, Greenfield in a letter disclosed his omission of the power of appointment in the 2008 will to the beneficiaries of the trust. ISBA Mutual alleged that this letter was an omission of liability and relieved it of its duty to defend Greenfield and the firm pursuant to ISBA Mutual insurance policy which contains a provision entitled "Voluntary Payments," which provides: "The INSURED, except at its own cost, will not admit any liability, assume any obligation, incur any expense, make any payment, or settle any CLAIM, without the COMPANY'S prior written consent."[24]

The court first addressed the question of whether the voluntary payments provision in ISBA Mutual's insurance policy was enforceable. If it was not enforceable, then the second question of whether Greenfield admitted liability or merely admitted the facts concerning his mistake was immaterial. As an attorney, Greenfield had a duty to disclose his mistake to the beneficiaries. Attorneys have an ethical obligation to keep clients apprised of major developments in their cases. In fact, ISBA Mutual made it clear that "ISBA Mutual *does not* contend that its policy required Greenfield to be silent about the disparity between Muriel's intentions in her 2008 will and the actual expected distributions under the actual legal instrument." The court noted that this was a case of first impression, since there was very little case law concerning the effect of a "voluntary payments" clause. The public policy considerations at issue dealt with an attorney's ethical obligations to his client. ISBA Mutual claimed that it would not have interfered with Greenfield's discharge of his professional duties, but argued that it "would certainly have played a role in his disclosure of his error and its consequences, even if only by advising Greenfield in how to fulfill his ethical obligations in a way that would not compromise his defense to a malpractice

23. *Id.* at ¶ 7.
24. *Id.*

case."[25] The court was uncomfortable with the idea of an insurance company advising an attorney of his ethical obligation to his clients, especially since the insurance company may advise the attorney to disclose less information than the attorney would otherwise choose to disclose. Instead, absent instruction from the rules of professional conduct or the Attorney Registration and Disciplinary Commission, it is the attorney's responsibility to comply with the ethical rules as he understands them. The court held that the provision at issue here is against public policy, since it may operate to limit an attorney's disclosure to his clients. Consequently, the voluntary payment clause did not provide a defense to ISBA Mutual.

*2.* Illinois State Bar Association Mutual Insurance Co. v. Gold

Holding: In an application for a claims-made malpractice insurance policy, an attorney need not inform the prospective insurer about every client who has expressed dissatisfaction with the attorney's services.[26] A letter in which a client mentioned the possibility of suing an attorney for malpractice, and in which the client requested further professional services from the attorney on the client's behalf, did not notify the attorney of a claim for malpractice.

In *Illinois State Bar Association Mutual Insurance Co. v. Gold*,[27] Messner hired Gold to represent him in a lawsuit he filed against Cynthia and Sarabeth Krenzelak. The trial court entered a judgment against Messner. Messner sent Gold a letter expressing displeasure with how Gold handled Messner's lawsuit. However, in the same letter Messner asked Gold to perform further work on his behalf. When Gold sought to obtain new liability insurance from Illinois State Bar Association Mutual Insurance Company ("ISBA Mutual"), he did not inform ISBA Mutual about the letter from Messner. Three years after Messner sent the letter to Gold, Messner sued Gold for legal malpractice. Gold tendered defense to ISBA Mutual, who filed a declaratory judgment action in which it contended that it had no duty to defend or indemnify Gold for the claim because Gold knew of the claim at the start of the policy period. Gold filed a counterclaim asking the court to impose sanctions on ISBA Mutual for its vexatious claims practices.

The court reviewed whether Gold should have informed ISBA Mutual of the letter from Messner regarding his dissatisfaction and whether pursuant to the policy ISBA Mutual had a duty to defend and indemnify.

---

25. *Id*. at ¶ 24.
26. Illinois State Bar Association Mutual Insurance Co. v. Gold. 2013 IL App (1st) 122401-U (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
27. *Id*.

Messner's claim was covered under ISBA Mutual's policy. The policy took effect on September 1, 2006. As of that date, Gold knew that Messner sent him a letter, in March 2004, which accused Gold of being a lazy advocate, failing to use due diligence and failing to distill the information provided to Gold by Messner into a viable complaint. In the same letter however, Messner asked Gold to continue to represent him in negotiations with the Krenzelaks and later Messner agreed that Gold should prepare the brief for the appeal from the adverse decision the trial court rendered. The appellate court affirmed the trial court's judgment and Messner took no further action and made no further complaints against Gold for more than a year from the date of the decision and the effective date of the policy.

The letter sent in 2004 informed Gold that Messner had considered "going to war" against Gold, but the letter did not state a clear and unmistakable intent to bring a claim for professional malpractice.[28] Further, Messner continued to seek and use Gold's professional services, both in the letter he sent in 2004 and thereafter, in negotiations and in an appeal. After, Messner made no further mention of dissatisfaction with Gold for more than two years before Gold applied for the insurance policy at issue here. The entire course of the attorney-client relationship showed that the threat of a claim has apparently dissipated before Gold applied for the policy that covered claims brought in 2006 and 2007. As of the effective date of the policy in 2006, Gold had no knowledge of a claim by Messner, and therefore the policy covered the claim Messner first made in 2007.

## IV. FIRST PARTY COVERAGE, PROPERTY DAMAGE CLAIM, HOMEOWNER CLAIMS

### A. Commercial Property Insurance

#### *1.* Ryding v. The Cincinnati Special Underwriters Ins. Co.

Holding: A guardian's potential liability for injury to property of the ward's estate gave the guardian an insurable interest in the property.[29]

In *Ryding v. The Cincinnati Special Underwriters Ins. Co.*,[30] Kathleen R. Ryding, a supervised administrator of the estate of Helen Z. Fairchild, deceased, filed a lawsuit against the Cincinnati Special Underwriters Insurance Company ("Cincinnati"), which sought a declaratory judgment that a property insurance policy issued by Cincinnati covered fire damage to certain real property included in the estate.

---

28. *Id.* at ¶ 18.
29. Ryding v. The Cincinnati Special Underwriters Ins. Co., 2013 IL App (2d) 120833.
30. *Id*.

Prior to her death, Fairchild was a ward of the public guardian of Du Page County ("Public Guardian"). On December 23, 2008, Cincinnati issued or renewed policy of commercial property insurance with a declarations page identifying the named insured as: "Office of the Public Guardian for Dupage Co." The policy period was from December 23, 2008 to December 23, 2009. The policy provided that "the words 'you' and 'your' refer to the Named Insured shown in the Declarations. The words 'we', 'us' and 'our' refer to [Cincinnati]." A "Commercial Property Premises Schedule" was attached to the policy. Among the scheduled properties was certain improved real estate in Darien owned by Fairchild.[31] Fairchild died on February 1, 2009. On March 5, 2009, the Public Guardian was discharged and the public administrator for Du Page County was appointed as administrator of Fairchild's estate. On September 24, 2009, a residence and a detached garage on the Darien property was destroyed by fire. Cincinnati denied a claim for the loss, asserting that the policy cover the Public Guardian's insurable interest in the property and that the Public Guardian, having previously been discharged after Fairchild's death, had no insurable interest in the property at the time of the loss.

The issue before the court was whether the policy covered the Public Guardian's insurable interest in the property. Cincinnati argued that, after the Public Guardian was discharged, it no longer had an insurable interest in the Darien property and thus Fairchild's estate, as a loss payee, was no longer entitled to recover under the policy. The court reasoned that the portion of the declarations page specifying the insured under the policy not only named the Public Guardian, but also made reference to an apparently nonexistent "Named Insured Schedule."[32] This gives reason enough for an inquiry into the intention of the parties as to the identity of the insured. It is clear from the face of the policy that the Public Guardian obtained coverage not to protect his own property interest but to protect the property interest of his wards.[33] Further, under basic principles of guardianship law, the premiums associated with coverage to Fairchild's property were chargeable to her estate. The court thus held that Fairchild's estate—not the guardian of the estate was intended to be the insured under the policy and that the damage to the Damien property was a covered loss.

31. *Id.* at ¶ 3.
32. *Id.* at ¶ 2.
33. *Id.* at ¶ 11.

B. Homeowner Insurance Coverage

*1.* Womick v. West Bend Mutual Insurance

Holding: That no ambiguity existed in the insurance policy issued to the insured and that the insured's costs to remove damaged tree debris from his property were not covered under the terms of the policy.[34]

In *Womick v. West Bend Mutual Insurance*,[35] John Womick sustained damage to several of his trees due to a storm that passed through the area. Womick alleged that strong winds broke several tree limbs but that these broken limbs were still connected to the trees and left hanging. Womick further alleged that because children played near the area, it was necessary to remove the damaged trees and other debris in order to make his property safe. Expenses to cut down the damaged branches, clean up the area, and remove the cut branches and other debris cost the Womicks $23,247.18. His property was insured by West Bend Mutual Insurance. The insurer paid the insured $1,000, which is all it claims Womick was entitled to under the terms of the policy. Womick filed a complaint against the insurer seeking a declaration that the terms of the policy are contradictory and ambiguous and that the ambiguity should be resolved against the insurer, as the drafter of the policy.

The issue before the court was whether the terms of the policy were ambiguous and would provide coverage for the entire amount of $23,247.18 expended by the insured in order to remove the allegedly hazardous partially broken tree branches from his property.

Covered property, as stated in section I of the property coverages portion of the policy, included the dwelling ("paragraph A"), other structures ("paragraph B"), and personal property ("paragraph C"). The parties do not contest that the plaintiff's house was considered the "dwelling." Paragraph A further states that although the dwelling was covered under the policy, the policy did not cover "land, including land on which the dwelling is located." Paragraph E under that same section, which lists the additional coverage, states that the insurer will pay the insured's reasonable expenses for the removal of "[d]ebris of covered property." Thus, a plain reading of this provision revealed that only debris from the dwelling itself, which would be Womick's house, would be covered in this instance. Paragraph E of the policy did provide partial coverage for felled trees, up to a $1,000 limit. The record shows that the insured already paid the insurer the $1,000 for his expenses to remove felled trees from his property. The policy may not

34. Womick v. West Bend Mutual Insurance., 2013 IL App (5th) 120327-U. (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).

35. *Id*.

specifically define the term "debris," but it can be clearly determined that only reasonable expenses incurred from removing debris from covered property was reimbursable. It also can be clearly determined that debris from trees or felled trees was not covered property as stated in the policy's "Property Coverages" section. Therefore, the court found no ambiguity nor did the court find any ambiguity created by the policy's lack of a "felled tree" definition, especially considering that Womick already received the maximum amount of reimbursement allowed under the policy for his expenses incurred from removing felled trees from his property.

C. Leased Premises

*1.* Doyle Trust v. Country Mutual Insurance Co.

Holding*:* That because the insurance policy defined personal and advertising injury as including "wrongful eviction[s]," Country Mutual had a duty to defend the Doyles in a federal lawsuit that involved allegations that the Doyles wrongfully evicted a tenant.[36] Further, the policy's exclusions were too broad to be enforced and also created an ambiguity in coverage that the court must resolve in the Doyles's favor. In the cross-appeal, the court found that the trial court did not abuse its discretion in denying the Doyles's request for sanctions pursuant to section 155 of the Insurance Code.[37]

In *Doyle Trust v. Country Mutual Insurance Co.*,[38] John T. Doyle Trust, Kevin C. Doyle, Michael W. Doyle, and Pamela Doyle (collectively, the Doyles) leased work space to Christian K. Nakiewicz-Lane. During the lease term, the Doyles sold the leased premises and in the process removed Nakiewicz-Lane's personal items. As a result, Nakiewicz-Lane filed a lawsuit against the Doyles in federal district court where he alleged that he had a valid lease to rent the premises, but he was still evicted. The Doyles requested defense and indemnity from Country Mutual Insurance pursuant to their insurance policy. Country Mutual denied having an obligation to provide defense and indemnity.

The issue before the court was whether the insurer had a duty to defend. The court determined that Country Mutual had a duty to defend the Doyles in the federal lawsuit pursuant to the policy's "personal and advertising injury" coverage provision. Nakiewicz-Lane alleged in the federal lawsuit that the Doyles violated the Illinois Forcible Entry and Detainer Act by evicting him and disposing of his personal contents. He further alleged that

36. Doyle Trust v. Country Mutual Insurance Co., 2013 IL App (2d) 121238-U. (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).

37 *Id.*

38. *Id.*

the Doyles did not compensate him for the value of those items. Section F.14(c) in the policy specified personal and advertising injury as including "*wrongful eviction* from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling, or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor."[39] The court stated that if the parties intended to limit the commonly understood definition of "eviction" to include only wrongfully evicting a person and not property, they could have added express language in the policy to reflect that intent. The court refused to restrict the definition of eviction because the policy listed that phrase under "personal and advertising injury" as opposed to under "property damage." In any event, to the extent an ambiguity is created by listing "wrongful eviction" under "personal and advertising injuries," and not under "property damages," the court must construe ambiguity liberally in favor of the Doyles. In sum, by listing "wrongful eviction" under the policy's "personal and advertising injury" section, the parties did not intend to limit the plain and ordinary meaning of "eviction" to cover only physical harm to a person. Accordingly, because Nakiewicz-Lane alleged in the federal lawsuit that his personal property was damaged as a result of Doyles's wrongful eviction, Country Mutual had a duty to defend the Doyles in that proceeding.

The second issue before the court was whether the Doyles are entitled to section 155 sanctions. 29 Section 155 of the Insurance Code allows for an award of attorney fees and costs for an insurer's "unreasonable and vexatious" refusal to comply with its policy obligations. However, an insurer will not be liable for fees and costs merely because it litigated and lost the issue of insurance coverage; that is, if a *bona fide* dispute existed regarding insurance coverage, the insurer's delay in settling a claim does not violate section 155.[40] The court determined that Country Mutual had a bona fide reason with which to challenge coverage. Country Mutual could have believed that the policy encompassed such harm as Nakiewicz-Lane suffered.

39. *Id.* at ¶ 13.
40. *Id.* at ¶ 29.

D. Property Damage: Fire

*1.* Murphy v. State Farm Fire and Casualty Co.

Holding: An insured had an insurable interest in building at time of fire even though they had previously contracted for demolition of building.[41]

In *Murphy v. State Farm Fire and Casualty Co.*,[42] Sean and Eric Murphy (Murphys) brought suit seeking recovery for fire damage to their property, which was insured by State Farm Fire and Casualty Company. In 2004, the Murphys bought a parcel of property with a multi-unit residential building at 2128 N. Winchester, Chicago, Illinois (the building). State Farm insured the building. Initially, tenants occupied three of the four units in the building. However, the Murphys never renewed any of the tenants' leases as they began to consider demolishing the building and constructing a new residential luxury home on the property. The last tenant left the building in the fall of 2004. After the building was left vacant, the Murphys canceled all the utilities and had the gas meters removed. In front of the existing building, the Murphys had posted a sign advertising the sale of a new single-family luxury home that they considered constructing on the site. The sign contained pictures of the planned home with the caption, "Coming soon." The Murphys had consulted an architect for the purpose of drawing up plans for the new home and obtained a loan. They also acquired permits from the City of Chicago for demolition. Six months after the Murphys signed the demolition contract there was a fire. State Farm representatives surveyed the property and estimated the damage to the building at about $60,000. State Farm denied liability. It claimed that the Murphys concealed and misrepresented facts and also contended that the building had an actual value. The Murphys filed a claim in which they sought recovery for the fire damage and asserted claims for breach of contract and a statutory violation, pursuant to section 155 of the Illinois Insurance Code,[43] based on the unreasonable and vexatious delay to settle their claim. State Farm filed affirmative defenses and a motion for summary judgment, in which it asserted that the Murphys had no insurable interest at the time of the fire.

The issue before the court was whether a property owner had an insurable interest when the building was under contract to be demolished but the demolition had not yet begun. Most Illinois courts have adhered to defining insurable interest as "a person has an insurable interest in the property whenever he would profit by or gain some advantage by its continued existence and suffer loss or disadvantage by its destruction."[44] A

41. Murphy v. State Farm Fire and Casualty Co., 2012 IL App (1st) 112143.
42. *Id*.
43. 215 ILL. COMP. STAT. 5/155 (West 2006).
44. *Id*. at ¶ 9.

party may have an insurable interest in the property even if he or she does not possess the property or even own it. The court stated that an insurable interest should be determined at the moment of loss and should be determined by speculating about uncertain events.[45] The mere existence of a demolition contract should not control whether the insured possessed an insurable interest in the property prior to the demolition beginning. Here, six months had elapsed since the Murphys entered into the contract to demolish the building and no physical destruction had started. A number of possible future events could have occurred that would cause the Murphys to not demolish the building.

E. Property Damage: Water

*1.* Grinnell Mutual Reinsurance Company v. Hubbs

Holding: It was well settled that an insurer may either seek a declaratory judgment or defend the suit against its insured under a reservation of rights.[46] The court determined that there was no authority to support the proposition that an insurer must defend a claim under a reserve action of rights.

In *Grinnell Mutual Reinsurance Company v. Hubbs*,[47] the insurance company, Grinnell Mutual Reinsurance, brought a declaratory judgment against Larry and Leeann Hubbs and John Mercer. Mercer brought an action against the insured and alleged damage to his cropland caused by the insured's alteration of the flow and level of surface groundwater caused by the Hubbs' construction of a holding pond. The Hubbs tendered Mercer's claim to Grinnell for defense. By letter Grinnell denied coverage based upon the following policy exclusions: "We do not cover property damage resulting from diversion or obstruction of streams or surface water, or from interference with natural drainage to or from the land of others."[48]

The court addressed the question of whether the language of the policy was clear and unambiguous as to exclude Mercer's claim from coverage. Illinois law has long recognized that insurance policies, including exclusionary provisions, will be applied as written unless they violate public policy. The policy at issue excluded coverage for damage that resulted from "diversion or obstruction of streams of surface water" or property damage that resulted from "interference with natural drainage to or from the land of others."[49] The insured maintained that: (1) there was no proof in the record that the construction of the retention pond "resulted" in damage to Mercer's

45. *Id*. at ¶ 16.
46. Grinnell Mutual Reinsurance Company v. Hubbs, 2013 IL App (3d) 110861.
47. *Id*.
48. *Id.* at ¶ 1.
49. *Id*. at ¶ 9.

property; and (2) the term "drainage" in the exclusion is ambiguous since it could be read as to apply only to "surface" drainage and not "subsurface" drainage.[50] The insured further maintained that if the construction interfered with the drainage of Mercer's property it only impaired "subsurface" drainage and the policy can be read to provide coverage for Mercer's alleged property damage.

The court stated however that the insured's argument failed as a matter of law. In Illinois, the term "drainage" applied to both surface and subsurface drainage patterns. Therefore, as a matter of law the term drainage in the policy exclusion must be read to include both surface and subsurface. The court reviewed the pleadings and supported attachments and found no genuine issue of material fact. The record clearly established that construction of the retention pond interfered with the natural drainage on Mercer's land and resulted in damage to Mercer's property. The insured also argued that the trial court erred in considering testimony of experts, because a trial court may not consider any evidence beyond the four corners of the insurance policy when determining whether a duty to defend exists under the policy. The Illinois Supreme Court had rejected that notion. All evidence properly before the court may be considered when determining whether an insurance company had a duty to defend the insured under the policy.[51] The court therefore determined that it was appropriate to consider the testimony of the witnesses. Insured's final argument was that Grinnell's declaratory judgment should be denied because it can defend the claim under a reservation of rights. The court determined that that argument lacked merit. It is well settled that an insurer may either seek a declaratory judgment or defend the suit against its insured under a reservation of rights. The court determined that no authority had been offered to support the proposition that an insurer must defend a claim under a reserve action of rights.

F. Valuation of Property Damage

*1.* Area Erectors Inc. v. Travelers Property Casualty

Holding: (1) actual cash value of damaged crane, rather than replacement cost, was appropriate method of value; (2) owner lacked private right of action under statute listing acts committed by an insurance company that constitute improper claims practices; (3) insurer did not act in a vexatious or unreasonable manner in handling claim regarding one crane; and (4) insurer did not act in a vexatious or unreasonable manner when responding to claim for second crane.[52]

50. *Id.*
51. *Id.* at ¶ 11.
52. Area Erectors Inc. v. Travelers Property Casualty, 2012 IL App (1st) 111764.

In *Area Erectors Inc. v. Travelers Property Casualty*,[53] Area Erectors Inc. (AEI) filed a complaint for declaratory judgment against Travelers Property Casualty which sought a declaration that it was entitled to recover the replacement costs of its damaged property and seeking statutory penalties from Travelers for its vexatious refusal to settle its claim. At issue is the measure of the valuation of the property under the policy. In its complaint for declaratory judgment AEI alleged that on July 21, 2008 an American 7150 crane that it owned was damaged when an unexpected microburst storm came through a construction site and toppled concrete walls onto the crane. Two days later a Link-Belt crane owned by AEI was damaged in an unrelated incident when the boom hoist cable snapped and fell onto the manlift. AEI was insured under the commercial inland marine insurance policy issued by Travelers. AEI filed claims under the policy for the two damaged cranes.

The court addressed four issues: whether actual cash or replacement cost were the appropriate method of valuation; whether the insured was entitled to statutory penalties and attorney fees; whether the insurer acted vexatiously and unreasonably and whether the insurer in handling the claim for the second crane acted vexatiously and unreasonably.

To determine whether replacement costs of the 7150 crane was the appropriate valuation for the loss of the crane the court looked to the endorsement titled "'Contractors Equipment' Coinsurance and Valuation." Paragraph A of the endorsement established the minimum amount of insurance AEI was required to maintain on its equipment before a coinsurance penalty is incurred. Regardless of the age of the equipment, AEI was required to insure its property for at least 80% of its value to avoid the penalty in the event of a loss. The value of "listed" items less than five years old is the replacement cost. The value of listed items over five years old and unlisted items was the actual cash value. Here it was undisputed that both cranes were more than five years old at the time of the loss. Paragraph B of the endorsement provided two formulas to calculate the value of lost property depending upon which of the two valuations applies. The court determined that when the policy was read as a whole, including paragraphs A and B of the "'Contractor's Equipment' Coinsurance and Valuation," the endorsement was not ambiguous and the actual cash value was the proper method of valuation for the damaged American 7150 crane.

In regard to the second issue of whether AEI's claims fall under section 154.6 of the Insurance Code, the court found that this section does not give rise to a private remedy or cause of action by a policyholder against an insurer but was instead regulatory in nature. Under the section the State Director of Insurance was vested with the authority to charge a company with section

53. *Id.*

154.6 improper claims practices and serve the company with notice of a hearing date. If a company was found at the hearing to have engaged in improper claims practice, the Director can order the company to cease it practices and has discretion to suspend the company's certificate of authority and/or impose civil penalty. Therefore, the court stated that AEI cannot personally seek damages from Travelers under 154.6. However, a private action was available under section 155 if there was an issue of liability of a company on a policy or policies of insurance or the amount of the loss payable or for unreasonable delay in settling a claim and it appeared to the court that such action or delay was vexatious and unreasonable.[54] The court found that Travelers did not act in a vexatious and unreasonable manner in regard to the 7150 claim because a bona fide coverage dispute existed. This bona fide coverage dispute resulted in instant action. Therefore AEI was not entitled to 155 penalties. In regard to section 155 penalties for the Link-Belt crane, Travelers failed to affirm or deny liability within a reasonable time. Approximately five weeks from the date the crane was damaged Travelers informed AEI of its repair estimates and the amount it would pay under the policy. Therefore the court could not conclude that the action by Travelers was vexatious and unreasonable. The record showed that Travelers responded in a reasonable time to AEI's initial claim on the Link-Belt claim. It also responded accordingly when AEI disputed the amounts Travelers offered in the settlement of the claim. The record shows a bona fide coverage dispute existed and therefore section 155 penalties are not warranted for Travelers' handling of the Link-Belt claim.

G. Tolling of the Limitation Period

*1.* Burress-Taylor v. American Security Insurance Company

Holding: (1) letter from insurer to insured did not constitute a denial of insured's claim, so as to restart tolled limitations period, and (2) insured's consumer fraud claim was not preempted.[55]

In *Burress-Taylor v. American Security Insurance Company,*[56] fire damaged Ollia Burress-Taylor's home and she brought an action for breach of contract, deceptive conduct in violation of the Illinois Consumer Fraud and Deceptive Business Practice Act, and a declaratory judgment against American Security Insurance Company that sought to recover insurance proceeds under her claim. Burress-Taylor's home was secured by a mortgage from Homecomings Financial, LLC and she had a force-placed residential insurance policy included in her mortgage. A forced-place insurance policy

54. *Id*. at ¶ 31.
55. Burress-Taylor v. American Security Insurance Company, 2012 IL App (1st) 110554.
56. *Id*.

is a policy procured by the lender. The policy was underwritten by American Security Insurance Company and provided for $124,000 in dwelling coverage. There was a provision in the policy that stated that if there is any other insurance, which would attach if the insurance under this policy had not been affected, this insurance shall apply only as excess and in no event as contributing insurance and then only after all other insurance has been exhausted. The policy also contained an Illinois Amendatory Endorsement which stated that no action shall be brought unless there was compliance with the policy provisions and the action had started within one year of the loss. Burress-Taylor was also insured by a policy that she had procured from Hanover Fire Casualty Insurance. Hanover's policy contained a "Pro Rate Liability" clause. The clause states that Hanover "shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not."[57] Hanover issued a check in the amount of $56,854.64 for the fire damage to the dwelling to Burress-Taylor and Homecomings. Homecomings took possession of the Hanover check and disbursed $18,951.55 to Burress-Taylor. The mortgage agreement between her and Homecomings provided that Homecomings had the right to "disburse [insurance] proceeds for the repairs and restoration in a single payment or in a series of progress payments as the work is completed."[58] Homecomings did not make further disbursements of the Hanover proceeds. Burress-Taylor requested that Hanover disburse more funds, it denied on the basis that the shared liability between Hanover and American Security was in dispute. American Security sent a letter to Burress-Taylor that informed her that its policy will not respond until all other insurance has been paid. The letter further explained that Hanover would need to "pay up to $100,000 [under its policy] before [American Security] would pay" and that the "final due" amount payable under American Security policy was $23,709.56 after subtracting the $500 deductible. The $23,709.56 "final due" amount was calculated based on its assertion that Hanover was liable for $100,000 in dwelling coverage.

The court addressed whether the letter from the insurer to the insured constituted a denial of the insured's claim which would trigger the commencement of one-year limitation period. The court determined that the letter was not a denial. Nothing in the letter indicated that Burress-Taylor's claim was denied. American Security was unable to point to language in the letter that could be interpreted as a denial of her claim. At most, the letter informed Burress-Taylor of the status of her claim and the policy's limits. Section 143.1 of the Insurance Code was an important statutory restriction

57. *Id.* at ¶ 6.
58. *Id.* at ¶ 6.

on contractual time limitation provisions. The purpose of 143.1 was to prevent an insurance company from sitting on a claim, allowing the limitation period to run which deprived the plaintiff of the opportunity to litigate the claim. Here, the insured failed to advise Burress-Taylor in the letter of the number of days the limitation period was tolled or how many days remained before her time to file suit expired as the insured would have been required to do by section 919.80(d)(8)(c) of title 50 of the Administrative Code upon denial of her claim.

The second issue addressed by the court was whether insured's consumer fraud claim was preempted. The relevant inquiry regarding a Consumer Fraud Act claim was whether the alleged conduct implicated consumer protection issues. To state a claim under the Consumer Fraud Act, a plaintiff must allege: "(1) a deceptive act or practice by the defendant; (2) the defendant's intent that the plaintiff rely on the deception; and (3) the occurrence of the deception during a course of conduct involving trade or commerce."[59] A consumer fraud claim may not be based on a breach of a promise contained in the insurance policy. Insurer argued that insured's consumer fraud claim was preempted by section 155 because it was not separate and independent of her breach of contract claim. The court found her consumer fraud claim separate and independent of her breach of contract claim. Although her consumer fraud claim incorporated by reference and realleged the factual basis underlying her claims, it was not based on insured's breach of contract based on the insurance policy. Rather her property raised the three elements of fraud claim set forth above.

## V. AUTOMOBILE COVERAGE, THIRD PARTY LIABILITY, FIRST PARTY UM AND UIM COVERAGE

### A. Policy Terms, Conditions and Exclusions

#### *1.* Am. Country Ins. Co. v. Chicago Carriage Cab

Holding: A passenger's injuries did not arise out of the operation, maintenance, or use of a vehicle, and were found not to be covered under a taxicab company's automobile insurance policy.[60]

In *Am. Country Ins. Co. v. Chicago Carriage Cab*,[61] an automobile insurer brought a declaratory judgment action in which it alleged that it had no duty to indemnify Steven Cox, passenger, of insured taxi for injuries sustained during a robbery. Cox hailed a taxi at the corner of Randolph and

59. *Id.* at ¶ 29.
60. Am. Country Ins. Co. v. Chicago Carriage Cab, 2012 IL App (1st) 110761.
61. *Id.* at ¶¶ 1–2.

Halsted in Chicago. The taxi contained license and registration for a driver along with a photograph. Cox instructed the driver to proceed on Halsted to Milwaukee Ave. The driver turned the wrong way down Wayman Street and stopped in an alley. A moment later a man in a ski mask entered the backseat of the taxi and robbed Cox. After the crime, Cox identified Williams as the man he believed had involvement in the robbery.

Williams testified that he allowed his friend Kingsley to drive the taxi at night. Williams knew that Kingsley's driver's license was suspended. Williams left his photo and license posted in the taxi when Kingsley so passengers believed that someone with a valid license was driving. Hail Hacking Corporation held the license and medallion for the taxi, and procured the insurance policy that covered the taxi from American Country Insurance Company. American Country filed its declaratory judgment action to absolve it of an obligation to pay damages.

The court reviewed the passenger's injuries that arose out of the ordinary use of the taxi as covered by the American Country policy. Coverage under the American Country policy applies if the damages were "caused by an, accident and resulting from the ownership, maintenance or use of the covered auto."[62] Negligent entrustment of a cab involved the "use of a covered auto" as provided by the policy.[63] The salient question is whether what happened to Cox commenced with the use of the taxi qualifies as an "accident" under the terms of the policy. The court reasoned that when criminal acts occurred that were related to an auto but outside the realm of typical use of an auto, there was no coverage. A connection must exist between the accident or injury and the ownership, use, or maintenance of the vehicle in order for the accident or injury to be covered under the policy. The fact that a vehicle was the site of an injury was not enough to create a connection between the use of the vehicle and the injury to make the injury covered by the policy. For coverage to exist, the driver's actions must conform to the typical use of an automobile. An injury that resulted from an assault inside the vehicle was not a normal consequence of operating the vehicle.

Cox alleged in his complaint that he was assaulted, battered, and robbed in the taxicab. Cox's testimony was provided in the underlying case and included in the summary judgment proceeding. As a result of that testimony, he was judicially estopped from now claiming that a material issue of fact exists. Cox testified that Kingsley took him into an area where he did not want to go, exited the cab and together with the other man who arrived at the scene proceeded to beat and rob him. After the beating and robbery, Kingsley, along with the other assailant returned to their vehicles and drove

62. *Id.* at ¶ 13.
63. *Id.* at ¶ 2.

away and left Cox in the street. Since coverage here was determined based on the undisputed facts of the case, Cox was judicially estopped from presenting a new position in a legal proceeding contrary to a position that was successfully argued in an earlier legal proceeding.

Williams argued that Hail Hacking was deficient in obtaining proper liability insurance as required under the Chicago Municipal Code. However, the Municipal Code requires a minimum policy of $350,000 per occurrence to cover injuries that resulted from occurrences caused by or that arose out of the operation or use of the licensee's vehicles.[64] The Municipal Code does not require licensees to carry policies for anything beyond occurrences that arose out of the normal operation or use of a vehicle. Hail Hacking obtained liability coverage from American Country to cover injuries caused by accidents that resulted from ownership, maintenance, or use of the covered vehicles.

The court determined that passenger's injuries did not arise out of the operation, maintenance, or use of a vehicle, and thus, were not covered under the taxicab company's automobile insurance policy.[65] Passenger was judicially estopped from arguing that his injuries resulted from taxicab driver's negligent act of stopping in an unsafe area that constituted a use of a covered auto under cab company's automobile policy; and taxicab license and medallion holder complied with city municipal code requirements by obtaining a policy of insurance in the amount of at least $350,000 per occurrence to cover injuries caused by or arising out of the operation or use of licensee's vehicles.

64. Chicago Municipal Code § 9–112–220 (amended July 12, 1990).
65. *Id*. at ¶ 31.

B. Named Insured Exclusion

*1*. Hastings Mutual Ins. Co. v. Carpentier

Holding: The insured's farm owners' umbrella policy applied to a vehicle accident covered by an underlying farm owners' automobile policy, and the farm owners' personal vehicle policy did not cover the accident.[66]

In *Hastings Mutual Ins. Co. v. Carpentier*,[67] Ross Conrady, Katherine Carpentier, Christopher McGlasson, and Katelyn McCarty died as a result of injuries sustained when a Ford F–150 truck driven by Ross Conrady crashed. The truck was owned by Tri Pork Inc, a livestock operation controlled by the Conradys. Hastings Mutual Insurance ("Hastings"), Conradys' insurance company, filed an amended complaint for declaratory judgment.

The court reviewed two issues (1) whether Conradys' farmowners umbrella policy provided coverage for the accident as to Tri Pork based on the underlining insurance provision of the policy and (2) whether Conradys' personal automobile policy ("749 policy") provided additional coverage. At the time of the accident, Tri Pork Inc. was insured through a farmowners policy and a farm umbrella policy. Tri Pork was also identified as an additional insured in the personal auto policy ("756 policy") issued to Conrady. At issue is whether there was an existing underlying insurance for Tri Pork in order for it to be covered under the farm umbrella policy. Hastings' argument was that since the underlying insurance did not provide coverage for the subject accident, neither did the farm umbrella policy. The Conradys argued that the underlying insurance as described in the umbrella's declarations is in fact the '756' policy and since the '756' was in effect at the time of the accident, the umbrella's underlying insurance requirement was satisfied.

Considering the umbrella policy as a whole, rather than in isolated parts, an ambiguity existed because (1) no account number was listed, identifying the underlying policy or policies and (2) both of Tri Pork's policies include "comprehensive coverage" for the farm operation with $500,000 limits. Despite the ambiguity, Schedule A provides insight into which policy underlies the umbrella policy. Subsection "B" of Schedule A describes the underlying policy as being subject to the limits specified in Schedule A ($500,000) and "INSURES ALL LAND MOTOR VEHICLES OWNED OR HIRED BY THE INSURED AT INCEPTION OF THE CURRENT POLICY PERIOD."[68] The court found that the "Farmers Comprehensive

66. Hastings Mutual Ins. Co. v. Carpentier, 2013 IL App (4th) 120281-U (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
67. *Id*.
68. *Id*. at ¶ 21.

Liability" policy listed in Schedule A refers to Tri-Pork's automobile policy ending in "756."

In regard to the issue of whether Conradys' personal automobile policy ("749 policy") provided additional coverage, the 749 policy insured Conradys as to their 2005 Lincoln Aviator and 2006 Pontiac G6. The court interpreted the "749" policy to mean that it covered Ross Conrady for liability resulting from accidents involving the Lincoln and Pontiac. The exclusion in the policy stated that Hastings did not provide Liability Coverage for the ownership, maintenance or use of any vehicle, other than [the Lincoln and Pontiac], which was: (a) owned by any 'family member'; or (b) furnished or available for the regular use of any family member. However there was an exception to this exclusion. The exception did not apply to David and Lisa Conrady while they were maintaining or occupying any vehicle which was (a) owned by any 'family member'; or (b) furnished or available for the regular use of any family member. So the exception to the general exclusion to all vehicles except the Lincoln and Pontiac would have been applied to David and Lisa if they had occupied the Ford F-150 truck because they were "named insured" but did not apply to Ross because he was not a "named insured." So the court found that the policy contained an exclusion applied to the accident and barred coverage under the policy to the Estate of Ross Conrady.

*2.* American Access Cas. Co. v. Reyes

Holding: A provision that constituted a full exclusion of the named insured from liability coverage, as opposed to an exclusion of coverage only in limited circumstances specified in the insurance contract was invalid because the sole named insured, was not covered by liability insurance.[69]

In *American Access Cas. Co. v. Reyes*,[70] an automobile insurance policy was issued on September 2007 by American Access Casualty Company to Anna Reyes. The policy's statement of declarations listed Reyes as the "named insured," as well as the titleholder to the insured vehicle, a 1999 Chrysler 300M. However, in the policy's section identifying the "operators" of the vehicle, the policy listed two persons: (1) Reyes, with the notation "EXCLUDED" instead of a driver's license number; and (2) Jose M. Cazarez, with an "out of country/international" driver's license number. Further, Reyes executed an endorsement providing that American Access would not afford any coverage under the policy to any claim or suit that occurred as the result of Reyes operating any vehicle. Finally, the policy

69. American Access Cas. Co. v. Reyes, 2012 IL App (2d) 120296.
70. *Id*. at ¶¶ 1-3.

contained a provision excluding bodily injury and property-damage liability coverage for "any automobile while in control of an excluded operator."

On October 30, 2007, Reyes drove her car and struck pedestrians Rocio and Sergio Jasso. Rocio was seriously injured and Sergio, a minor, dies as a result of the injuries. Rocia and Sergio's father sued Reyes alleging negligence. In response, American Access filed an action in which they sought a declaration that, because Reyes was driving at the time of the accident, its policy provided no coverage for and no duty to defend any claims and litigation arising there from. State Farm, which provided uninsured motorist coverage to the pedestrians answered American Access's complaint and filed a countercomplaint for declaratory judgment, asking that American Access be estopped from excluding coverage for Reyes. State Farm argues that American Access attempted to exclude Ana Reyes, the titleholder, payer on the insurance policy, and resident at the address of where the vehicle was garaged and located with full access to the vehicle was contrary to law and public policy and cannot be enforced. Ana Reyes' exclusion would result in no one insured under the policy.

The court reviewed whether the exclusion of the only named insured and automobile owner form coverage as a driver under a liability insurance policy contravenes public policy. The court reviewed Section 7–601(a) of the Illinois Safety and Family Financial Responsibility Law which stated that "[n]o person shall operate, register or maintain registration of, and no owner shall permit another person to operate, register or maintain registration of, a motor vehicle designed to be used on a public highway unless the motor vehicle is covered by a liability insurance policy."[71] The insurance mandated by section 7–601(a) must meet certain requirements, pursuant to section 7–317(b)(2) of the Safety and Family Financial Responsibility Law. The statute mandates that a liability insurance policy insure the named insured *and* permissive users. The purpose of these mandatory liability insurance requirements is to protect the public by securing payment of their damages. An insurance policy provision that conflicted with section 7–317(b)(2) violated public policy and will be void.[72]

In the policy at issue, Reyes was sole named insured. Reyes was covered under the policy, since it provided Reyes with uninsured-motorist, bodily-injury, property-damage, and medical-payment coverage in the event that she was injured in an accident in which she was not the driver. However, that did not equate to liability coverage. The policy exclusion denied coverage when Reyes drove the vehicle, and was liable for an accident. Therefore, contrary to section 7–317(b)(2)'s mandate, the liability insurance policy did not cover the named insured. However, insurers may, without

71. *Id.* at ¶ 9 (citing 625 ILL. COMP. STAT. 5/7–601(a) (2006)).
72. *Id.*

running afoul of public policy, legitimately contract to limit the scope of their coverage but here there was not a mere restriction or limitation on Reyes' liability coverage: she had none. The provision constituted a full exclusion of the named insured from liability coverage, as opposed to an exclusion of coverage only in limited circumstances specified in the insurance contract. The court determined that the exclusion was invalid because the sole named insured, is not covered by liability insurance.

*3.* American Service Ins. Co. v. Arive

Holding: The named-driver exclusion was enforceable even though the policy insurance cards did not name the excluded driver.[73]

In *American Service Ins. Co. v. Arive,*[74] Kayla Schultz collided with a bus driven by Denise Arive. Arive filed an action against Kayla and Marenda Schultz for injuries sustained as a result of the accident. American Service Insurance ("American Service"), insured of Marenda Schultz, filed a declaratory judgment action against Arive, Kayla Schultz, Marenda Schultz, and the bus company that operated the bus during the incident. The policy covered Marenda's Chevrolet Astro van. American Service argued that it did not have a duty to defend or to indemnify with respect to any claims arising from the accident because Kayla Schultz was an excluded driver on the liability policy. Arive argued that the named-driver exclusion is void if the excluded driver's name does not appear on the insurance card provided to the insured.

The court reviewed whether an insurer, in order to enforce a named-driver exclusion in an automobile liability policy, must list the names of the excluded drivers on the insurance card it provides the insured. The court looked to section 7–602 of the Illinois Vehicle Code. The court reasoned that the plain language of this statute recognized that insurance policies may exclude named drivers from coverage. The court determined that from the "underlying purpose" of section 7–602, the statute's requirements as to the form of an insurance card are wholly unrelated to the validity of exclusions that appear in the policy. The insurance card was simply a form of "evidence," that was presented by a driver as proof of insurance to a law enforcement officer. An insurance card did not substitute the language of the policy. The purpose of section 7–602 is to ensure that law enforcement officers have adequate proof of insurance to assess whether a driver is in fact a named insured on the policy.[75] Section 7–602, indicated that the legislature "recognize[d] that insurance policies may exclude named drivers from coverage" and that such exclusions were therefore consistent with the public

73. American Service Ins. Co. v. Arive, 2012 IL App (1st) 111885.
74. *Id*.
75. *Id*. at ¶ 17.

policy of Illinois.[76] The court noted some public policy rationales for a named-driver exclusion: (1) protecting all potential claimants from damages resulting from automobile accidents by enabling drivers with family members having poor driving records to obtain affordable insurance; and (2) deterring insured drivers from entrusting their vehicles to unsafe excluded drivers.[77] Without a clear directive from the legislature that requirements as to the form of an insurance card dictate the enforceability of policy exclusions, the court cannot declare the exclusion here void as against public policy.

Therefore, court concluded that the named-driver exclusion was enforceable even though the policy insurance cards did not name the excluded driver. Where it is undisputed that the American Service policy excluded coverage for Kayla Schultz, American Service had no duty to defend or indemnify the Schultzes in the Arive suit.

C. Personal Automobile Liability Coverage

*1.* State Farm Mutual Automobile Insurance Co. v. Rodriguez

Holding: That seizure of the claimants' vehicles did not constitute "damage to" the vehicles and therefore was not a loss for purposes of comprehensive coverage under the State Farm automobile insurance policies.[78]

In *State Farm Mutual Automobile Insurance Co. v. Rodriguez*,[79] Heriberto Rodriguez, Raul Diaz, Ramiro Victoriano, Leonel and Josefina Alvarez purchased their cars from a private individual. After purchasing the automobiles, the cars were seized by law enforcement. They did not steal the automobiles nor were they aware that the vehicles were stolen at the time of purchase. Following the seizure of their automobiles, they each made claims for comprehensive coverage on their State Farm policies. State Farm issued automobile insurance policies to Heriberto Rodriguez, Raul Diaz, Ramiro Victoriano, Leonel and Josefina Alvarez and there was no dispute that the their State Farm policies were in force at the time of the seizures of the vehicles. State Farm provided rental car coverage which was extended twice while their claim was being investigated. State Farm ultimately denied the claim. After the denial of the claim, State Farm filed two declaratory judgment actions.

The court reviewed whether the seizure of insured's automobile by law enforcement constituted damage to the automobile and therefore insured

76. *Id.* at ¶ 9.
77. *Id.*
78. State Farm Mutual Automobile Insurance Co. v. Rodriguez, 2013 IL App (1st) 121388.
79. *Id*.

sustained an insurable loss. The claimants argued that they have an insurable interest in the vehicles, given that they were good-faith purchasers. They also argued that because the term damage was undefined in the policy, the court must look to the dictionary definition. In determining whether a good-faith purchaser of a stolen vehicle has an insurable interest in the vehicle the question becomes whether seizure of a vehicle by law enforcement constituted direct, sudden and accidental damage to the covered vehicle.[80] The court stated that although a seizure of a vehicle does constitute damage to the defendants, it does not constitute damage to the covered vehicle.[81] The defendants have not claimed that the seizure resulted in physical damage to the vehicles. The defendant further failed to suggest a reasonable interpretation of the term "damage" under which their vehicles, as opposed to the defendants themselves have been damaged.

Therefore, the court determined that the seizure of the claimants' vehicles did not constitute "damage to" the vehicles.

D. Cancellation by Insurer

*1.* Edwards v. State Farm Ins. Co.

Holding: Acceptance of a premium after the insurance company learns of a loss was one factor in determining whether an insurance company has waived its right to cancel. However, whether or not an insurer impliedly waived its written cancellation when it accepted a late premium from its insured is, at least in part, a question of fact that should be resolved by trial.[82]

In *Edwards v. State Farm Ins. Co.*,[83] Madeline Edwards brought a breach of contract cause of action against State Farm Insurance Company and State Farm Insurance agent Gaylord Nelson. Edwards purchased a six-month insurance policy from State Farm on July 7, 2008 and made a partial payment. On October 5, 2008 a balance of $3478.58 was due. Edwards did not pay and on October 10, 2008 State Farm mailed her a written cancellation notice that acknowledged her nonpayment. It also informed her that she had to make a payment by October 23, 2008 or her policy would be cancelled. If payment was made after October 23, 2008 she would receive notice of whether the policy would be reinstated. The notice informed Edwards that there would be no insurance coverage between the date of cancellation and the date of reinstatement. Edward's policy was cancelled on October 23, 2008. A month after the auto insurance was cancelled, Edwards was involved in an accident. Two days after the accident, Edwards called State Farm and

80. *Id.* at ¶ 25.
81. *Id.* at ¶ 26.
82. Edwards v. State Farm Ins. Co., 2012 IL App (1st) 112176.
83. *Id*. at ¶ 1.

stated she had been in an accident and now wanted to make her payment. Edwards was informed that the State Farm claims department would determine if it would provide coverage. Without any assurances, Edwards sent a payment of $347.58 via a cybercheck. However, the cybercheck did not clear due to insufficient funds. A week later, on November 28, 2008, she paid the $347.60 in cash to a clerk at her agent's office. Her auto insurance policy was reinstated effective November 28, 2008, and on December 3, 2008 State Farm sent a check to Edwards for $96.95, which was the amount calculated to be due back to her for the period the policy was not in force because of cancellation for nonpayment.

The issue before the court was whether State Farm waived its right to enforce the October 23, 2008 cancellation when an insurance agent's clerk accepted a late premium payment after the cancellation date. There was no dispute that Edwards failed to discharge her obligation in connection with the payment of her auto insurance premium. There was no dispute that State Farm afforded Edwards an appropriate grace period within which she could have made her late payment of the insurance premium. There was no dispute that the State Farm cancelled her auto insurance because of nonpayment of the premium and there was no dispute that she received State Farm's notice. Edwards did finally make a payment of the premium and the amount was accepted. State Farm processed the payment and applied it to the policy. State Farm acted consistently with the language in the notice. It reinstated the policy but did not provide retroactive coverage. The language in the notice informed Edwards that retroactive coverage would only be provided if the premium payment was made by a date certain. She did not pay her premium by that date and allowed her policy to be cancelled for nonpayment.

The facts provided by Edwards were not materially sufficient to support an allegation of State Farm's actual waiver of its defense that the policy was cancelled. Though she argued that the mere act of accepting Edward's payment after cancellation was enough to reinstate and backdate the policy to provide coverage for an accident that occurred during the cancellation period. Illinois cases that considered acceptance of a premium after the insurance company learned of a loss was one factor in determining whether an insurance company had waived its right to cancel.[84] However, those cases did not include the unequivocal language in a written notice regarding how the insurance company would treat a payment made after cancellation that State Farm used in its notice to Edwards.[85]

E. Contract Formation and Construction

84. *Id.* at ¶ 19.
85. *Id.*

*1.* Progressive Premier Ins. Co. of Illinois v. Emiljanowicz

Holding: When the contractor agreement provided that the insured corporation had exclusive possession, control and use of a leased vehicle, and at the time of the accident the vehicle was being operated on directions from the corporation, the vehicle was being used in the business of the corporation.[86]

In *Progressive Premier Ins. Co. of Illinois v. Emiljanowicz,*[87] SSTS and Emiljanowicz entered into a contractor operating agreement in which Emiljanowicz agreed to lease his freightliner to SSTS for the purpose of hauling freight. The president of SSTS, Alex Sandrzyk, stated that pursuant to the agreement the defendant would furnish the freightliner "for the exclusive possession, Control and use of" SSTS and "shall transport only freight of" SSTS. The contractor, however, assumed "complete responsibility for the operation of equipment for the duration of this agreement." Sandrzyk stated that it was SSTS policy to require its contractors to have their equipment inspected and serviced by a mechanic before transporting freight for the company. Once the agreement was signed Emiljanowicz was instructed to have his freightliner inspected by a mechanic. SSTS also issued decals to the Emiljanowicz that had to be placed on his freightliner. The decals indicated the authority to operate the freightliner pursuant to Department of Transportation regulations. Later that day, Emiljanowicz drove the truck to pick up a friend that would come with him so he could drop off the truck at the mechanic. Emiljanowicz stated that the truck did not have problems but he needed to have everything checked before he started his new job. On his way to pick up his friend, Emiljanowicz collided with a vehicle driven by Barbara Karawacki-Horowitz. At the time of the accident, Emiljanowicz was covered by an insurance policy issued by Progressive. Occidental issued a liability insurance policy to SSTS for coverage of all vehicles in service for SSTS, whether owned or leased by SSTS. Barbara Karawacki-Horowitz filed a claim against Emiljanowicz. Progressive defended the claim under a reservation of rights, and the claim was subsequently dismissed pursuant to a settlement. Progressive then filed a declaratory judgment action in which it sought a declaration of coverage under the Occidental policy for reimbursement for the defense and settlement of the Horowitz claims. Occidental filed a counterclaim and alleged no coverage under its policy since Defendant was not insured because he drove his vehicle to pick up a friend and was not engaged in the business of transporting property on behalf of SSTS at the time of the accident.

86. Progressive Premier Ins. Co. of Illinois v. Emiljanowicz, 2013 IL App (1st) 113664.
87. *Id*.

The court reviewed whether the corporation's insurance policy covered the freightliner when the contractor agreement provided that the insured corporation had exclusive possession, control and use of the vehicle, and at the time of the accident the vehicle was operated on directions from the corporation.

The determinative factor was whether SSTS had exclusive possession, control, responsibility and use of the freightliner at the time of the accident. Emiljanowicz was instructed to get his freightliner inspected and serviced by a mechanic pursuant to SSTS policy. Approximately three hours later, the accident occurred as he drove to get his friend. Emiljanowicz provided no other reason for driving the freightliner to his friend's house, and no testimony contradicted him on this issue. The court held that under the terms of Occidental's policy, Emiljanowicz was a covered insured.

Occidental's policy contained no specific provision for coverage of leased autos acquired after the policy begins. However, Emiljanowicz's freightliner was a leased "auto" within the definition of the policy. Occidental's policy also listed the freightliner as a specifically described auto in the "SCHEDULE OF COVERED AUTOS YOU OWN" section of the declarations.[88] It appeared that SSTS listed all of its leased trucks as specifically described autos. Occidental's policy was ambiguous insofar as it does not specify whether leased vehicles listed as a specifically described auto could be designated as such after the policy begins. The court found that Emiljanowicz's freightliner fell within the definition of covered autos for determining coverage acquired after the policy begins. The parties did not dispute that Occidental's policy covers all of the trucks SSTS leased to transport property. SSTS also added the freightliner within 30 days of the signed contractor agreement with Emiljanowicz. According to the terms of Occidental's policy, the freightliner is a covered "auto" under Occidental's policy. Further, the accident occurred as Emiljanowicz was in the process of taking his vehicle to the mechanic. Therefore, he was operating or maintaining his freightliner on behalf of SSTS at the time of the accident and as a result Progressive's contingent liability endorsement applies to exclude coverage.

*2.* State Farm Fire & Cas. Co. v. Abesamis

Holding: Negligent supervision, and not negligent operation or use of the vehicle, must be the sole proximate cause of the injury in order to be covered under the policy.[89]

88. *Id.* at ¶ 12.

89. State Farm Fire & Cas. Co. v. Abesamis, 2012 IL App (1st) 120541-U (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).

In *State Farm Fire & Cas. Co. v. Abesamis*,[90] Darline Abesamis was injured in an automobile accident. She was a passenger in a van that was transporting goods to New Orleans. Rossano Tolentino, the driver, fell asleep at the wheel. The van veered off the highway and overturned and as a result Abesamis was ejected from her seat. Abesamis in her complaint alleged negligence and negligent supervision against Ko, the employer, Ko d/b/a 1 Chiban Inc. ("Chiban"), and the driver, Rossano Tolentino. Specifically, Abesamis alleged that Ko directed his employees to transport merchandise from Chicago, Illinois to New Orleans, Louisiana. Ko knew that the Abesamis would accompany his employees on this trip. Further, Abesamis alleged that Ko instructed his employees to make this 14-hour, non-stop journey at night, despite the fact that he knew that they worked the previous day. With regard to the claim of negligent supervision, Abesamis alleged that Ko negligently packed and secured the merchandise in the cargo hold of the van, and negligently allowed three passengers to occupy the two-seat van.

State Farm issued an automobile policy to Ko as well as a business policy to Chiban. State Farm tendered its automobile policy limits of $100,000 in an effort to settle the claim. However, State Farm also filed a declaratory judgment in which it alleged that its business policy did not cover the incident because of the policy's motor vehicle exclusion. According to the exclusion, the insurance did not apply to "to bodily injury or property damage arising out of the ownership, maintenance, use or entrustment to others of any aircraft, auto, or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and loading or unloading."[91]

The issue before the court was whether a negligent supervision claim that arose from a vehicle-related occurrence must be completely independent of any negligent operation of the vehicle. Abesamis failed to identify any act of negligent supervision by Ko that did not depend on some form of vehicle negligence, whether it be the circumstances under which the vehicle was driven, the way in which the cargo was loaded, or the number of passengers allowed to occupy the vehicle. Because the success of Abesamis' negligent supervision claim against Chiban, premised on the negligent usage and operation of the vehicle, coverage is necessarily precluded by the motor vehicle exclusion in State Farm's policy. Consequently, the court held that negligent supervision, and not negligent operation or use of the vehicle, must be the sole proximate cause of the injury.

*3.* Grinnell Mutual Reinsurance Co. v. Haight

90. *Id*.
91. *Id*. at ¶ 5

Holding: A UIM Endorsement contained its own definition of who was insured and for individuals that included the named insured and family members, with no requirement that they occupy a covered auto. Also the Business Auto Coverage Form deemed "insureds" for liability coverage only to be persons who occupied covered autos did not preclude UIM coverage for daughter.[92]

In *Grinnell Mutual Reinsurance Co. v. Haight*,[93] Nicole Haight was hurt in a single-car accident, while a passenger in the car driven by Brian Day. Her medical bills exceeded $50,000 in bodily injury coverage that Day had through his carrier, Country Insurance. She then sought a claim for underinsured motorist coverage on a policy Grinnell Mutual Reinsurance Co. had been issued to her father. Day is not related to the Haights, nor did he work for Shawn Haight, and Day's car was not one of the two vehicles listed on Shawn Haight's policy. Grinnell Mutual maintained that Nicole was not entitled to UIM coverage under the policy issued to her father because she did not ride in a "covered auto" during the accident; Grinnell filed this action in which it sought a declaratory judgment to that effect.

The court reviewed whether Haight was entitled to UIM coverage under the policy because the car in which she rode in was not a covered auto. The UIM endorsement contained a "Named Insured" box, and "Shawn Haight" was filled in. He was also the "Named Insured" on the Business Auto Coverage Form Declarations. Some of the other documents referred to "Shawn Haight d/b/a SMH Rebuilding," but Grinnell did not contend that those references meant that the "Named Insured" in the UIM endorsement was something other than an individual. There was also no dispute that Nicole was a "family member" of Shawn Haight under the terms of the endorsement. The UIM endorsement defined "family member" to include a person related to the named insured by blood who resides in the named insured's household. Nicole was a teenager at the time of the accident, with parents who shared joint custody, and the parties do not dispute that she resided with her father for purposes of the policy.

Grinnell, however, contended that a read of the policy as a whole demonstrates that Nicole needed to occupy a "covered auto" to be afforded UIM coverage. Nicole was not in a covered auto during the accident, so Grinnell says she does not receive UIM coverage under the policy. The court concluded that the policy affords UIM coverage to the individual named insured and his family members but that did not require occupation of a covered auto. Nicole is therefore entitled to coverage.

The Business Auto Coverage Form stated that the "insured" meant the person qualifying as an insured in the "Who Is an Insured" provision of the

92. Grinnell Mutual Reinsurance Co. v. Haight, 697 F.3d 582 (7th Cir. 2012).
93. *Id*.

applicable coverage.[94] The applicable coverage here, the UIM Endorsement, stated in its "Who Is an Insured" section that when as here the named insured is an individual, then pursuant to B.1.a the named insured and any family members are "insureds."[95] So Nicole was entitled to coverage by the terms of B.1.a., as there was no qualification in B.1.a that the named insured or family member must have been occupying a covered auto. The Business Auto Coverage Form only deemed "insureds" for liability coverage to be persons who occupied a covered auto however that did not change the court's analysis. The "Who Is an Insured" provision in the liability coverage form specified that persons must be in a covered auto to be insured. But that is a liability provision, not a UIM provision, and the form also specified that "insured" meant the person or organization who qualified as an insured in the "Who Is an Insured" provision of the applicable insurance. The UIM endorsement had its own provision that defined who the insured was for its purposes. Grinnell also emphasized that the declarations page of the Business Auto Coverage Form showed "7" next to the selected coverage, including UIM coverage, which signified that the coverage only applied to "Specifically Described 'Autos.'" The court did not render the "7" designation irrelevant. Which autos are covered can be relevant in determining UIM coverage, including when sections B.1.b and B.2 apply, so the identity of covered autos was necessary and relevant.[96] But when there is no reference to a "covered auto," reference to the list of covered autos was not necessary.

*4.* State Farm Mutual Automobile Ins. Co. v. Woods

Holding: If the party moving for summary judgment supplies facts that, if not contradicted, would warrant judgment in its favor as a matter of law, the opposing party cannot rest on its pleadings to create a genuine issue of material fact.[97]

In *State Farm Mutual Automobile Ins. Co. v. Woods*,[98] Blake and Peggy Woods and their son, Chase, were involved in an accident when a car driven by Elizabeth Leonardi crossed the center line and struck the Woods's car head-on. Blake and Peggy Woods and their son were all injured. Leonardi's car was insured by Met Life and had liability limits of $25,000 per person and $50,000 per occurrence. Virzi's car was insured by Allstate and had underinsured motorist limits of either $250,000 or $500,000 per person and

94. *Id.* at 588.
95. *Id.*
96. *Id.* at 589.
97. State Farm Mutual Automobile Ins. Co. v. Woods, 2013 IL App (2d) 120556-U (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
98. *Id*.

$500,000 per occurrence. The Woods settled with Met Life and Allstate, receiving a total of $50,000 from Met Life and $450,000 from Allstate. Of those amounts, Blake was allocated $162,500, consisting of $12,500 from Met Life and $150,000 from Allstate.

Woods had insurance policies with State Farm. State Farm issued Woods an automobile insurance policy for a 2001 Dodge Caravan (policy no. 981 8998-B14-13F) and a personal liability umbrella policy (policy no. 13-VB-4928-1). State Farm also issued a policy to a corporation, The Blake Lathom Woods Group, Inc., for a 1999 Saab 9-S (policy no. 779 7541-B21-13Q). In August 2010, Blake asserted underinsured motorist claims under these policies. State Farm filed a complaint for a declaratory judgment. State Farm alleged that the three policies were in effect on "September 2, 2008." State Farm argued that there was no underinsured motorist coverage.

State Farm alleged that it issued an automobile policy to defendants for the Dodge Caravan "which policy was periodically renewed and which policy was in effect on September 2, 2006." State Farm noted that the certification for the policy was made by an underwriting team manager of State Farm, Gwen Wood, and that Wood stated that she was the custodian of records pertaining to the issuance of policies for the Fox Division of State Farm. State Farm maintained that these facts showed that the attached policy was the certified policy in effect on the loss date of September 2, 2006, with amendatory endorsement 612JJ having been added on February 14, 2006.

State Farm further cited policy provisions. Under the heading, "When Coverage Applies," the policy stated: "The coverage you chose apply to accidents and losses that take place during the policy period. The policy period is shown under "Policy Period" on the declarations page and is for successive periods of six months each for which you pay the renewal premium. Payments must be made on or before the end of the current policy period. The policy period begins and ends at 12:01 A.M. Standard Time at the address shown on the declarations page."[99] State Farm maintained that the policy, once issued, renewed automatically for the next policy term upon payment of the renewal premium. State Farm further cited a policy provision stating that the policy's terms may be changed by endorsement.

The court reviewed whether submitting an affidavit was sufficient to establish the effective date of the endorsement. The basic question of what policy was in effect on a given date was generally a factual issue rather than a legal conclusion. Regarding Wood's competency to make that statement, Rule 191 was satisfied if, the affidavit as a whole appeared to be based on the affiant's personal knowledge and there was a reasonable inference that the affiant could competently testify to its contents at trial.[100] Defendants

99. *Id.* at ¶ 28.
100. *Id.* at ¶ 33.

correctly point out that the attached declarations page listed various endorsements but not amendatory endorsement 6127JJ.

However, this was consistent with the affidavit and declarations page; Wood stated that the endorsement became effective on February 14, 2006, whereas the policy period listed on the declarations page is August 13, 2005, to February 14, 2006. While Wood argued that the relevant declarations page would logically have a policy period of August 13, 2006, to February 14, 2007, there was no evidence that State Farm issued a new declarations page every six months. As State Farm pointed out, the policy language stated that the policy period was shown on the declarations page "and is for successive periods of six months each for which you pay the renewal premium."[101] The policy also included language automatically renewing the policy for the next policy period when the renewal premium is paid.

F. Contract Construction: Policy Limitations

*1.* State Farm Mutual Automobile Ins. Co. v. LeBeau

Holding: Uninsured motorist coverage which required the bringing of a suit, action or arbitration request within two years did not violate public policy merely because it was applied to an insured that had an accident in a state, where the limitation period is three years.[102]

In *State Farm Mutual Automobile Ins. Co. v. LeBeau,*[103] LeBeau was driving an Oldsmobile Intrigue in Milwaukee, Wisconsin when she collided with an uninsured vehicle driven by Eris Brewer. State Farm Mutual Automobile Insurance Company sought a declaratory judgment against LeBeau. State Farm alleged that LeBeau could not recover uninsured motorist coverage under their policy. LeBeau demanded UM benefits under the policy. The policy's limitation clause stated, "Under the uninsured motor vehicle coverages, any arbitration or suit against us will be barred unless commenced within two years after the date of the accident."[104] At the time *Country Preferred Insurance Co. v. Whitehead,*[105] was just decided by the Illinois Supreme Court. In *Whitehead,* the Illinois Supreme Court held that uninsured motorist coverage which required the bringing of a suit, action or arbitration request within two years did not violate public policy merely

101. *Id.* at ¶ 29.
102. State Farm Mutual Automobile Ins. Co. v. LeBeau, 2013 IL (2d) 120443-U. (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
103. *Id*.
104. *Id.* at ¶ 5.
105. Country Preferred Ins. Co. v. Whitehead, 2012 IL 113365 (Ill. 2012).

because it was applied to an insured that had an accident in Wisconsin, where the limitation period is three years.[106]

The court reviewed the same issue that the Illinois Supreme Court just ruled on. Whether bringing a suit, action or arbitration request within two years violated public policy because the accident occurred in Wisconsin where the limitation is three years. The court followed the Illinois Supreme Court holding in *Whitehead*[107] and state that there was no violation of public policy just because Wisconsin has a longer limitation period.

G. Express Permissive User

*1.* Founders Insurance Co. v. Jose J. Leal

Holding: The insurance company seeking a declaratory judgment has the burden of proving that it was entitled to a declaratory judgment.[108]

In *Founders Insurance Co. v. Jose J. Leal*,[109] Founders Insurance Company ('Founders") brought a lawsuit seeking a declaration that it had no duty to defend or indemnify Jose Leal ("Jose") for an automobile accident which involved a vehicle that Founders insured because he was not a named insured on the policy. Founders alleged that the Juan Leal ("Juan") was the named insured on the policy issued to him and it covered a 1995 Ford pick-up truck. On February 26, 2010, Jose was involved in an accident while driving the truck. The policy that was issued to Juan provided liability coverage only to "Persons insured." That term was defined as "the named insured" and "any other person using such automobile with the permission of the named insured."[110] After the accident, Founders conducted an investigation and concluded that Jose was "non-permissive driver" of the truck. This conclusion was based upon recorded statements obtained from Juan and Jose. Therefore, Founder's alleged that Jose was not a person insured under the policy and it had not duty to defend or indemnify Jose. During trial, Juan testified that he did not give Jose permission to drive the truck but he was not aware that Maria, Juan's wife and Jose's mother, gave permission to Jose. Maria then testified that she gave Jose permission to drive the truck.

The court reviewed whether Jose was a permissive driver and whether Founders met their burden of proof. The court reasoned that Founders had the burden to prove that it was entitled to declaratory judgment because Jose

106. *Id.* at ¶ 6.
107. *Id*.
108. Founders Insurance Co. v. Jose J. Leal, 2013 IL App (1st) 121113-U (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1).)
109. *Id*.
110. *Id.* at ¶ 5.

was not entitled to insurance coverage since he was not a permissive driver.[111] The construction of an insurance policy's provisions and the ultimate determination of the parties' rights and obligations under the policy are a question of law which the court reviews de novo.

There was no dispute that the policy of insurance issued to Maria and Juan provided liability coverage with respect to the use of the truck to Juan and Maria and name insureds and any person using the automobile with their permission. The policy was required to cover the named insured and any person using the vehicle with the name insured's permission. At trial testimony was presented that indicated that Jose was given permission. The finding of fact is entitled to great deference by the court, because the circuit court was in a superior position to observe the witnesses to judge their credibility and determine the weight of their testimony. Founders reasserted the credibility attacks of the witnesses' testimony. However the court stated that resolving conflicts relating to the credibility of witnesses and the weight to be afforded their testimony is the province of the trial court. The court found that Founders had a duty to defend or indemnify because Jose had express permission to drive the truck.

H. Duty of Insurer to Defend

*1.* Economy Premier Assur. Co. v. Faith in Action of McHenry County

Holding: In *Economy Premier Assur. Co. v. Faith in Action of McHenry County*,[112] Reckamp, a volunteer for Faith In Action of McHenry County (FIA) was driving Matisse to the hospital in Coral Township, Illinois. During this time, Reckamp's vehicle was struck by a dump truck which caused Matuszek to suffer fatal injuries. As executor of the estate, Matuszek's son filed the underlying action against Reckamp and FIA.[113]

The complaint alleged that at the time of the accident, Reckamp was the agent, employee and servant of FIA. FIA had assigned Reckamp to transport Matuszek to the hospital because she was unable to drive. The complaint further alleged that Reckamp was negligent in operating the vehicle and, as a result, Matuszek suffered various injuries that caused her death.[114]

FIA's insurance (FNIC) denied coverage under its policy with FIA to defend or indemnify relating to the allegations of the complaint. FNIC quoted to portions of its policy in support of its determination, namely the "Non-owned and Hired Auto Liability (Coverage L)" section of its policy. FNIC

111. *Id.* at ¶ 24.
112. *Id*.
113. Economy Premier Assur. Co. v. Faith in Action of McHenry County, 2013 IL App (1st) 112329-U (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
114. *Id.* at ¶ 12.

stated that "[t]he police report confirms you were the owner and driver of the 1998 Olds involved in the accident on 9/2/2005" therefore the exception to non-owned vehicles applied.[115]

FNIC asserted that in the complaint Reckamp was identified as the owner of the vehicle in the accident and operated that vehicle as the agent, employee and servant of FIA and tendered its defense under Economy's primary policy. FNIC stated that Economy owed the primary obligation under its Reckamp policy with limits of $250,000/$500,000 and an additional $2 million under an umbrella policy.[116]

The court reviewed whether the insurer had a duty to defend. The insurer waited over 21 months after denying coverage to argue that the police report of the accident indicated the insured owned the vehicle and insured's personal automobile insurer admitted as much in response to insurer's counterclaim for declaratory judgment. The court held that insurer had a duty to defend because insurer waited to seek declaratory judgment and there was no admission by insured or other conclusive proof that he owned vehicle to meet non-owned vehicle exception of insured's policy and overcome potential for coverage in complaint.[117]

The court also determined that FNIC was estopped from asserting defenses including a claim that it was merely an excess insurer, for failure to timely seek declaration of rights. The court determined this based on the fact that FNIC denied coverage but did defend and sought declaratory action over 21 months after denial of coverage and only after insured filed declaratory action. Since the insurer was estopped it could not find refuge in proposition that claim is covered by a co-insurer to avoid duty to indemnify.[118]

*2.* Indiana Insurance Company v. Philadelphia Indemnity Insurance Co.

Holding: The court found that because a declaratory judgment was not filed to show that the 1995 International truck was not a scheduled vehicle, the insured owed a duty to defend under Illinois law. [119]

In *Indiana Insurance Company v. Philadelphia Indemnity Insurance Co.*,[120] Cougle Commission Company (Cougle) was in the business of distributing meat and poultry. Indiana Insurance Company (Indiana) insured the vehicles used in Cougle's delivery operation under a business auto policy up to $1 million. Indiana's policy provided coverage for scheduled autos

115. *Id.* at ¶ 19.
116. *Id.* at ¶ 20.
117. *Id.* at ¶ 44.
118. *Id.* at ¶ 60.
119. Indiana Insurance Company v. Philadelphia Indemnity Ins., Co., 2013 WL 1289058 (Ill.App. 1 Dist). (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
120. *Id*.

including leased vehicles and coverage for the lessor when a lease agreement required. Cougle entered into a truck lease agreement with Chicago Truck Leasing, Inc. (Chicago Truck), a company that leases commercial vehicles. On the schedule of leased vehicles was a 1995 International truck. Indiana provided coverage on the truck and for lessor Chicago Truck as an "insured" on the Cougle policy. Chicago Truck was insured by Philadelphia under a business auto policy and also a contingent and excess policy. Both policies required the lessor to provide Chicago Truck with primary insurance coverage. The Philadelphia business auto policy insured Chicago Truck up to $1 million and supplied coverage to anyone operating a scheduled motor vehicle with Chicago Truck's permission. The 1995 International truck was not scheduled on the Philadelphia policy. The Philadelphia contingent and excess policy insured only the named insured, Chicago Truck, up to $1 million.[121]

On July 28, 2004, Chicago Truck replaced the 1995 International truck with a 2005 International truck. Cougle informed Indiana to remove the 1995 truck from its insurance policy and replace it with the 2005 truck. On July 30, 2004, an agent from Cougle contacted Chicago Truck to get an extra truck for the day. Cougle and Chicago Truck entered into a one-day oral lease agreement for an extra truck. The vehicle provided by Chicago Truck was the 1995 International truck, which had been removed from the lease and was not scheduled as a covered vehicle under the Indiana or Philadelphia policies. On July 31, 2004, Illinois Department of Transportation employee Richard Donovan was assisting a disabled motorist on the shoulder of the Dan Ryan Expressway in Chicago when he was struck by the 1995 International truck driven by Cougle employee, Nicholas Pangallo. Donovan filed a complaint for against Pangallo and Cougle.

Pangallo and Cougle, filed a third-party complaint against Chicago Truck, where they alleged that Chicago Truck failed to inspect, maintain and repair the accident vehicle prior to leasing it to Cougle. The attorney for Pangallo and Cougle argued in a letter to Philadelphia that the allegations in the Donovan complaint triggered a duty to defend. Pangallo and Cougle sought a defense from the Donovan lawsuit and coverage from Philadelphia under Chicago Truck's business auto policy and contingent and excess policy. Philadelphia denied coverage based on the requirements under both Chicago Truck policies that the lessee, Cougle, provided primary coverage. Philadelphia also denied coverage because the 1995 International truck had never been scheduled on either of Chicago Truck's policies. Pangallo and Cougle defense was taken up by Indiana.[122]

121. *Id.* at. ¶¶ 5–8.
122. *Id.* at ¶ 16.

The Donovans filed an amended complaint that added Chicago Truck as a defendant. Indiana, Cougle, and Pangallo filed a two-count complaint for declaratory judgment against Philadelphia, Chicago Truck, and the Donovans. Cougle and Pangallo sought a declaration that Philadelphia breached a duty to defend them in the Donovan lawsuit based on Chicago Truck's business auto policy. They alleged that the business auto policy provided "permitted user" coverage for anyone using an automobile owned by and leased by Chicago Truck. They also alleged the "Other Insurance Conditions" section of the policy provides primary coverage for autos owned and leased by its insured, Chicago Truck. In count II, they sought a declaration that Philadelphia owed a duty to defend the Donovan lawsuit under Chicago Truck's contingent and excess policy.[123]

The court reviewed whether there was a duty to defend. To determine whether the underlying suit alleged a situation potentially within the insurance coverage, the court compared the bare allegations of the complaint to the relevant provisions of the insurance policy. Philadelphia argued that since Pangallo and Cougle were not parties to the insurance contract with Chicago Truck, they did not have standing to seek enforcement of the Chicago Truck policy. The court found evidence that the contracting parties intended coverage for permissive users of Chicago Truck's vehicles by including the "permitted users" clause in the policy. In addition, both the business auto policy and the contingent and excess policy provide coverage for "leased vehicles."[124] The record showed that Cougle and Chicago Truck entered into a long-term lease for a truck. With the inclusion of the permitted users' clause along with coverage for leased vehicles, the court determined that there was potential for coverage here.

*3.* Delatorre v. Safeway Ins. Co.

Holding: Insurer breached its duty to defend, and insurer was liable for entire amount of default judgment in excess of policy limits.[125]

In *Delatorre v. Safeway Ins. Co.*, Delatorre was a passenger in a car driven by Ruben when they were involved in an accident. Delatorre was injured. The drivers of the other car, Thomas Zentefis, as well as his passenger William Zenko, were injured. At the time of the accident, Ruben was insured under a personal automobile insurance policy issued by Safeway Insurance.[126]

123. *Id.* at ¶¶ 19–23.
124. *Id.* at ¶ 42.
125. Delatorre v. Safeway Ins. Co., 2013 IL App (1st) 1683596 (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
126. *Id.* at ¶¶ 4–5.

In December 1991, Delatorre made a demand for the policy limits, which Safeway refused; however, after learning of the negligence suits brought against Ruben, Safeway agreed to defend Ruben under a reservation of rights. In November 1992, it informed Ruben via letter that it retained an attorney to undertake his defense in the negligence suit brought by Delatorre. The letter stated that because Delatorre could potentially recover a judgment in excess of the policy limits, it could be prudent for Ruben to consider retaining additional counsel at his own expense.

The attorney filed an appearance and answer on behalf of Ruben on December 15, 1992, but there was no evidence that he took any further action to defend Ruben after that date. Safeway admitted that it paid no fees to the attorney in connection with his defense of Ruben, nor did the attorney submit statements for work he performed on Ruben's behalf. Delatorre moved for sanctions, and the court entered an order of default against Ruben on October 4, 1994. The order specified that the basis for the default was Ruben's "failure to comply with outstanding discovery."[127] Delatorre's attorney sent the order directly to Safeway. According to an affidavit by Safeway's claims manager the order was sent to the attorney on receipt. But this was the only written communication Safeway had with attorney since it retained him. A prove-up hearing on the default judgment was held in November 1995, and Delatorre was awarded $250,000 in damages. Ruben filed a complaint in which he alleged a breach of an insurance contract because insurer breached its duty to defend and he sought punitive damages against the insurer. As a result of Safeway's failure to provide an adequate defense, he became subject to a default judgment against him in the amount of $250,000.[128]

At the same time, Safeway pursued a declaratory judgment action against Delatorre, Ruben, Zentefis and Zenko. Specifically, Safeway sought a declaration that it was not liable for damages alleged against Ruben in the negligence actions due to the fact that Ruben had misrepresented his marital status on his application for insurance, this rendered his policy void.[129]

The court reviewed whether an insurer that has retained counsel to defend its insured, may, in certain limited circumstances, still be found to have breached its duty to defend and whether judgment can be entered against its insured. The policy carried a bodily injury liability limit of $20,000 per person and $40,000 per accident. The policy obligated Safeway to defend any suit brought against the insured for bodily injury or property damage covered by the policy, with the understanding that Safeway had no obligation to the insured once the policy limits were exhausted by payment. Here, Safeway informed its insured that it would undertake his defense in the personal injury suits against him, subject to a reservation of rights. And,

127. *Id.* at ¶ 7.
128. *Id.* at ¶¶ 6–7.
129. *Id.* at ¶¶ 8–9.

Safeway retained an attorney, who entered an appearance on behalf of the insured.

Safeway argued that it did more than merely retain an attorney. When it had learned that the insured had been subject to an order of default, it sent the order to the attorney. The court did not question the means that Safeway used to contact the attorney, but the fact that there was no evidence that Safeway made any further effort to obtain from the attorney why a default was entered or whether he sought to have it vacated. Safeway's passive, one way communication with the attorney lead the court to conclude that the Safeway breached its duty to defend.[130]

The court then reviewed whether Safeway was liable for the judgment entered against its insured in excess of the policy limits. Mere failure to defend did not, in the absence of bad faith, render the insurer liable for that amount of the judgment in excess of the policy limits. Damages for a breach of the duty to defend are measured by the consequences proximately caused by the breach. The entry of the final judgment by default in the underlying personal injury action included that portion in excess of policy limits and it directly flew from the breach of contract. The proximate cause of the default judgment, entered about 13 months following the default order, was Safeway's breach. This situation could have been averted altogether had Safeway seen to it that its insured was actually defended as contractually required.[131] Therefore, the insurer breached its duty to defend, and insurer was liable for entire amount of the default judgment in excess of policy limits.

*4.* Greenwich Ins. Co. v. John Sexton Sand & Gravel Corp.

Holding: The prior lawsuit triggered a duty to defend under the policies issued for the period of June 1, 2005, to June 1, 2006, as well as the later primary, excess and umbrella policies. [132]

In *Greenwich Ins. Co. v. John Sexton Sand & Gravel Corp*.,[133] the case deals with insurance coverage dispute regarding the operation of a landfill in Hillside, Illinois. Greenwich Insurance Company and Indian Harbor Insurance Company issued policies to John Sexton Sand & Gravel Corporation, Congress Development Company, Allied Waste Transportation Inc. and Republic Service Inc. Greenwich issued primary policies to Sexton and Congress for the policy period of June 1, 2005 to June 1, 2006, and June 1, 2006 to June 1, 2007.

130. *Id.* at ¶¶ 20–22.
131. *Id.* at ¶ 32.
132. Greenwich Ins. Co. v. John Sexton Sand & Gravel Corp., 2013 IL App (1st) 950755.
133. *Id.*

The policy stated that Greenwich agreed to pay the sums that the insured became legally obligated to pay as damages because of bodily injury or property damage. The policies are modified by an absolute pollution exclusion endorsement. The insurance does not apply to pollution. 'Bodily injury' or 'property damage' which would not have occurred in whole or part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants' at any time. The exclusion does not apply to 'bodily injury' or 'property damage' arising out of heat, smoke or fumes from a 'hostile fire' unless that 'hostile fire' occurred or originated: (a) At any premises, site or location which is or was at any time used by or for any insured or others for the handling, storage, disposal, processing or treatment of waste.

Indian Harbor issued the excess and umbrella policies to Sexton and Congress for the policy periods of June 1, 2005 to June 1, 2006, and June 1, 2006 to June 1, 2007.

These policies stated that Indian Harbor shall have the right and duty to defend any suit against the insured seeking damages covered by the policies, which provided two coverages. Coverage A provided "follow form" excess coverage, which means that, with exceptions not relevant here, the insurer provides coverage on the same terms as the underlying primary policies for loss amounts exceeding the limits of the underlying primary policies. Coverage B provided umbrella coverage for damages not covered by the primary policies. However under coverage B the insurance did not apply to: **"**Bodily Injury, Property Damage, Personal Injury or Advertising Injury arising out of the actual or threatened discharge, dispersal, seepage, migration, release or escape of Pollutants anywhere in the world; any loss**,** cost or expense arising out of any governmental direction or request that we, the Insured or any other person or organization test for, monitor, clean up, remove, contain, treat, detoxify, neutralize or assess the effects of Pollutants**;** or any loss**,** cost or expense, including but not limited to costs of investigation or attorney's fees, incurred by a governmental unit or any other person or organization to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize Pollutants**.**"[134]

Indian Harbor also issued a pollution policy to Republic for the period from July 30, 2009 to July 30, 2010. The pollution policy provides that Indian Harbor shall have the right and duty to defend an insured against a claim seeking damage for a loss or remediation expense. The policy also generally provides coverage for loss and related legal expenses resulting from any "pollution condition" on, at or migrating from any covered location, including the landfill at issue here. A "pollution condition" is defined as including the discharge, release, seepage, migration or escape of pollutants

134. *Id*. at ¶ 6.

"into or upon land, or structures thereupon, the atmosphere, or any watercourse or body of water including groundwater." An endorsement to the pollution policy contains a "contamination exclusion," which stated that the policy shall not apply to any loss, remediation expense or related legal expenses based on or "arising from" constituents including "[a]ll airborne contamination resulting in odors" or affecting the "[a]ir," where such constituents are "on, at, under or migrating from" the landfill.[135]

On December 23, 2009, hundreds of neighbors of the landfill filed a complaint against Congress as owner of the landfill, Sexton and Allied Transportation as general partners of Congress, and Allied Industries as a guarantor of Allied Transportation's obligations (Amber defendants). In *Amber v. Allied Waste Transportation, Inc.*,[136] ("Amber lawsuit") the neighbors asserted claims of bodily injury and property damage arising from negligence, trespass and nuisance on the part of the Amber defendants. The Amber complaints contained allegations regarding fires at the landfill. The intrusion of air into the landfill's gas collections system was allegedly caused by two subsurface fires and one surface fire at the landfill in 2002. Ignition of the waste allegedly generated additional gas at the landfill. Portions of the waste allegedly continued to burn below the surface of the landfill. In 2004 and 2005, high temperature readings caused Congress to conclude there was a subsurface fire at the landfill. In 2006, an Illinois EPA memorandum noted that scans of the landfill cover from January and February showed "classic signs of an underground fire." The Amber complaint specifically alleged that Congress had been unable to extinguish the fire below the surface of the landfill. In addition, the Amber complaint alleged that underground tremors from explosions at the landfill caused structural damage to the Amber plaintiffs' properties.[137]

The issue before the court was whether the insurance policy covered the contamination caused by the landfill and therefore the insurer had a duty to defend. In determining whether the allegations in the underlying complaint met that threshold requirement, both the underlying complaint and the insurance policy must be liberally construed in favor of the insured. "[T]he duty to defend does not require that the complaint allege or use language affirmatively bringing the claims within the scope of the policy."[138] All doubts are resolved in the insured's favor. In construing an insurance policy, the court must ascertain the intent of the parties to the contract by construing the policy as a whole, with due regard to the risk undertaken, the subject matter that is insured and the purposes of the entire contract. Where the words

135. *Id.* at ¶ 7.
136. *Id.* at ¶ 8 (citing Amber v. Allied Waste Transportation, Inc., No. 09 L 15741).
137. *Id.* at ¶ 8.
138. *Id.* at ¶ 21 citing International Insurance Co. v. Rollprint Packaging Products, Inc., 312 Ill.App.3d 998, 1007 (2000).

in the policy are clear and unambiguous, "a court must afford them their plain, ordinary, and popular meaning."[139] However, if the words in the policy are susceptible to more than one reasonable interpretation, they will be considered ambiguous and will be strictly construed in favor of the insured and against the insurer who drafted the policy.[140]

The Amber lawsuit alleged that the neighbors suffered bodily injuries from inhaling *and otherwise being exposed* to the chemical compounds in the landfill gas, without limitation to contaminants producing odors. The alleged other types of exposure are not specifically limited to airborne contamination or odors. The Amber lawsuit also alleged that Congress, Allied Transportation and Sexton were liable for trespass and property damage simply by allowing the migration of the landfill gas, including underground, onto neighboring properties. This damage may not be limited to airborne contamination or odors. Thus, liberally construing the complaint and the policy language in favor of the insured, the Amber lawsuit alleged facts that fall within, or potentially within, the coverage of Indian Harbor's pollution policy.[141]

A primary factor considered in determining if an occurrence constituted 'traditional environmental pollution' and, thus, was not covered under the absolute pollution exclusion, rests upon whether the injurious 'hazardous material' was confined within the insured's premises or, instead, escaped into 'the land, atmosphere, or any watercourse or body of water.' In this case, the Amber lawsuit alleged that the flares were part of the landfill operation's on-site attempt to treat and mitigate the escape of gases. This part of the landfill operation was confined within its premises. Moreover, the explosions are hardly traditional environmental pollution as such. To extend "but for" causation to encompass the alleged explosions here would run contrary to the limitation of the exclusion to traditional environmental pollution adopted by our supreme court in *Koloms*[142] and raise the potential for absurd results. Accordingly, the court concluded that the explosion-related allegations of the Amber lawsuit fall outside the absolute pollution exclusions in plaintiffs' policies.[143]

The circuit court relied on the Amber complaint's general allegation that "underground tremors from explosions in the flares at the Landfill caused many homes owned by the Neighborhood Property Damage Residents to shake, causing structural damage and further reducing the value of their properties." Resolving all doubt in favor of the insured, the court concluded

139. *Id.* at ¶ 21.
140. *Id.* at ¶ 21.
141. *Id.* at ¶¶ 23.
142. American States Insurance Co. v. Koloms, 177 Ill.2d 473 (1997).
143. *Id.* at ¶ 25.

that the general allegation raises the possibility of explosions prior to those in the more specific allegations of the Amber complaint.[144]

*5.* Empire Indemnity Ins. Co. v. Chicago Province of the Society of Jesus

Holding: The court held that the underlying complaint: (i) alleged facts that triggered either the "expected or intended" or the "Condition 1.a" exclusion; or (ii) alleged injuries that took place outside of the policies' effective dates.[145]

In *Empire Indemnity Ins. Co. v. Chicago Province of the Society of Jesus*,[146] Empire filed a declaratory judgment action (which FNIC, RLI, Mt. Hawley, and Pennsylvania General eventually joined) seeking a finding that there was no duty to defend the Jesuits against allegations of sexual abuse by Donald J. McGuire, a former priest and member of the Jesuits.[147] FNIC issued a nonprofit multiple-peril insurance policy effective from November 30, 1998, to November 30, 1999, and subsequently renewed the policy on an annual basis to November 30, 2004.

The bodily injury coverage provided that FNIC would pay sums that the Jesuits became legally obligated to pay as damages due to "bodily injury or property damage to which this coverage applies." This coverage was limited to bodily injury and property damage occurring "during the Term of Coverage" and specifically excluded damages "expected or intended from the standpoint of the insured." The sexual abuse or molestation coverage stated that FNIC would pay damages that the Jesuits become legally obligated to pay "arising out of any actual, threatened, intentional or unintentional sexual molestation of any person to which this coverage applies."[148] The sexual abuse/molestation coverage was also limited to sexual abuse or molestation occurring "during the Term of Coverage" and, under "Condition 1.a," the coverage would be cancelled "if any executive officer, supervisory employee, director or trustee [had] actual knowledge of any act, incident or alleged act of sexual abuse or sexual molestation."[149]

Pennsylvania General issued a one-year general liability policy beginning on November 30, 1990, and renewed the policy annually until November 30, 1998. The coverage for bodily injury liability excluded such injury "expected or intended from the standpoint of the insured," except for bodily injury "resulting from the use of reasonable force to protect persons

144. *Id.* at ¶ 26.
145. 2013 IL App (1st) 112346-U, ¶ 32 (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
146. Empire Indemnity Insurance Company v. The Chicago Province of the Society of Jesus, 2013 IL App (1st)112346.
147. *Id.* at ¶ 3.
148. *Id.* at ¶ 5.
149. *Id.*

or property."[150] With respect to the pastoral counseling professional liability, coverage was excluded, *inter alia*, for damages arising out of: (i) "the willful violation of a penal statute . . . committed by or with the consent of the insured"; (ii) "the actual or alleged conduct of a sexual nature" (although Pennsylvania General agreed to defend the Jesuits in any suit seeking damages from such conduct until judgment was rendered); and (iii) dishonest, fraudulent, or criminal acts or omissions of the insured.[151]

Empire issued a one-year umbrella liability insurance policy beginning on November 30, 2002, and renewed the policy annually to November 30, 2005. The policy indemnified the Jesuits for bodily injury liability caused by an "occurrence" in excess of a retained limit. An occurrence was defined as an "accident, including continuous or repeated exposure to substantially the same harmful conditions." The Empire policy also excluded coverage for bodily injury "either expected or intended from the standpoint of the insured."[152] RLI and Mt. Hawley both issued an umbrella liability policy to the Jesuits. RLI's one-year policy began November 30, 1990, and was renewed annually to November 30, 2001. Mt. Hawley's policy was effective from November 30, 2001, to November 30, 2002. Both policies provided bodily injury liability coverage, and as with the Pennsylvania General and Empire policies, they also excluded coverage for bodily injury "expected or intended from the standpoint of the insured."[153]

Several John Does sued the Jesuits, alleging that they had been either sexually abused or sexually molested by McGuire, then a priest and member of the Jesuits who had also been a "teacher and scholastic advisor" at Loyola Academy. The complaints all alleged negligence, intentional infliction of emotional distress, and fraud against the Jesuits.

The issue before the court was whether a Catholic religious order was insured for potential losses that resulted from alleged molestation of minors by one of its priests. To determine whether the insurer has a duty to defend the insured, the court must look to the allegations in the underlying complaint and compare those allegations to the relevant provisions of the insurance policy.[154]

The Jesuits contended that the complaints in the underlying litigation had allegations that the Jesuits either should have known, should have been aware, or had constructive notice of McGuire's prior sexual abuse of minors. They alleged that these allegations did not rise to the level of actual knowledge and therefore the "expected or intended exclusion" could not apply. However, the court stated that the terms "intended" and "expected,"

150. *Id.* at ¶7.
151. *Id.*
152. *Id.* at ¶ 9.
153. *Id.* at ¶ 11.
154. *Id.* at ¶34.

as used in similar insurance policy exclusionary clauses, are not synonyms: an "expected" injury is merely one that should have been "reasonably anticipated" by the insured.[155] Here, the factual section preceding the various counts of the complaints alleged that the Jesuits were aware of McGuire's abuse of minors in 1969 and had subsequently received numerous other complaints all of which took place prior to the respective times of the John Does' abuse. These allegations set forth that the Jesuits reasonably should have anticipated (or expected) McGuire's abuse of the underlying John Doe plaintiffs. As such, the expected or intended exclusion applies.[156]

Next the Jesuits claim that the policies unambiguously proved that any injury occurring during the policy term (including lingering emotional or psychological injuries) is covered regardless of when the harm giving rise to the injury occurred. In this case, the policy defined "sexual abuse or sexual molestation" in pertinent part as: "the infliction of harm of a sexual nature upon a person by any employee, agent or representative of [the Jesuits], whether such harm is physical, emotional or psychological."[157] The court does not agree with the Jesuit's interpretation that the manifestation of emotional or psychological injury during a policy period would under all circumstances relate back to the infliction of the sexual abuse causing that injury. The precise act giving rise to coverage is the infliction of some type of harmful or inappropriate sexual contact, not the subsequent emotional or psychological ill effects from that contact, even if those ill effects persist long after the sexual contact occurred. To hold as the Jesuits contend would improperly transform this occurrence-based policy into a claims-based policy. The court therefore found that the claims are not covered under FNIC policy.[158]

Condition 1.a cancelled any subsequent sexual abuse coverage if a "supervisory employee" of the Jesuits had "actual knowledge of any alleged act of sexual abuse or sexual molestation" committed by any "employee, agent, representative or volunteer worker." Furthermore, it is undisputed that McGuire, a teacher and scholastic advisor at Loyola Academy, was an employee of the Jesuits. The complaints alleged that supervisory employees (the president, principal, and the headmaster of the academy) had actual knowledge of an alleged act of sexual abuse by an employee, agent, representative or volunteer worker. In light of these allegations Condition 1.a barred any coverage for the underlying complaints.

Lastly, Jesuits argued that questions of material fact existed in regard to the content of Pennsylvania General's policies because Pennsylvania General, in support of its claims that it had no duty to defend or indemnify

155. *Id.* at ¶ 39 citing Bay State Insurance Co. v. Wilson, 96 Ill.2d 487, 494 (1983).
156. *Id.* at ¶ 38.
157. *Id.* at ¶ 52.
158. *Id.* at ¶ 50.

the Jesuits and in its subsequent motion for summary judgment, relied on generic, preprinted policy forms as opposed to actual, complete copies of its insurance agreements with the Society. Pennsylvania General has not found a full copy of its own actual policy that insured the Jesuits. Pennsylvania General, as the plaintiff, had the burden to provide as much of the written document as necessary to the determination at hand, which meant the entire policies, not just portions. As a result, absent proof by Pennsylvania General that the attached documents were the best evidence of the Jesuits' policies, the documents were insufficient and Pennsylvania General had failed to meet its burden.[159]

I. Duty to Indemnify

*1.* Metzger v. Country Mut. Ins. Co.

Holding: It was analytically and legally possible for the driver, in his personal capacity as owner of the truck, to convey possession and use of it to the corporation.[160] Since it is possible to lend out the vehicle it would not be covered as a non-owned vehicle under the policy. As a matter of law, there is no potential coverage under the business policy for the vehicle. Since there is no possibility that defendant will have a duty to defend the underlying lawsuit, there will arise no duty to indemnify regarding that suit.[161]

In *Metzger v. Country Mut. Ins. Co.*, Metzger was injured in a motor vehicle accident with Brian McKee. At the time, Brian was vice-president of McKee Custom Masonry, a subchapter S corporation whose sole shareholders were Brian and his wife. Metzger sought a declaration that the liability policy provided coverage for the truck that driver's vehicle collided with. The insurance policy was in effect at the time of the accident, and covered the truck as a non-owned vehicle operated in the business.[162]

The court reviewed whether the insurer had a duty to indemnify and a duty to defend. The court explains that the duty to indemnify can arise only after damages are fixed in their amount. The duty to defend may arise as soon as damages are sought in some amount. A declaratory judgment action brought to determine an insurer's duty to defend is ripe upon the filing of a complaint against the insured. A declaratory judgment action brought to determine an insurer's duty to indemnify an insured is not ripe for adjudication until an insured becomes legally obligated to pay the damages in the underlying action.

159. *Id.* at ¶ 61.
160. Metzger v. Country Mutual Insurance Company, 2013 IL App (2d) 120133.
161. *Id.* at ¶ 37.
162. *Id.* at ¶ 5.

Metzger filed a complaint against the McKee so business's liability Country Mutual Insurance's duty to defend against a lawsuit brought against McKee by a third-party was ripe for adjudication. To determine whether an insurer had a duty to defend, the court compared the allegations in the underlying complaint to the relevant provisions of the insurance policy and liberally construes both in the insured's favor. If the underlying complaint's allegations fell within, or potentially within, the policy's coverage, the insurer was obligated to defend its insured. The duty to indemnify arises only if the insured's activity and the resulting damage actually fall within the policy's coverage. The duty to defend is broader than the duty to indemnify, if an insurer owes no duty to defend, it owes no duty to indemnify. However, if there was potential coverage, the insurer must assume the defense of the underlying lawsuit, unless the insurer was secondary or excess, in which case the insurer's duty to defend will not arise until the limits in the primary policy are reached. However if there is no potential coverage, the insurer, whether primary or secondary, does not have to defend the underlying lawsuit.[163]

The court determined that the borrowed truck being driven by shareholder of the corporation at the time of accident was not a "non-owned" vehicle under corporation's business liability policy, and thus, exclusion of coverage for bodily injury or property damage applied, and there was no potential coverage under liability policy even if the truck was owned by shareholder individually and used for business purposes. The policy in this case defined "non-owned" vehicle as "any 'auto' you do not own, lease, hire or borrow which is used in connection with your business." The court held that since the corporation was a legal entity that existed independently of its sole shareholders. It was analytically and legally possible for the driver, in his personal capacity as owner of the truck, to convey possession and use of it to the corporation. Since it is possible to lend out the vehicle it would not be covered as a non-owned vehicle under the policy.[164]

## J. Duty to Provide Notice

### *1.* Progressive Ins. Co. v. Gause

Holding: Insured's failure to report an uninsured motorist accident per the requirements of the policy, resulted in insured not being entitled to an uninsured motor vehicle claim under the "hit-and-run" vehicle provision.[165]

---

163. *Id.* at ¶ 7.
164. *Id.* at ¶ 22.
165. Progressive Ins. Co. v. Gause, 2013 IL App (5th) 120492-U, ¶ 1 (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).

In *Progressive Ins. Co. v. Gause*, Lawrence Gause was traveling on his motorcycle when he observed a truck traveling in front of him.[166] The truck merged into the right-turn lane and Gause proceeded to pass the truck. As Gause began to pass, the truck moved back in Gause's lane. Gause tried to avoid a collision. He accelerated, swerved to the left and struck the median. He was injured. The motorcycle and truck never came in contact with each other. Gause did not report the accident to the police nor did any other individual report the accident on his behalf.

A day after the incident, the Gause spoke with a representative of Progressive Insurance to request a claim for uninsured motorist bodily injury coverage under the policy. Progressive denied his claim and on March 26, 2012, filed a complaint for declaratory judgment. On July 5, 2012, Progressive filed a motion for a summary judgment, which was granted.[167]

The court reviewed whether Gause was entitled to an uninsured motor vehicle claim under Progressive's hit-and-run policy when he failed to report the accident to police. The policy would pay for damages that an insured person was legally entitled to recover from the owner or operator of the uninsured vehicle or underinsured vehicle because of bodily injury sustained by an insured person, caused by an accident that arose out of the ownership, maintenance or use of an uninsured motor vehicle or underinsured motor vehicle. However, the vehicle provisions of the policy contained a caveat which stated that such a claim was available, provided that the insured person, or someone on his or her behalf, reported the accident to the police or civil authority within 24 hours or as soon as practicable after the accident.[168] Therefore, Gause is not entitled to an uninsured motor vehicle claim under the "hit-and-run" vehicle provisions because he failed to report the accident and the policy stated that such a claim is available, provided that the insured person**,** or someone on his or her behalf, reports the accident. The policy requirements for making an uninsured motor vehicle claim were not met.[169]

*2.* Auto-Owners Ins. Co. v. Yocum

Holding*:* Automobile insurer is required to apply any excess funds in its hands towards insured's unpaid premium, and thus, because insurer was aware that there were excess funds in insured's account due to the removal of two vehicles from its policy, insurer had no basis to cancel the policy based on nonpayment.[170]

166. *Id*. at ¶ 4.
167. *Id.* at ¶¶ 4–5.
168. *Id.* at ¶ 8.
169. *Id.* at ¶ 9.
170. Auto-Owners Ins. Co. v. Yocum, 2013 IL App (2d) 111267, ¶ 31.

In *Auto-Owners Ins. Co. v. Yocum*, Yocum Trucking had an automobile insurance policy with Auto-Owners Insurance Company. On September 22, 2005, Gary Dowding, while driving a truck owned by Yocum and hauling a trailer owned by Harmon Grain, LLC (Harmon), was in an automobile accident with a car. The driver of the car died. Driver's representative filed a wrongful death suit against Yocum, Dowding, and Harmon. Yocum, Dowding, and Harmon tendered their defense to Auto-Owners Insurance Company. Michigan Millers Mutual Insurance Company (Millers) insured Harmon and asserted a claim against Auto-Owners for equitable contribution. Auto-Owners filed a declaratory judgment action seeking a declaration that it had no duty to defend or indemnify in the underlying suit because Yocum's policy had been effectively cancelled prior to the date of the accident. Yocum's policy was cancelled for nonpayment. However, Yocum argues that there was a premium credit on his account and that the insurance company should have used that credit to cover the outstanding amount due for the premiums he had not paid.[171]

The court reviewed whether Auto-Owners had an obligation to use the premium refund due to Yocum to satisfy his July premium payment. The auto policy provided that "[p]remium adjustments will be made at the time of such changes or when we [Auto-Owners] become aware of the changes, if later." Auto-Owners removed two vehicles from Yocum's policy. Auto-Owners conceded that Yocum had requested the change to his policy on June 30. At the very latest, however, Auto-Owners were aware of the change by August 30, when it sent an endorsement letter. This was one day before it sent the cancellation notice on August 31. The removal of the two vehicles reduced the monthly premium from $257.25 to $104. Yocum had paid $514.50 toward the premium on his policy therefore at the time the July premium was due, there was excess premium on Yocum's account. Auto-Owners consequently never had any basis to cancel the policy based on nonpayment of the premium. Auto-Owners had sufficient funds in its hands at the time the July premium were due and should have applied those funds toward the payment of that premium.[172]

*3.* MHM Services, Inc. v. Assurance Co. of America

Holding: Insured's failure to give notice to excess insurer until two years after service of suit was unreasonable and deprived insurer of any meaningful participation in defense.[173]

171. *Id.* at ¶ 1.
172. *Id.* at ¶ 22.
173. MHM Serv., Inc. v. Assurance Co. of America, 2012 IL App (5th) 112171, ¶ 1.

In *MHM Services, Inc. v. Assurance Co. of America*,[174] the insured is MHM Services, Inc. ("MHM"). MHM contracted with healthcare services, including mental health services on behalf of governmental entities. In April 2003, MHM contracted with the Illinois Department of Corrections, ("IDOC"), to screen IDOC inmates who were nearing the end of their prison terms but were candidates for indefinite confinement as provided by the Illinois Sexually Violent Persons Commitment Act. On June 5, 2006, A.B. sued MHM, for failure to recommend to the State of Illinois to pursue indefinite confinement of Christopher Hanson as a sexually violent person. Hanson had been eligible for parole in late 2004 but had a series of criminal convictions, most of which were for sexual assaults on women in Libertyville, Illinois. Hanson attacked A.B., then a teenager, on June 6, 2005, while she was running on a bike path in a forest preserve in Libertyville. He sexually assaulted A.B., stabbed her in the neck, and repeatedly cut her throat until she appeared lifeless. MHM had two liability insurers.[175]

MHM had professional liability coverage through CampMed Casualty and Indemnity Company, which could provide up to $1 million, in addition to MHM's self-insured retention of $250,000. When MHM was served with A.B.'s suit on June 14, 2006, the company's then-general outside counsel tendered the case to CampMed, but not to Assurance. CampMed received notice on June 16, 2006, it exercised its right to hire Chicago attorney Jeffrey Singer to defend MHM. Singer's initial approach was to move to dismiss the suit on grounds of sovereign immunity.[176]

The court reviewed whether MHM notice was unreasonably late in relation to the proper interpretation of the policy's notice clause. Compliance with a notice clause enables the insurer to conduct a timely and thorough investigation into the insured's claim, assess whether settlement or litigation is the best course of action, and participate in the insured's defense. Under Illinois law, a clause requiring the insured to give its insurer notice of a suit "as soon as practicable" requires notice to be made within a reasonable time in light of the facts and circumstances of the particular case. The insured was expected to act diligently in giving notice. A court considered the insured's reason for not providing notice sooner, and if the court concludes the insured's excuse was invalid, the court will find the insured's failure had absolved the insurer of its contractual duties. The factors a court considered when evaluating whether the insured's excuse was valid may include: (1) the specific language of the policy's notice provision; (2) the insured's sophistication in commerce and insurance matters; (3) the insured's awareness of an event that may trigger insurance coverage; (4) the insured's diligence and reasonable care in ascertaining whether policy coverage was

174. *Id*. at ¶ 2.
175. *Id*. at ¶ 3.
176. *Id*. at ¶ 5.

available; and (5) whether the insured's delay caused prejudice to the insurer.[177]

The court determined in respect to factor number one that MHM was not contractually entitled to exercise discretion as to whether to give notice. Pursuant to paragraph 4.07, MHM was contractually required to give Assurance notice of *every* claim or suit "as soon as practicable" regardless of the amount of potential liability or whether MHM had reason to believe the Assurance excess policy might be implicated. As for MHM's sophistication in commerce and insurance, MHM was savvy enough to have both primary and excess/umbrella coverage, it retained a part-time and later a full-time general counsel it had the benefit of local litigation counsel, in 2008 it retained coverage counsel, and it had cash on hand to pay its litigation expenses and its share of settlement to A.B.

The court did not consider the second factor particularly helpful, but it weighed in favor of finding that MHM's delay in giving notice was unreasonable. The third factor favors neither party because there was no indication MHM was aware of the underlying tort before A.B. sued MHM. The fourth factor unquestionably weighed against MHM. The record indicates MHM initially looked at the Assurance policy for primary coverage, determined primary coverage was subject to policy exclusion for professional liability, and looked no further in the policy.

The fact that MHM had abandoned its reliance on that primary coverage exclusion was an indication that MHM did not exercise reasonable "diligence in ascertaining whether policy coverage." The fifth and final factor also weighs against MHM, because by the time Assurance was given notice, its right to participate in the defense was prejudiced. By the time Assurance was notified on July 9, 2008, the only unanswered question was the specific dollar amount A.B. would receive from MHM for her injuries. By the time notice was given on July 9, 2008: (1) MHM had exhausted its arguments through motion practice and was facing a late 2008 trial date; (2) MHM's litigation counsel had advised that a trial and postjudgment appeal was foolhardy; (3) the judge and MHM's litigation counsel had advised that, without question, a jury would give A.B. a substantial, multimillion dollar judgment; (4) discovery was nearly complete and MHM's litigation counsel was adamant that A.B. would realize the real strength of her case if she were able to depose MHM's psychologists, who were scheduled for depositions in June or July (the record did not disclose specific deposition dates); and, (5) finally, MHM was actively negotiating a settlement with A.B. These are indications that Assurance was deprived of any meaningful participation in the defense until the case was in the last possible stage.[178]

177. *Id.* at ¶ 51.
178. *Id.* at ¶ 56.

## VI. THIRD-PARTY LIABILITY COVERAGE, DEFINITIONS, EXCLUSIONS

### A. UM and UIM Coverage

*1.* Klehr v. Illinois Farmers Ins. Co.

Holding: a parties' dispute over a discovery order remains unripe for adjudication, and it will remain unripe until the arbitrators issue their final award.[179]

In *Klehr v. Illinois Farmers Ins. Co*., Klehr was a passenger in a car that was involved in a hit-and-run accident, and she filed an uninsured motorist claim with the driver's insurance carrier. The insurer settled Klehr's claim after she filed a declaratory judgment action against it, but the settlement was insufficient to completely cover her injuries so she filed an additional claim with her own insurance carrier, Illinois Farmers Insurance Company. Not long after filing that claim, Klehr demanded arbitration under the arbitration provision in her insurance policy and the matter was referred to the American Arbitration Association (AAA) for resolution.

After the arbitration process began, Illinois Farmers Insurance served several discovery requests on Klehr, which included interrogatories, document requests, and a request to appear for a sworn statement. Klehr refused to comply, contending that discovery of the type sought by the insurance company was not permissible under the terms of the arbitration clause and applicable Illinois law or, alternatively, that any discovery must be conducted within 180 days of the initiation of the claim. Klehr did not bring the dispute to the arbitrators for a ruling, but instead filed a declaratory judgment action. She sought a declaration that the discovery period was closed and therefore not required to answer defendant's discovery requests.[180]

The court reviewed if a valid arbitration agreement existed and the parties had begun but not completed the arbitration process, can one of the parties obtain judicial review of the arbitrators' interlocutory ruling on a discovery issue by filing a declaratory judgment action. The arbitrators may order discovery if they so choose, which they have done in this case. Klehr argued that the arbitrators could not order discovery pursuant to Rule 6 because the 180-day discovery period had already lapsed, but the arbitrators disagreed with Klehr's interpretation of the rule. American Arbitration Association's Uninsured/Underinsured Motorist Arbitration and Mediation Rule 37 empowered the arbitrators to interpret and apply these rules insofar

179. 2013 IL App (1st) 121843, 984 N.E.2d 524 (1st Dist. 2013), ¶ 21.
180. *Id*. at ¶ 3.

as they relate to the arbitrator's powers and duties. All other rules shall be interpreted and applied by the AAA matter jurisdiction.[181]

Based on the comments to the Uniform Arbitration Act, this is precisely the type of dispute that the drafters intended to be reviewed by the courts only at the conclusion of arbitration as part of a motion to vacate the award, and for the courts to step into this dispute before the end of the arbitration process is contrary to the intent of the Act. If the court allowed Klehr to obtain interlocutory review of the arbitrators' ruling it would undermine the entire point of arbitration. Illinois public policy favors arbitration as a dispute-resolution mechanism because it promotes the economical and efficient resolution of disputes. If a declaratory judgment could be used to circumvent the limited role of the courts in arbitration, then any party aggrieved by an interlocutory order of the arbitrators could obtain judicial review prior to completion of the arbitration process, which would reduce the efficiency and cost effectiveness of arbitration as a dispute-resolution mechanism. The court held that the parties' dispute over the discovery order remained unripe for adjudication, and it will remain unripe until the arbitrators issue their final award.[182]

*2.* American Economy Ins. Co. v. Greeley

Holding: The plain definition of "settlement agreement" provided in the parties' insurance contract, this typical exchange of letters by the insured and the insurer showed that the parties reached an agreement.[183]

In *American Economy Ins. Co. v. Greeley*, American Economy Insurance filed a declaratory judgment against Andrew Greeley, who sought uninsured motorist benefits on his policy and his company's policy. Greeley purchased a commercial insurance policy package for himself and his company that included underinsured motorists coverage for a million dollars. Greeley suffered permanent brain injury as he exited a taxi. He filed a personal injury case against the taxi drivers and its owner. His $250,000 insurance policy did not fully compensate for his injuries. Greeley made a UIM claim with the policy he held with American Economy Insurance Company. The insurance company maintained that Greeley was not entitled to UIM coverage because he was not a named insured and in any event the insurance company was entitled to an offset for amounts Greeley received as a worker's compensation benefits.[184]

The court reviewed whether the insurer can be allowed to setoff for worker's compensation benefits received by the insured. American Economy

181. *Id.* at ¶ 8.
182. *Id.* at ¶ 13.
183. American Economy Ins. Co. v. Greeley, 2013 IL App (1st) 968250, ¶ 41.
184. *Id.* at ¶ 3.

Insurance's policy contained an UIM endorsement that provided the limits of liability to one million dollars per occurrence. The UIM portion of the insurance policy in question contained a section entitled "Limits of Insurance" and set forth UIM limits both when there was and there was not a settlement agreement. In the event of a settlement the policy allowed for the limit of the insurance to be reduced by all sums paid or payable. However, there was also a provision that stated that under any workers' compensation, disability benefits or similar law, the limits of insurance for the coverage shall not be reduced by any sums paid or payable under Social Security benefits.[185]

On July 20, 2009, Greeley wrote to his insurance company, American Economy Insurance and notified it that the amount of monetary damages he sustained as a result of his traumatic brain injury would result in a UIM claim under his policy with the insured. Again, on January 22, 2010, the insured wrote to his insurance company and notified it that he had a settlement offer from the owner of the underinsured motor vehicle for the full policy limits of $250,000.00 and requested directions from his insurance company on how to proceed. Greeley's insurance company inquired about other existing insurance policies that might reduce his UIM claim. However, the letter did not discuss the issue of setoffs as outlined in the policy if a settlement agreement was reached between the parties. A settlement agreement under the policy merely requires the insurer and insured to agree that the insured [Greeley] is legally entitled to recover damages from the tortfeasor and agree on the amount of damages.[186]

Therefore, the court determined that given the plain definition of "settlement agreement" provided in the parties' insurance contract, this typical exchange of letters by the insured and the insurer shows that the parties reached an agreement that Greeley was entitled to recover the tortfeasor's policy limits of $250,000 that was offered and more since American Economy Insurance did not wish to subrogate. Because there exists an agreement between the parties that this settlement was justified, section D (3) of the Insurance Policy together with section F (3) which defined "settlement agreement" dictates that the only setoff to be applied to the parties one million insurance policy is the $250,000 amount paid by the underinsured.[187]

*3.* Kimberly Hosier v. Melvin Dulgar

Holding: The common-law collateral source rule applies, and Hosier is permitted to recover the full measure of damages, without setoff.[188]

185. *Id.* at ¶¶ 27–33.
186. *Id.* at ¶ 35.
187. *Id.* at ¶ 41.
188. Kimberly Hosier v. Melvin Dulgar, 2013 IL App (4th) 1790903, ¶ 1.

In *Kimberly Hosier v. Melvin Dulgar*, Kimberly Hosier filed a complaint against Melvin Dulgar for injuries she sustained as a result of an automobile accident. Dulgar filed an Admission of Negligence and reserved the issue of causation and damages. Dulgar also request a setoff of $5,000 for medical payments made by Hosier's insurance company, State Farm Mutual Automobile Insurance Company. A jury awarded Hosier $25,000 of which $9,508 was itemized for medical expenses. The court then reduced the award by $5,000.[189]

The court reviewed whether a defendant can reduce a plaintiff's compensatory award via a setoff. Hosier argued: (1) State Farm did not hold a right of subrogation against her; (2) because her medical payment benefits did not exceed $25,000, section 2–1205.1 of the Code[190] does not permit reduction of plaintiff's recovery; and (3) because the March 2011 release between State Farm and Dulgar's insurance company, United, was not properly authenticated, Dulgar did not carry his burden of proof for the setoff.[191]

The court found State Farm as a matter of common law, would not have a right of subrogation against Hosier because she is the insured party. State Farm, as insurer-subrogee, had a right of subrogation against Dulgar based upon Hosier's insurance claim. As a substantive rule of damages, the collateral source rule "bars a defendant from reducing the plaintiff's compensatory award by the amount the plaintiff received from the collateral source." The collateral source rule applies because plaintiff received outside benefits from State Farm, her automobile insurer. As a matter of common law, plaintiff may receive the full damages award—without regard to benefits paid by State Farm—unless a statutory modification, section 2–1205 or section 2–1205.1, applies.[192]

Before addressing whether State Farm had right of recoupment against Hosier, the court determined whether section 2–1205.1 applies. According to its plain language, section 2–1205.1 applies where (1) section 2–1205 does not apply, and (2) the "benefits provided for medical charges, hospital charges, or nursing or caretaking charges" exceed $25,000. Because Hosier's action did not concern the negligence of a licensed hospital or physician, section 2–1205 does not apply and the court then looked at the $25,000 threshold. The evidence at trial showed Hosier's medical expenses totaled $9,508. The jury awarded $9,508 for "[t]he reasonable expense of necessary medical care, treatment and services received." Dulgar contended that he is entitled to a $5,000 setoff because his insurer paid Hosier's insurer for "Med Pay" benefits. Dulgar's insurer paid plaintiff's insurer $11,275.69 in

189. *Id.* at ¶ 2.
190. 735 ILL. COMP. STAT. 5/2–1205.1 (2010).
191. *Id.* at ¶ 25.
192. *Id.* at ¶ 30.

settlement and not the full $15,969.61 requested by State Farm. This reflects approximately 70.6% of the requested payment. Dulgar claimed he was entitled to a setoff of 100% of the value of the medical payments where his insurer only paid 70.6%. Dulgar by his own admission asserted that Hosier received $5,000 in benefits for medical charges, hospital charges, or nursing or caretaking charges, not an amount in excess of $25,000 as required by section 2–1205.1.[193] Because section 2–1205.1 was not applicable to the facts of the case, the common-law collateral source rule applied, and Hosier was permitted to recover the full measure of damages, without setoff, although she was also compensated by her automobile insurance.[194]

193. *Id.* at ¶¶ 37–52.
194. *Id.* at ¶ 53.

*4.* Alshwaiyat v. American Service Ins. Co.

Holding: ASI was not required to provide any greater UM or UIM coverage in the second policy as long as that policy was a "renewal, reinstatement, reissuance, substitute, amended, replacement or supplementary policy.[195]

In *Alshwaiyat v. American Service Ins. Co.*, Hatem Alshwaiyat, a taxi driver, sought a declaration that the automobile policy insurance issued to his employer, Mojo Enterprises ("Mojo") provided $500,000 in underinsured motorist ("UIM") coverage for an automobile accident. On June 17, 2008, Alshwaiyat was a taxi driver employed by Mojo when he was in an accident with a vehicle operated by Robert Pas. As a result of this accident, Alshwaiyat suffered significant physical injuries and his wife, a passenger in the taxi, suffered injuries that resulted in her death. Claims against Mr. Pas were settled for $100,000 each. Alshwaiyat alleged that he and Mojo were both insured under an automobile insurance policy issued to Mojo by American Service Insurance ("ASI"). The policy was effective from January 1, 2008, through January 1, 2009. The insurance policy allegedly included $500,000 in liability coverage for bodily injury and property damage. Alshwaiyat alleged that, Mojo never rejected the uninsured motorist (UM) and underinsured motorist (UIM) coverage in an amount equal to $500,000 and therefore the policy must be construed to provide for $500,000 in underinsured motorist coverage. ASI believed that the insurance policy issued to Mojo did not provide any UIM coverage for the accident.[196]

The ASI policy provided a combined single limit (CSL) of $300,000 in bodily injury and property damage liability coverage. In applying for this policy, Mojo's president was informed of Mojo's right to UM or UIM coverage in an amount equal to the bodily injury and property damage coverage. Mojo's president signed a written rejection of such coverage. The original policy provided UM coverage in the amount of $20,000 per person and $40,000 per accident. It did not provide for any coverage for UIM coverage. ASI issued Mojo a subsequent renewal policy that covered the period of January 1, 2008, through January 1, 2009 and provided the same amount of liability (a $500,000 CSL) and UM coverage ($20,000 per person and $40,000 per accident). The policy was in effect at the time of the accident. Mojo did not sign another written rejection of higher UM or UIM coverage in connection with either the endorsement increasing the liability limits or the renewal policy, nor did Mojo make a specific request for any additional UM or UIM coverage.

195. Alshwaiyat v. American Service Ins. Co., 2013 IL App (1st) 123222, ¶ 54.
196. *Id.*

The issue before the court was whether the second policy issued by ASI effective January 1, 2008, through January 1, 2009 was a renewal of the prior policy and if it was a renewal whether the insured was required to provide any greater UM or UIM coverage in the second policy. The Insurance Code specifically requires that all policies of liability insurance must provide UM insurance. Such UM insurance must provide coverage limits that are, at a minimum, equal to the statutory minimums.[197]

The court held that the second policy was self-identified on its declaration page as being a "RENEWAL." The policy was identified by a policy number largely identical to the number that identified the original policy; it was issued to Mojo, the same named insured listed in the original policy; it covered the same drivers insured in the original policy; it contained policy language that was identical to the policy language contained in the original policy; it provided the same coverage limits as the original policy; and it came into effect upon the expiration of the six-month term of the original policy. For these reasons, it was evident that the second policy was a "renewal" policy for purposes of the paragraph (2) of section 143a–2, which allowed any named insured to reject UM or UIM coverage in excess of the statutory minimums. Section 143a–2 further provided that an insurer need not provide in any renewal, reinstatement, reissuance, substitute, amended, replacement or supplementary policy, coverage in excess of that elected by the insured in connection with a policy previously issued unless the insured subsequently makes a written request for such coverage. ASI was not required to provide any greater UM or UIM coverage in the second policy as long as that policy was a "renewal, reinstatement, reissuance, substitute, amended, replacement or supplementary policy.[198]

B. Subrogation rights

*1.* Scheppler v. Pyle

Holding: common fund doctrine applies, and Scheppler's attorneys are entitled to recover a reasonable fee from Country.[199]

In *Scheppler v. Pyle*, Peggy Scheppler was involved in an automobile accident with a vehicle driven by Tom Pyle. At the time of the accident, Scheppler and her husband had an automobile insurance policy issued by Country Mutual Insurance. The policy contained a medical payment limit of $50,000 and an underinsured motorist coverage limit of $250,000. On

197. *Id.* at ¶ 7.
198. *Id.* at ¶¶ 39–40.
199. Scheppler v. Pyle, 2013 IL App (3d) 110380-U, ¶ 1 (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).

January 5, 2010, through counsel, the Scheppler filed a complaint against Pyle for personal injuries and loss of consortium arising out of the accident. American Family, the insured for Pyle, offered to settle. Settlement offer included payment of its policy limit of $100,000 in exchange for a release of Pyle's liability.

Scheppler's counsel wrote a letter to Country informing it of the settlement offer from American Family. In the letter, counsel demanded that Country either: (1) protect Country's subrogation rights by advancing payment to Peggy Scheppler in the full amount of American Family's policy limit within 30 days, or (2) approve the execution of a release in favor of Pyle, thereby waiving Country's subrogation rights against Pyle. In response to counsel's letter, a liability specialist at Country, wrote a letter that stated that Country will waive its subrogated rights to its $50,000 medical payments and take it as a setoff from its underinsured motorist bodily injury policy limits. Scheppler's attorneys also received a form letter asking them if they would be willing to represent Country's subrogation interests in the medical payments for a one-third contingency fee. Scheppler's counsel did not sign the letter. On March 1, 2011, the Scheppler's counsel received the settlement checks from American Family's counsel.[200]

On March 4, 2011, Scheppler's attorneys filed a Motion to Adjudicate Subrogation Claim of Country Financial. In their motion, Scheppler's attorneys argued that they recovered a common fund of $100,000 which benefited Country since it allowed Country to: (1) recover amounts it paid under the medical payments provision of the policy; and (2) limit its liability for Scheppler's underinsured motorist claim by deducting the amount of the common fund from its underinsured motorist liability. Scheppler's attorneys argued that Country had received these benefits thanks to the efforts of the attorneys without having to expend any of its own administrative or legal resources. Moreover, they argued that at no time did Country instruct the attorneys to retain them from taking action to recover its subrogation lien. In fact, prior to the settlement of the bodily injury claim, Country sent correspondence to the attorneys requesting that they represent Country for medical payment interests at resolution of the case for a third contingency fee.[201]

The court reviewed whether under the common funds doctrine, a lawyer who recovered an amount of money for the benefit of a person other than his client was entitled to reasonable attorney fee from the fund. The court held that the efforts of Scheppler's attorneys resulted in a $100,000 settlement from American Family. Country did not participate in the creation of that settlement fund in any way. Nor did it intervene in Scheppler's tort suit

200. *Id.* at ¶¶ 6–14.
201. *Id.* at ¶¶ 15–16.

against Pyle. Nor did it participate in the settlement negotiations, or file an arbitration demand against American Family to recover the medical payments it made to Scheppler. Moreover, the creation of the settlement fund benefited Country by allowing it to deduct the full amount of the settlement and the $50,000 in medical payments from its underinsured motorist liability. The court held that the common fund doctrine applied, and Scheppler's attorneys were entitled to recover a reasonable fee from Country.[202]

C. Dram Shop Insurance

*1.* Rogers v. Imeri

Holding: Any reduction for "other insurance" recoveries set forth in the Insurance Guarantee Fund statute would be applied first against the jury's verdict, and then reduced to the statutory maximum in the Dram shop Act.[203]

In *Rogers v. Imeri*, parents of driver fatally injured in collision with drunk driver brought action against bar owner and bar under the Dram shop Act. Rogers's son, sustained fatal injuries when the vehicle he was driving was involved in a head-on collision with a vehicle driven by John E. Winterrowd. Rogers's son died later the same day. He was 18 years old. According to the allegations of the complaint, Winterrowd was intoxicated after consuming alcohol served to him at Johnny's Bar and Grill, owned by Gani Imeri. Rogers received $26,550 from Winterrowd's liability insurance policy. They also received $80,000 from their own automobile insurance policy. Rogers subsequently filed an action under the Dram shop Act. They alleged that Winterrowd was intoxicated as a result of drinking alcoholic beverages at Johnny's Bar and Grill and that his intoxication contributed to the collision. They sought damages for the loss of the decedent's companionship, property damage to the vehicle, medical bills, and the decedent's pain and suffering before he died.[204]

Imeri's dram shop liability insurance carrier was insolvent, so it was represented by the Illinois Insurance Guaranty Fund. At the time the accident occurred, the bar owner maintained a dram shop liability policy with Constitutional Casualty Company. The policy provided a policy limit of $130,338.51, the statutory cap under the Dram shop Act. However, while this matter was pending, Constitutional Casualty Company was declared insolvent and liquidated. Consequently, the Illinois Insurance Guaranty Fund took over the defense of this litigation. The bar owner argued that his maximum dram shop liability is $130,338.51, the statutory damage cap, and that amount must therefore be reduced by the $106,550 received from other

202. *Id.* at ¶¶ 22–23.
203. Rogers v. Imeri, 2013 IL App (5th) 110546, ¶¶ 14–19.
204. *Id.* at ¶ 4.

insurance companies under section 546 of the Illinois Insurance Code. The parties agreed that Imeri is entitled to a setoff of the $106,550 that Rogers received from the two automobile insurance policies. Imeri argued that this amount is to be deducted from the statutory cap of $130,338.51. Rogers argue that it must be deducted from the jury's verdict and then reduced to the statutory cap if necessary.[205]

The court addressed the issue of whether a defendant in a dram shop case, who is being defended by the Illinois Insurance Guaranty Fund after defendant's liability insurer was declared insolvent, and the jury returns a verdict in excess of the defendant's maximum liability under the Dram Shop Act, is the reduction for 'other insurance' recoveries set forth in Section 546(a) of the Illinois Insurance Guaranty Fund Act applied against the jury's verdict or against the defendant's maximum dram shop liability. Section 546 of the Illinois Insurance Guaranty Fund (Guaranty Fund) statute provides that an insured or claimant must "exhaust all coverage provided by any other insurance policy . . . if the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the Fund."[206] The statute further provides that "the Fund's obligation" is to be reduced by amounts recovered."[207] At issue in this case is an interpretation of the phrase "the Fund's obligation." The Guaranty Fund is intended "'to place claimants in the same position that they would have been in if the liability insurer had not become insolvent.'" However, the Guaranty Fund is in essence a substitute for the insolvent insurer, not a separate source of recovery. Thus, unless specific limitations in the Guaranty Fund statute are applicable, the Guaranty Fund's obligation is determined by the Dram Shop Act. The Dram Shop Act expressly provides for a jury to determine the amount of damages without regard to the statutory limit.[208]

Whether the Guaranty Fund is obligated to pay the statutory maximum in a dram shop case depends on the facts of the case. If the jury returns a verdict of $500,000 in the instant case, that amount would be reduced to $393,450, which would then be reduced to the statutory dram shop maximum of $130,338.51. However, if the jury returns a verdict of $200,000, that would be reduced to $93,450, which is less than the statutory maximum. The court determined that these limits were sufficient to effectuate the purpose of section 546. Therefore the reduction for "other insurance" recoveries set forth in section 546(a) of the Guaranty Fund statute was applied against the jury's verdict and then reduced to the statutory maximum in the Dram Shop Act if necessary.

205. *Id.* at ¶¶ 5–7.
206. 215 ILL. COMP. STAT. 5/546(a) (West 2008).
207. 215 ILL. COMP. STAT. 5/546(a) (West 2008).
208. *Id.* at ¶ 8.

*2.* Marcelino Guzman, Bertha Guzman and Beverly Myers v. 7513 West Madison Street, Inc.

Holding: Under the Dram Shop Act when the bar was being defended by the Insurance Guaranty Fund after the bar's dram shop insurer became insolvent, the reduction for the other insurance recoveries required by the Guaranty Fund Act required that the recoveries plaintiffs received from other insurance policies be applied against the bar's maximum liability under the Dram Shop Act, rather than the jury verdict, if the jury's verdict was in excess of the bar's maximum liability.[209]

In *Marcelino Guzman, Bertha Guzman and Beverly Myers v. 7513 West Madison Street, Inc.*, Marcelino Guzman had operated a motor vehicle with a passenger, his wife, Bertha Guzman. Their car was struck by a vehicle driven by Nikki Klassert. Beverly Myers was a pedestrian who was injured as a result of the collision of the two vehicles. The Guzmans and Myers alleged that at the time of the accident Klassert was intoxicated and she had been served alcoholic liquors by Duffy's Tavern. The Guzmans filed a negligence action against Klassert. The case was settled by payment of $40,000, the policy limits of Klassert's automobile liability insurer, Safeway Insurance Co. On May 5, 2010, the Guzmans and Myers filed an action against Duffy's Tavern under the Dram Shop Act seeking damages for their injuries. The Dram Shop Act provides limited no-fault liability where a plaintiff can demonstrate that a patron was intoxicated as a result of liquor provided by a bar and the plaintiff suffered resulting injuries because of the patron's intoxication. The Dram Shop Act provides: "in no event shall the judgment or recovery for injury to the person or property of any person exceed" the maximum recovery allowed under the Act.[210] The maximum amount recoverable in a dram shop case may increase or decrease annually depending on a formula provided in the Act which is based on the consumer price index.[211]

At the time of the accident, Duffy's Tavern was insured under a liquor liability policy issued by Constitutional Casualty Company, which has a $1 million policy limit. Constitutional Casualty Company was declared insolvent and place into liquidation by the Illinois Department of Insurance. The Illinois Insurance Guaranty Fund has assumed responsibility for the obligations of the insurer to Illinois claimants and policyholders.[212]

The attorneys retained by the Fund filed an affirmative defense where they alleged that the Dram Shop Act set the maximum recovery of each

209. Marcelino Guzman, Bertha Guzman and Beverly Myers v. 7513 West Madison Street, Inc., 2013 IL App (1st) 122161, ¶ 2.
210. 235 ILL. COMP. STAT. 5/6–21 (West 2008).
211. *Id.* at ¶¶ 5–8.
212. *Id.* at ¶ 9.

claimant in this case at $58,652.33, and, therefore, $58,652.33 is the extent of the obligation of the Fund. Duffy's Tavern argued that under section 546(a) of the Guaranty Fund Act, the obligation of the Fund and the its liability to each of the claimants was required to be reduced in an amount equal to each claimant's recovery from other insurance companies. Therefore, because Marcelino and Bertha Guzman had each received $50,000 from other insurance, the Fund's obligation and Duffy's Tavern's liability to them is reduced in the same amount and the maximum recovery for each of the Guzmans would be $8,652.33. Beverly Myers would not be entitled to any recovery because her recovery from other insurance exceeded the $58,652.33 obligation of the Fund under section 546(a).[213]

The court reviewed a certified question of how the "other insurance" reduction required by section 546(a) of the Guaranty Fund Act impacts a dram shop claim made against a defendant where the defense has been assumed by the Illinois Insurance Guaranty Fund due to the insolvency of the insurer. The court explained that a claimant possessing a covered claim is required to exhaust his rights under any other policy of insurance which involved the same facts, injury or loss that gave rise to the covered claim. The obligation of the Fund is reduced by the amounts a claimant receives from other insurance. Therefore, for payments a plaintiff receives from his medical insurer or his own automobile insurer for the same facts, injury or loss, a deduction must be made from the Fund's liability to the plaintiff. The court has repeatedly stated that the Fund is a fund of last resort.[214] The court read the relevant provisions of the Guaranty Fund Act together with the Dram Shop Act, and found that the extent of the covered claims determines the obligation of the Fund. Since Duffy's Tavern's legal liability is limited to $58,652.33 per person, the extent of the covered claims is $58,652.33 per person. Therefore, the Fund is obligated to the extent of the covered claims. However, the obligation of the Fund must be reduced by recoveries from other insurance policies. Therefore, the reduction required for recoveries from other insurance in section 546(a) was required to be made from the $58,652.33 covered claim obligation in this case.[215]

213. *Id.* at ¶ 10.
214. *Id.* at ¶ 11.
215. *Id.* at ¶ 26.

D. Underinsured Coverage and Antistacking

*1.* State Farm Mutual Auto. Ins. Co. v. McFadden

Holding: The antistacking provision acknowledged that an insured may have other policies, each with a declarations sheet setting forth its own limit. However, the antistacking provision clarified that the insured's total coverage will not exceed "the limit of liability of the single policy providing the highest limit."[216] The court found that the declarations sheets, read in isolation, might leave open the question of stacking, but the antistacking provision unambiguously answers that question in the negative.[217]

In *State Farm Mutual Auto. Ins. Co. v. McFadden*, Dianna McFadden was injured when Mark Nies crashed into McFadden's motorcycle. Nies carried automobile insurance coverage in the amount of $250,000 and his insurer paid the McFaddens that amount in settlement. However, McFaddens' damages exceeded the $250,000 and they sought to collect $250,000 from their own insurer, State Farm. McFadden claimed that because they had five separate policies with State Farm, each with a $100,000 limit of liability for underinsured motorist coverage, their total limit was $500,000 and this amount should be offset against the Nies' liability limit. State Farm filed a complaint for declaratory judgment. It argued that (1) express language in each of the McFaddens' policies, prohibited the aggregation or "stacking" of the policies to provide total underinsured coverage in excess of the amount set forth in a single policy and, (2) even if the McFaddens' policies did not contain antistacking language, precedent required that Nies's policy be offset one-by-one against each policy's underinsured coverage amount before a policy amount may be stacked with the others.[218]

The court reviewed two questions: (1) whether the policies' antistacking language effectively limited coverage to the amount contained in the single policy that provided the highest limit and (2) whether the methodology was offset first, stack second or the other way around. The Illinois Insurance Code section that authorized antistacking provisions states "[n]othing herein shall prohibit an insurer from setting forth policy terms and conditions which provide that if the insured has coverage available under this Section under more than one policy . . . , any recovery or benefits may be equal to, but may not exceed, the higher of applicable limits of the respective coverage."[219] Each of McFaddens' five policies contained the same antistacking provision. It was comprised of the express antistacking language

216. State Farm Mutual Auto. Ins. Co. v. McFadden, 2012 IL App (2nd) 120272, ¶ 36.
217. *Id.*
218. *Id.* at ¶ 4–6.
219. 215 ILL. COMP. STAT. 5/143a–2(5) (West 2008).

(paragraph 1), the proration clause (paragraph 3), and a definition clause (paragraph 2). The court rejected the McFaddens' reading of the policy. Paragraph 1 merely limited the coverage amount to that of the single policy that provided the highest limit. Paragraphs 2 and 3 then set forth the rules to determine the coverage share, if any, of each policy. The court found that the proration clause at the end of the antistacking provision did not introduce ambiguity. The injured insured was covered by five policies. The single policy contained the highest limit provided $100,000. Therefore, under the antistacking language in the paragraph 1 of the policy this is the total cap. The 2004 Harley policy provided coverage on a "primary" basis. It contributed the first $100,000. This met the total cap, so no other policies contribute because there is only one policy providing coverage on a primary basis, and that same policy also provides the highest limit. The court did not need to look to the proration clauses' instruction that "[t]he total damages payable from all policies that apply on an excess basis shall not exceed the amount by which the limit of liability of the single policy providing the highest limit of liability on an excess basis exceeds the limit of liability of the single policy providing the highest limit of liability on a primary basis." The court found that the proration clause does not render ambiguous the express antistacking language.[220]

The McFaddens next argued that, even if the antistacking provision was clearly stated, it is rendered ambiguous when read in conjunction with each policy's declarations sheet. They asserted that, because each policy's respective declarations sheet reflected a separate premium amount for a full $100,000 limit of underinsured coverage without a single qualifying statement, an insured could reasonably believe that he or she was entitled to the cumulative amount of all five policies' coverage. They note that, where a policy was subject to more than one reasonable interpretation, it is ambiguous, and ambiguities must be resolved in favor of the insured. The court disagreed that the declaration sheets rendered ambiguous the antistacking provision. Three supreme court cases collectively establish that, when considering whether a declarations sheet renders ambiguous an antistacking provision, the relevant inquiry is whether: (1) the declarations sheet merely left open the question of stacking, which can be answered unambiguously in the negative by a clear antistacking provision; or (2) the declarations sheet was actually inconsistent with the antistacking provision, thereby it created an ambiguity on the issue of stacking to be resolved in favor of the insured. Here, the declarations sheets were not inconsistent with the antistacking provision. The antistacking provision acknowledged that an insured may have other policies, each with a declarations sheet setting forth its own limit. However, the antistacking provision clarified that the insured's

220. *Id.* at ¶ 11.

total coverage will not exceed "the limit of liability of the single policy providing the highest limit." The court found that the declarations sheets, read in isolation, might leave open the question of stacking, but the antistacking provision unambiguously answers that question in the negative.[221]

*2.* Boatright v. Illinois Farmers Ins.

Holding: due to ambiguity in insurance policies, the underinsured coverage limits of the plaintiffs' four insurance policies aggregate, or stack, to exceed each policy's underinsured motorist coverage limit.[222]

In *Boatright v. Illinois Farmers Ins. Co.,* Susan Boatright was injured in a two-vehicle accident in Carbondale, when a car driven by Ramona Halliday, the at-fault driver, struck Boatright's 2003 Chevy Astro van. Boatright suffered serious personal injuries and she incurred substantial medical bills. At the time Boatright was paying premiums on four separate automobile insurance policies covering their family vehicles.[223] Illinois Farmers Insurance Company, Aurora, Illinois issued the Boatrights a policy for Todd and Susan Boatright, listing the 2003 Chevrolet Astro Van, a second for a 1996 Chevrolet and a third for Todd Boatright listing a 1999 Chevrolet. All three listed underinsured motorist coverage limits at $100,000 for each person/$300,000 for each occurrence. However, on the fourth policy, the insurance name was identified as Mid-Century Insurance Company, Los Angeles, California. Todd and Josh Boatright, listed coverage for a 1995 Chevrolet Crew Cab, and provided underinsured motorist coverage limits of $100,000 per person/$300,000 per occurrence as well.[224] Each of the insurance policies had a provision that stated "the limits provide by the policy may not be stacked or combined with the limits provided by any other policy issued to you or a family member by any member company of the Farmers Insurance Group of Companies." Further the policies stated that "if you or a family member has another policy on another vehicle issued by any member company of the Farmers Insurance Group of Companies, a) the limits of this policy do not apply to any occurrence arising out of the ownership, maintenance, or use of such other insured vehicle."[225] Boatrights filed a declaratory judgment in which they sought to establish a right to underinsured motorist coverage under their four automobile insurance policies. They asserted that their underinsured motorist coverage under the

221. *Id.* at ¶¶ 24–26.
222. Boatright v. Illinois Farmers Ins. Co., 2013 IL App (5th) 120297-U, ¶ 1 (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
223. *Id.* at ¶ 5.
224. *Id.* at ¶ 6.
225. *Id.* at ¶ 9.

multiple policies stacked and that at-fault driver should be classified as an underinsured vehicle because if policies were stacked Boatright's four policies provided underinsured motorist coverage limits of $400,000.[226]

The court addressed the question of whether the language of the policies allows for stacking of the four policies. The court stated that the Illinois Supreme Court had determined that antistacking clauses in general do not contravene public policy. Moreover, the Illinois Insurance Code expressly authorizes the use of antistacking provisions in motor vehicle insurance policies. Antistacking provisions are unenforceable when the language employed is unclear or ambiguous.[227] The antistacking language in the policies stated: "The limits provided by this policy may not be stacked or combined with the limits provided by any other policy issued to you or a family member by any member company of the Farmers Insurance Group of Companies." "[A]ny member company of the Farmers Insurance Group of Companies" was not defined in the policies. Despite the ease of which to do so, neither "Illinois Farmers Insurance Company, Aurora, Illinois" nor "Mid-Century Insurance Company Los Angeles California" was identified in the policy as a "member company of the Farmers Insurance Group of Companies." Accordingly because this exclusionary language of the policy is susceptible to more than one meaning, it is ambiguous and should therefore be liberally construed for Boatrights.[228] The antistacking clause's application is tied by its own language to the insurance being issued by a member company of a specific insurance group, but the named insurer on the declarations page cannot be determined by policy language to be a member of that group. Because of the unclear language employed in the contracts of insurance, there is doubt or uncertainty as to its meaning, and it is fairly susceptible of two interpretations. Accordingly, the language is ambiguous, and the exclusionary "limits of coverage" antistacking language in the policies does not apply to deny the plaintiffs' coverage. Therefore, the plaintiffs may aggregate the $400,000 of underinsured coverage available under the four policies in effect at the time of the collision.[229]

226. *Id.* at ¶ 12.
227. *Id.* at ¶ 25.
228. *Id.* at 26.
229. *Id.* at 32.

E. Arbitration of Uninsured Motorist Claim

1. Reagan v. State Farm Ins. Co.

Holding: that if it appears on the face of an arbitration award that the arbitrators were "so mistaken as to the law that, if apprised of the mistake, the award would be different," a reviewing court may vacate an arbitration award on the grounds of gross mistake of fact or law.[230] The plaintiff was mistaken that such a mistake of law was present on the face of the arbitration award in the present case.[231]

In *Reagan v. State Farm Ins. Co.*, there was an automobile accident in which Warren Reagan's decedent, Michael Reagan, was killed. At the time of the accident, Warren Reagan ("Reagan") had an insurance policy with State Farm Insurance Company. The policy included benefits for damages due to the negligence of underinsured drivers. Reagan sought benefits pursuant to this policy, claiming that the driver of the other vehicle involved in the accident, Lloyd Searcy, was underinsured and that Searcy's negligence proximately caused the accident. The policy provided that in order to obtain payment pursuant to the underinsured provision, the insured and the insurer must come to an agreement with regard to whether the insured was "legally entitled to collect damages from the owner or driver of the uninsured motor vehicle or underinsured motor vehicle" and "[i]f so, in what amount?" If the parties could not come to an agreement on these two questions, the policy provided that arbitration would follow, and that "[s]tate court rules governing procedure and admission of evidence" would be used in arbitration. Arbitration proceeded and the arbitrators came to an award which was entered.[232]

The court reviewed whether an action to determine if there is insurance coverage is a burden on the insured to prove. In Illinois, an action to determine if there is insurance coverage is a burden on the insured. The insured needs to prove that its claim falls within the coverage of an insurance policy. Consequently, Reagan as the insured under its policy with State Farm, had the burden to show that it was entitled to collect payment under the policy. To do that, Reagan had to prove, pursuant to the language of the policy, that he was "legally entitled to collect damages from the owner or driver of the uninsured motor vehicle or underinsured motor vehicle." The arbitrators in their final award stated that Reagan "failed to meet its burden of proof on the issue of liability in this case" and that the deceased was more

230. Reagan v. State Farm Ins. Co., 2013 IL App (5th) 110251-U, ¶ 8 (Filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
231. *Id.*
232. *Id.* at ¶ 4.

than 50% at fault for the cause of the accident. There was no improper shifting of the burden of proof to the plaintiff. The Illinois Supreme Court has held that if it appears on the face of an arbitration award that the arbitrators were "so mistaken as to the law that, if appraised of the mistake, the award would be different," a reviewing court may vacate an arbitration award on the grounds of gross mistake of fact or law. The plaintiff was mistaken that such a mistake of law was present on the face of the arbitration award in the present case.[233]

F. Bad Faith in Settling Insured's UIM Claim

*1.* O'Connor v. Country Mut. Ins.

Holding: Insurer's lack of a manual or procedure for evaluating claims is not enough to constitute an improper claims practice so as to establish that insurer's conduct in settling insured's UIM claim amounted to an unreasonable and vexatious refusal to pay a claim as required entitling insured to statutory damages.[234]

In *O'Connor v. Country Mut. Ins. Co.,* Dorene O'Connor was injured in an automobile accident and sustained medical expenses. Country Mutual Insurance provided automobile insurance to O'Connor with a policy that included limits of $250,000 for underinsured motorist (UIM) coverage and $10,000 for medical payments coverage. Pursuant to the policy, Country Mutual paid O'Connor the full $10,000 in medical payments coverage. She also received payout from the tortfeasors' insurers. In November 2004, Country Mutual offered a settlement of $40,000 under the policy's UIM provisions. O'Connor offered to settle her claim for $97,500. The parties failed to reach an agreement on a settlement amount under the UIM provisions and in December 2005 proceeded to arbitration as required by the policy. The arbitrators entered an award of $213,295 for O'Connor, subject to $115,000 in setoffs. Country Mutual had to pay $98,295; it promptly paid the arbitration award and O'Connor deposited the check.[235]

O'Connor filed a two-count complaint, seeking damages under section 115 of the Illinois Insurance Code.[236] She alleged that (a) the arbitration award was more than twice Country Mutual's offer, "raising an inference that the defendant failed and refused to evaluate and pay plaintiff's claim . . . in an objectively reasonable sum prior to arbitration"; (b) Country Mutual gave

233. *Id.* at ¶ 8.
234. O'Connor v. Country Mut. Ins. Co., 2013 IL App (3d) 110870, ¶ 15.
235. *Id.* at ¶ 3.
236 . 215 ILL. COMP. STAT. 5/155 (2002).

insufficient deference to Plaintiff's interests; and (c) Country Mutual failed to use any objective criteria in evaluating Plaintiff's claim.[237]

The court reviewed whether the conduct of the Country Mutual was vexatious and unreasonable when it settled the claim. The court explained that Section 155 is an extracontractual remedy for policyholders available when an insurer's refusal to pay a claim is vexatious and unreasonable. The purpose of the statute is to provide a remedy for insurer misconduct and to make actions by policyholders economically feasible. The key question in an action under section 155 is whether the conduct of the insurance company was unreasonable and vexatious. The relevant inquiry is whether the insurer had a bona fide defense to the insured's claim. When an insurer presents a bona fide defense, a section 155 action cannot be maintained. Insurer's lack of a manual or procedure for evaluating claims did not constitute an improper claims practice so as to establish that insurer's conduct in settling insured's UIM claim amounted to an unreasonable and vexatious refusal to pay a claim as required to entitle insured to statutory damages. The insurer employed a method for investigating and evaluating insured's and other litigated claims, insurer's attorneys explained steps they employed in valuing insured's and other claims, and evidence was presented that insurer used reasonable standards for claims settlement and its witnesses were able to explain the basis of its proffered settlement.[238]

G. Unreasonable Delay in Recognizing Liability

*1.* Castellano v. State Farm Mutual Automobile Insurance Co.

Holding: The insured provided a modicum of factual support necessary to allege a cause of action for a breach of the insurance contract and claim relief under section 155.[239]

In *Castellano v. State Farm Mutual Automobile Insurance Co.*, Jeffrey M. Castellano filed a complaint against State Farm Mutual Automobile Insurance and alleged that State Farm vexatiously and unreasonably delayed payment of underinsured motorist benefits in breach of it duties under an automobile insurance contract. Castellano sought damages for extra contractual remedies pursuant to section 155 of the Illinois Insurance Code.[240]

Castellano was seriously injured when a vehicle driven by Roger Sigmon rear-ended his vehicle. At that time both vehicles were insured by

237. *Id.* at ¶ 4.
238. *Id.* at ¶ 13–14.
239. Castellano v. State Farm Mutual Automobile Insurance Co., IL App. (5th) 5519596-U, ¶ 16 (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
240. *Id.* at ¶ 2 (citing 215 ILL. COMP. STAT. 5/155(1) (2004)).

State Farm. Sigmon's policy provided a bodily injury liability limit of $50,000.[241] This amount was not sufficient to compensate for Castellano's injuries and damages. Castellano filed a claim for underinsured motorist benefits under his own auto insurance contract with State Farm. Pursuant to Castellano's policy covering underinsured motorist benefits, State Farm would pay for damages for bodily injury that an insured is legally entitled to collect from the owner of driver of an underinsured motor vehicle.

However two questions must be decided by agreement between the insured and State Farm: (1) is the insured legally entitled to collect damages from the owner or driver of the uninsured or underinsured motor vehicle; (2) if so, in what amount. If there is no agreement, these questions shall be decided by arbitration.[242] Castellano and State Farm agreed that Castellano was entitled to collect damages, however, the parties could not agree on the amount of damages. Castellano notified State Farm that he would pursue his contractual right to arbitrate and requested that State Farm tender $10,000 pending arbitration since the parties agreed that the claim was at least worth that. State Farm responded via a letter that it was preparing for arbitration and enclosed a check for $5,000. The claim was arbitrated and Castellano was awarded $25,000. At this point, Castellano filed an action against State Farm. Castellano filed a second amended complaint which pared to its core, the allegations of State Farm's breach of contract.[243]

The court addressed the question of whether the insured, Castellano, alleged sufficient facts to state a claim for a breach of his insurance contract and for section 155 penalties. Section 155 states: "In any action by or against a company wherein there is in issue the liability of a company on a policy or policies of insurance or the amount of the loss payable thereunder, or for an unreasonable delay in settling a claim, and it appears to the court that such action or delay is vexatious and unreasonable, the court may allow as part of the taxable costs in the action reasonable attorney fees, other costs, plus an amount not to exceed any one of the following amounts . . . ."[244] Section 155 does not establish an independent cause of action, but expands a plaintiff's relief to include attorney fees, costs, and a limited penalty in addition to a breach of contract action to recover the amount due under the insurance contract. Therefore a plaintiff must adequately allege a cause of action for a breach of an insurance contract as mere allegations of vexatious conduct are not sufficient, he must include modicum of factual support.[245] The key question in an action brought under section 155 is whether the insurer's conduct is vexatious and unreasonable. Whether an insurer's action or delay

241. *Id.* at ¶ 3.
242. *Id.* at ¶ 4.
243. *Id.* at ¶ 5.
244. *Id.* at ¶ 12 (citing 215 ILL. COMP. STAT. 5/155(1) (2004)).
245. *Id.* at ¶ 13.

is vexatious and unreasonable is a factual question and the decision whether to allow a section 155 fees and penalties lies within the discretion of the court. An insurer does not violate section 155 merely because it unsuccessfully litigates a dispute involving the scope of coverage or the magnitude of the loss or it delays settlement because of a *bona fide* coverage dispute. That said, an insurer's conduct may be vexatious and unreasonable if the insurer refuses to settle and proceeds to arbitration without presenting a *bona fide* defense. Therefore the court determined that Castellano provided a modicum of factual support necessary to allege a cause of action for a breach of the insurance contract and claim relief under section 155. He alleged sufficient facts to support a claim that State Farm, in breach of its contractual duties and its own internal company policy or practice, vexatiously and unreasonably refused to tender the undisputed amount of underinsured benefits pending arbitration, and instead arbitrarily tendered the amount of its first offer. In this first-party insurance claim, the allegations are adequate to allow for discovery on the factual questions regarding the insurer's attitude, its superior financial position, and its motivation for withholding payment of the undisputed sum of underinsured benefits pending arbitration.[246]

## VII. COMMERCIAL GENERAL LIABILITY INSURANCE AND PROFESSIONAL LIABILITY COVERAGE

### A. Duty to Defend and Indemnify the Policy Holder

#### *1.* Pekin Insurance v. Equilon Enterprise

Holding: Duty to defend additional insured based on language of endorsement for liability arising out of operations or premises owned or rented by insured.[247]

In *Pekin Insurance v. Equilon Enterprise*, Waldemar Zablocki filed suit for injuries he sustained while he lit a cigarette behind the gas station while a truck delivered gasoline to the underground tanks of the station. Equilon Enterprises and Shell Oil Company are subsidiaries of the Royal Dutch Shell Company. Summit signed certain franchise agreements with Shell, which imposed a duty on Summit to name Shell as an additional insured under Summit's liability policy.[248]

In its complaint for declaratory judgment, Pekin claimed its insurance policy extended coverage to Shell for negligence in the granting of a franchise and to claims of vicarious liability. The Zablocki complaint did not

246. *Id.* at ¶¶ 14–15.
247. Pekin Insurance v. Equilon Enterprise, 2012 IL App (1st)111529, ¶ 36.
248. *Id.* at ¶ 3.

allege that the Shell defendants were vicariously liable for Zablocki's injuries; nor did the complaint allege any fault by Shell in granting a franchise to Summit. Summit procured the Pekin policy as the named insured with an effective date of July 1, 2007. In accordance with certain franchise agreements, Summit listed Shell as "additional insured" to the Pekin policy. Under the "Optional Coverage" of the policy's "Businessowners Supplemental Declarations," there are two entries for the additional insured, each of which modifies the "Who is an Insured" clause of the policy.[249]

The court reviewed whether the insurer has a duty to defend the action. Pekin claimed the policy covers actions that allege negligence in the granting of the franchise by Shell under the first endorsement. Additionally, Pekin argued the second endorsement of July 1, 2007, afforded coverage only for vicarious liability based on the "arising out of" language, which the Zablocki action did not allege as the basis for his claims against Shell.[250]

There are two endorsements for optional coverage, which purported to provide coverage to the additional insured under the Pekin policy. The existence of these two endorsements for additional-insured coverage necessarily means that the "Grantors of Fran" endorsement does not provide the only coverage to Shell, as the additional insured. While the "Grantors of Fran" endorsement appeared to limit coverage as Pekin claims to negligence arising from the awarding of a franchise, Pekin did not, and cannot, argue that either coverage existed for Shell under that endorsement or it did not exist at all. Plainly, Shell was also listed as additional insured under the second endorsement. Thus, it cannot be that the first endorsement limits coverage under the entire policy as Pekin contended "negligence in granting a franchise" in light of the second endorsement. If the first endorsement limited coverage to only instances of negligence in granting a franchise, it would render meaningless the coverage provided by the second endorsement. "[A]ny ambiguities arising when several provisions of the policy are read together will be construed in favor of the insured." The second endorsement provided for coverage to Shell as additional insured, the "grantor of franchise" endorsement did not limit coverage under the Pekin policy to Shell in its "capacity as franchisor to Summit."[251]

The franchise agreements, as the driving force behind Summit's procurement of the Pekin policy, reinforced the court's decision that Pekin had a duty to defend Shell. Resolution of the duty to defend issue should not turn on the absence of allegations of vicarious liability when the allegations in the complaint do not preclude the possibility that the additional insured

249. *Id.* at ¶¶ 6–8.
250. *Id.* at ¶ 15.
251. *Id.* at ¶ 20.

could be found liable solely because of the acts or omissions of the named insured.[252]

Accordingly, the court rejected Pekin's implicit contention that in the context of this case, only if the allegations of the underlying complaint support a claim of vicarious liability can the court find a duty to defend owed by Pekin. The burden is on Pekin to demonstrate that the allegations in the underlying complaint do not potentially fall within the coverage of the policy.[253]

*2.* American Econ. Ins. Co. v. Haley Mansion Inc.

Holding: The insurance company had a duty to defend its insureds because not all of the defamatory statements alleged were employment related and the additional two policy exclusions did not apply.[254]

In *American Econ. Ins. Co. v. Haley Mansion, Inc.*, Mansion and Bussean filed a complaint against their former employee, Molburg. Mansion and Bussean alleged that Molburg, who was hired as the general manager, told other employees that Bussean installed hidden surveillance cameras and was secretly taping employees and female guests undressing in the bridal suite of the Mansion. Molburg also allegedly told employees that Bussean repeatedly made sexually graphic and vile statements to Molburg about each of them. As a result of Molburg's statements the employees quit. In response, Molburg filed a counterclaim where she alleged defamation per se, defamation per quod, and false light against the Mansion and Bussean. She also alleged sexual harassment, retaliatory discharge, retaliation, and a violation of the Illinois Consumer Fraud and Deceptive Trade Practices Act. In Molburg's counterclaim, she alleged that Bussean consistently made lewd comments about women's physical features, breasts, and bodies; would become enraged if women in his employ rejected him; installed a camera in the private bridal suite that sent a live feed to his office; and did not want married women to be hired, instead preferring single, attractive women. According to Molburg's counterclaim, on July 31, 2010, employees at the Mansion advised Molburg that the Joliet police department wanted to search the premises. Molburg met with the two detectives and told them that she did not have the authority to permit their request. Bussean then terminated her employment on July 31, 2010, and after that date, Bussean told others that she was "mentally unstable," "incompetent," "untrustworthy," a "cunt," "engaged in criminal activity," and a "dishonorable woman."[255] Molburg

252. *Id.* at ¶ 31.
253. *Id.* at ¶ 33.
254. American Econ. Ins. Co. v. Haley Mansion Inc., 2013 IL App (3d) 1760600-U, ¶ 1 (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
255. *Id.* at ¶¶ 4–7.

alleged, in part, that Bussean either knew the statements against her were false or acted with reckless disregard as to the falsity of the statements. On March 21, 2011, American Economy filed a complaint for declaratory judgment in the case. It sought a declaration that American Economy had no duty to defend its insureds, the Mansion, Bussean, and Bussean Catering, with regard to Molburg's counterclaim.[256]

According to American Economy's second amended complaint, the insureds were covered under a commercial general liability policy from September 1, 2009, to September 1, 2010, and from September 1, 2010, to September 1, 2011. The policy stated that American Economy had a duty to defend its insureds against any lawsuit seeking damages for a "personal and advertising injury." The policy defined personal and advertising injury to include any oral or written publication that slandered or libeled a person's goods, products, or services, or violated a person's right to privacy. However, the policy also included multiple exclusions to this coverage. The first exclusion involved "Employment-Related Practices" and excluded coverage for claims of any person that arose out of (1) termination of the person's employment or (2) employment related practices, policies or acts or omission, like coercion, demotion, evaluation reassignment, discipline, defamation, harassment, humiliation, discrimination, or malicious prosecution directed at that person. The second exclusions involved "Knowing Violation of Rights of Another" and excluded coverage for claims of any person that arose out of personal and advertising injury cause by the insured with knowledge that the act would violate the rights of another and would inflict personal and advertising injury. The third exclusion in the policy involved "Material Published with Knowledge of Falsity" and excluded coverage for claims based on "personal and advertising injury" that arose out of oral or written publication of material, if done by or at the direction of the insured with knowledge of its falsity.[257]

The court addressed the question of whether the policy exclusions apply. American Economy contended that an employer's alleged defamatory statements need not be related to the employee's performance for the exclusion to apply. American Economy suggested that when an employer shares no other relationship with the employee outside the workplace, an alleged defamatory remark by the employer should be automatically considered to arise out of the employment relationship and the defamation is therefore employment-related. The court disagreed because the plain language of the exclusion specifically excluded coverage of any claims of person that arose out of "employment-related practices, policies, acts or omissions, such as…defamation…directed at that person." Thus with regard

256. *Id.* at ¶ 8.
257. *Id.* at ¶¶ 9–11.

to the act of defamation, the exclusion applies if the statement relates to the employment of the alleged defamed person. The court therefore focused on the content of the statement, not the nature of the relationship between the parties, to determine if the exclusions applied to Bussean's actions. The court concluded the policy, by its own terms, is clear that the exclusion applied to any employment- related statement by Bussean that gives rise to a defamation claim.[258]

The court in analyzing the other two exclusions, "Knowing Violation of Rights of Another" and "Material Published with Knowledge of Falsity," determined based on the plain language of the policy, that in order for these exclusions to apply, the insured had to cause injury, in this case, defamation, with knowledge of its falsity. The case law provided that the allegations of recklessness may bring a defamation claim within the potential coverage of a policy which covers defamation but excluded knowing falsehoods. Thus the court found that these two policy exclusions do not apply.[259]

*3.* Country Mutual Insurance Co. v. Molburg

Holding: That the business pursuit exclusion of insurance policy did not apply to relieve insurance company of its duty to defend its insured in a defamation action.[260]

In *Country Mutual Insurance Co. v. Molburg*, County Mutual filed a complaint for declaratory judgment seeking a declaration that County Mutual had no duty to defend Molburg against claims filed by Molburg's former employer for purported defamatory conduct. Country Mutual's complaint named Molburg, Haley Mansion ("the Mansion"), and Jeffrey Bussean ("Bussean"), the owner of the Mansion. Molburg's personal umbrella policy required County Mutual to defend her against claims for personal injury or property damage involving alleged libel, slander, defamation of character, or invasion of rights of privacy, but the policy excluded coverage for claims arising out of any "business pursuit of the insured." Just before voluntarily leaving her employment as general manager on July 30, 2010, Molburg breached her fiduciary duty to her employer by making false statements about her employer's "vile conduct" with the intent to cause other employees to leave. Specifically, the complaint alleged on July 30, 2010, Molburg told other employees that Bussean installed hidden surveillance cameras and was secretly taping employees and female guests undressing in the bridal suite of the Mansion. Molburg also allegedly told employees that Bussean repeatedly

258. *Id.* at ¶ 20.
259. *Id.* at ¶ 25.
260. Country Mutual Insurance Co. v. Molburg, 2013 IL App (3d) 120364-U, ¶ 20 (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).

made sexually graphic and vile statements about each of them. As a result of Molburg's alleged statements, the employees abruptly quit and the Mansion was unable to host several events that it had booked. The complaint also alleged that after voluntarily leaving her employment on July 30, 2010, Molburg continued her campaign to harm the Mansion and Bussean by making false statements to third parties, including but not limited to the Joliet police department.[261]

The court addressed the issue of whether the statements made by Molburg would fall under the policy exclusion of claims arising out of any business pursuit of the insured. Molburg's umbrella policy defines "business" as any gainful employment, trade, occupation or enterprise other than farming. The court reasoned that Molburg's position as general manager of the Mansion was gainful employment under the terms of the policy and that her employment therefore falls within the concept of business. Next the court focused on the term "business pursuit" which was not defined by the policy. However, the court had continuously defined the term as a continuous or regular activity done for the purpose of earning a profit. In this case, the court determined that the complaint does not allege Molburg made any statement to a third party for the purpose of obtaining her financial profit. Instead these statements appeared to be motivated by personal insecurity, a desire to keep her employment and vindictiveness. Absent allegations that Molburg's statement arose out of a continuous and regular activity, done for the purpose of making a profit, the court could not conclude that purported defamation arose out of Molburg's own business pursuit as defined by case law.[262]

B. Notice of Occurrence, Notice of Suit

*1.* Mt. Hawley Insurance Co. v. Robinette Demolition Inc.

Holding: That (1) a subcontractor's breach of its duty to notify insurer of its employee's workplace injury and the employee's personal injury lawsuit did not bar coverage for contractor and (2) construction company was an additional insured under policy.[263]

In *Mt. Hawley Insurance Co. v. Robinette Demolition Inc.*, Mt. Hawley Insurance Company, filed a complaint against Robinette Demolition Company and Valenti Construction, LLC seeking a declaration that Mt. Hawley did not owe a duty to defend and indemnify Robinette Demolition Company and Valenti Construction, LLC in a personal injury suit filed by Richard Bucholz, an employee of one of the Robinette's subcontractors,

261. *Id*. at ¶ 6.
262. *Id.* at ¶¶ 18–20.
263. Mt. Hawley Insurance Co. v. Robinette Demolition Inc., 2013 IL App (1st) 3864520, ¶ 56.

Cobra. Robinette and Cobra Concrete Cutting Service, Inc. (Cobra) entered into an "ongoing sub-contract agreement" (the Agreement) under which Cobra would perform concrete cutting services for Robinette on future projects. The Agreement required Cobra to "defend, indemnify and hold harmless" Robinette and "any and all other Additional Insureds specified in Schedule 'B' hereof against all claims, damages, losses, costs, expenses, judgments and liabilities." Schedule B delineated the type and amounts of insurance coverage and required that the insurance policy obtained by Cobra include an endorsement naming Robinette and "any other parties as may be reasonably required by [Robinette]" (emphasis omitted) as additional insureds. Robinette tendered its defense and indemnification to Mt. Hawley. Mt. Hawley responded denying liability coverage because Robinette was potentially an additional insured; it was subject to all policy terms. Mt. Hawley's first notification of the Bucholz's accident was Robinette's tender which was almost two years after the accident. Since Mt. Hawley was not notified of the accident in accordance with the terms of the policy, it denied any coverage. Mt. Hawley further determined that Valenti was not an additional insured under the policy because the agreement did not require Valenti to be added as an insured.[264]

The court addressed the issue of whether the named insured's breach of its duty to notify under the policy bars coverage for additional insureds who have complied with their duty under the policy notice provision.

The court ascertains the parties' intent from the policy language. There is nothing in the notice provision of the policy making coverage for the additional insured contingent on the named insured's compliance with its duty to notify. The court cannot import language into a policy that was not placed there by the parties but must determine what the policy is, not what a party argues it should be. The language of the notice provision does not evidence the parties' intent to make the coverage for the additional insureds contingent on the named insured's compliance with its duty to notify under the policy. Since Robinette Demolition Company complied with their duty under the notice provision of the policy they are entitled to coverage as additional insureds.[265]

The court then addressed the issue of whether there was a duty to defend and indemnify Valenti. Due to the ongoing nature of the Agreement, the unambiguous language of schedule B reflects the parties' intention that, in addition to Robinette, Cobra was required to obtain additional insured coverage for other entities to be designated at a future time by Robinette. The work order referred back to the parties' Agreement, which set forth that requirement. The fact that the certificate of insurance was issued by Cobra's

264. *Id.* at ¶ 1–3.
265. *Id.* at ¶ 39.

agent rather than Mt. Hawley's agent is not dispositive. By itself, the certificate of insurance did not fulfill the policy's written contract requirement. The certificate did provide an additional writing which supports a finding that the written agreement between Cobra and Robinette contemplated that, at a future time, Robinette would name other entities to be added as additional insureds. Construed together, the Agreement, the work order and the certificate of insurance satisfied the policy requirement that there be a written contract requiring Cobra to name Valenti as an additional insured. Contrary to Mt. Hawley's position and the circuit court's determination, the policy's written contract provision did not require that Valenti's name appear in the Agreement. Therefore, the court concluded that Mt. Hawley was required to provide insurance coverage for Valenti as an additional insured.[266]

C. Targeted Tender Doctrine

*1.* United National Insurance Company v. 200 North Dearborn Partnership

Holding: United National had a duty to defend the "non-identified defendants" under the "additional insured" endorsement since they were partners of 200 North Dearborn. The court also determined that defendants had targeted tender to United National rather than to Hartford and United National was required to reimburse Hartford for all sums paid in defense and settlement of the underlying lawsuit.[267]

In *United National Insurance Company v. 200 North Dearborn Partnership*, Marian Gal, a janitorial worker, died due to an elevator malfunction at a building located at 200 North Dearborn Parkway in Chicago. The accident occurred on July 19, 2001. A complaint was filed on or about August 21, 2001. The fifth amended complaint, was filed on June 22, 2006, the named defendants were 200 North Dearborn Partnership, Aargus Security Systems, Inc., Schindler Elevator Corporation, Baird & Warner, Inc., Baird & Warner Management Group, Inc., B & W Management Group, Inc., Elzie Higgenbottom, Kenilworth, Inc., and Warner Investment Company, Inc., f/k/a Kenilworth, Inc. The suit was ultimately settled in November 2006. Aargus Security contracted with 200 North Dearborn in a continuing services agreement (Agreement) to provide certain services with respect to the property located at 200 North Dearborn Parkway in Chicago. The Agreement provided that Aargus would name Baird & Warner, Inc., and the "owner" as

266. *Id.* at ¶ 48.
267. United National Insurance Company v. 200 North Dearborn Partnership, 2012 IL App (1st) 100569, ¶¶ 3–5.

"additional insureds." "Owner" was defined as "200 North Dearborn Partnership."[268]

United National issued a commercial general liability policy to Aargus, which covered the time period when Gal's accident occurred. The "additional insured" endorsement did not specifically name who was an additional insured; rather, it stated "blanket where required by contract." The "additional insured" endorsement contained two limitations. First, the insurance would not apply to an additional insured's own acts or omissions. Second, if liability was to be imposed on the additional insured because of its acts or omissions and those of the named insured, the insurance would serve as "coinsurance with any other insurance available to the additional insured, in proportion to the limits of liability of all involved policies." The policy also contained an employer's liability exclusion, which excluded coverage for bodily injury to an employee of the insured arising out of and in the course of employment by the insured. United National initially denied coverage to 200 North Dearborn and Baird & Warner; however, United National later provided a defense under a reservation of rights.[269] 200 North Dearborn was also insured by Hartford Casualty Insurance Company. Hartford issued a commercial general liability insurance policy to 200 North Dearborn, which covered the relevant time period when Gal's accident occurred. United National acknowledged that it had agreed under a reservation of rights to defend 200 North Dearborn and Baird & Warner pursuant to the "additional insured" endorsement in its policy with Aargus.[270]

The issue before the court is first whether United National was not estopped from contending coverage. The court finds that United National was not estopped from contesting coverage because United National defended 200 North Dearborn and Baird & Warner under a reservation of rights and also filed a declaratory judgment action which sought a determination of its rights to defend the "non-identified defendants" (Kenilworth, Warner and Higgenbottom). The record indicated that 200 North Dearborn first tendered its defense to United National on September 27, 2002. On February 12, 2003, Baird & Warner also tendered its defense to United National. Both 200 North Dearborn and Baird & Warner were targeting tender to United National and wanted United National to exclusively defend them rather than their own insurance provider, Hartford. United National's declaratory judgment suit was filed within a reasonable amount of time so as to preclude estoppel. 200 North Dearborn and Baird and Warner tendered their defense to United National in 2002 and 2003, and United National agreed to defend them under a reservation of rights in 2005. United National only learned the "non-identified defendants" were seeking

268. *Id.* at ¶¶ 4–6.
269. *Id.* at ¶ 7.
270. *Id.* at ¶ 8.

coverage under United National's "additional insured" endorsement sometime in 2005 or 2006. Therefore, its filing of the declaratory judgment suit in August 2006 was not so delayed or unreasonable to apply estoppel. United National defended 200 North Dearborn and Baird & Warner under a reservation of rights and subsequently filed a declaratory judgment action shortly after learning the "non-identified defendants" claimed coverage under its policy.[271]

The second issue before the court is whether the employee liability exclusion in United National's policy excluded coverage by Gal because he was the insured's employee. The court found that Gal was the insured's employee, and as such, the employee liability exclusion in the policy precluded indemnification.[272]

On cross-appeal the issue before the court was whether the "non-identified defendant" were additional insureds under the "additional insured" endorsement in the policy. The court however finds that there is no such language in the policy excluding any past or present partners of 200 North Dearborn. The court declined to adopt United National's interpretation that as "owner," "200 North Dearborn Partnership" did not include the partners within the partnership. Therefore, United National had a duty to defend the "non-identified defendants" under the "additional insured" endorsement. United National was obligated to provide for all of defendants' defense costs, up to the policy limits.[273]

200 North Dearborn and Baird & Warner sought coverage under United National's "additional insured" endorsement in 2003 and informed United National that they would not invoke any coverage from their insurer, Hartford. However, when United National initially refused to defend 200 North Dearborn and Baird & Warner, they turned to Hartford to provide a defense. Subsequently, United National defended 200 North Dearborn and Baird & Warner under a reservation of rights, but only reimbursed Hartford 50% of the defense costs since it believed its policy only acted as coinsurance. However, an insured who is covered under more than one policy may choose which insurer would be required to defend and indemnify it and the insurer may not seek contribution from another insurer notwithstanding an "other insurance" clause in the policy. Therefore, United National should have provided 100% of the defense. Since 200 North Dearborn and Baird & Warner targeted their defense to United National, there was no other "available" insurance for United National's policy to as act as coinsurance.[274]

271. *Id.* at ¶ 22.
272. *Id.* at ¶ 23.
273. *Id.* at ¶¶ 32–33.
274. *Id.* at ¶ 37.

*2.* West Bend Mutual Ins. v. Home and Garden Supply Inc.

Holding: That "operations" exclusion did not preclude coverage; (2) both insured's "excess clauses" cancelled each other out and the targeted tender rule applied; and, (3) insured had not waived right to reimbursement.[275]

In *West Bend Mutual Ins. v. Home and Garden Supply Inc.*, Barbara Meisel filed suit against Home & Garden, Target and Waldschmidt & Associates, Inc. She alleged that she was injured when she slipped and fell on snow and ice in Target's parking lot. Waldschmidt provided snow plowing services for Home & Garden and Target.[276] At the time of Meisel's accident, Waldschmidt had a contract with Home & Garden to provide snow removal services for Target. The terms of the contract provided that snow removal services would commence at "freezing rain and ice conditions and/or snow level of 1.5 inches." Waldschmidt was required to maintain an "ice/snow free environment." The contract contained an indemnification provision in which Waldschmidt agreed to assume responsibility for all injuries or damages arising out of its performance or failure to perform and agreed to defend, indemnify and hold harmless Home & Garden against any and all claims arising out of Waldschmidt's performance. Further, the contract required Waldschmidt to include Home & Garden and Target as additional insureds on a commercial general liability policy it was required to maintain.[277]

Home & Garden and Target tendered their defense to West Bend, alleging they were additional insureds under Waldschmidt's policy. West Bend refused the tender and filed this declaratory judgment action. Ohio Casualty defended Home & Garden and Target and ultimately settled the underlying suit with Meisel on May 5, 2010. Ohio Casualty subsequently intervened in the declaratory judgment action seeking equitable subrogation and contribution against West Bend.[278] West Bend issued a commercial general liability policy to Waldschmidt that was in effect at the time of Meisel's accident. The policy contained an additional insured endorsement that included as an additional insured "any person or organization that you are required to add as an additional insured on this policy under a written contract or written agreement."

It was not contested that Home & Garden and Target were additional insured under the policy. The additional insured endorsement contained an exception, which the parties refer to as the "completed operations" exception,

275. West Bend Mutual Ins. v. Home and Garden Supply Inc., 2012 IL App (1st) 112728-U, ¶ 7 **(**This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
276. *Id.* at ¶ 3.
277. *Id.* at ¶ 10.
278. *Id.* at ¶ 2.

which provided that it did not apply to bodily injury occurring after (1) "all work on the project (other than service maintenance or repairs) to be performed by or on behalf of the additional insured at the site of the covered operations has been completed" or, (2) "that portion of 'your work' out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as part of the same project."[279] West Bend argued that the "completed operations" exclusions precluded coverage for Home & Garden and Target because when Waldschmidt finished plowing the parking lot, its operations for the day was completed and the parking lot had been put in its intended use.[280]

The first issue that the court addressed was whether the "completed operations" exception in the policy applied. However, here, as provided in Waldschmidt's contract with Home & Garden, Waldschmidt was required to maintain an "ice/snow free (i.e. bare pavement) environment." The contract specifically included the term "bare pavement" and the parties mutually assented to the use of that term. Waldschmidt's snow removal duties were not complete until the condition of the parking lot was "bare pavement." When Waldschmidt left the parking lot, a dusting of snow had begun to accumulate. Meisel fell at about 10 a.m. where new snow had covered an icy surface. Since the parking lot had not been cleared to "bare pavement," Waldschmidt had not completed its operations when he left. Therefore, the court concluded that the "completed operations" exclusion in West Bend's policy with Waldschmidt does not preclude coverage.[281]

The court next addressed the issue of whether West Bend's insurance policy was excess over any other insurance and whether the targeted tender rule could be utilized to require West Bend to provide a defense.[282] Both the West Bend and Ohio policies contained "other insurance" provisions, which provided that they were excess over any other insurance. Primary policies and excess policies are clearly distinct and serve different purposes.[283] A "true" excess policy exists as part of an overall insurance package and provides a secondary level of coverage to protect the insured where a judgment or settlement exceeds the primary policy's limits of liability. An excess policy will not be triggered until the limits of the primary insurance coverage are exhausted. The West Bend and Ohio policies are not "true" excess policies. They are primary policies with "other insurance" provisions that contain "excess" clauses. Both "excess" clauses intend to apply over and above or after any other available insurance. West Bend and Ohio Casualty

279. *Id.* at ¶ 11.
280. *Id.* at ¶ 12.
281. *Id.* at ¶ 18.
282. *Id.* at ¶ 20.
283. *Id.* at ¶ 21.

policies contain "other insurance" provisions with "excess" clauses. The "excess" clauses are not identical but similar in that each clause provides that when any other insurance is available, the policy applies as excess.[284] Since the two clauses are mutually repugnant and incompatible they must cancel each other out. Given that the excess clauses cancel each other out, both the West Bend and Ohio Casualty policies would share the costs of defending and indemnifying the underlying lawsuit if not for the target tender rule. The target tender rule allows an insured covered by multiple concurrent insurance policies the right to select which insurer will defend and indemnify it regarding the specific claim. Here, Home & Garden and Target targeted tender to West Bend. West Bend was solely obligated to defend and indemnify Home & Garden and Target in the underlying lawsuit.[285]

Lastly the court addressed the issue of whether Ohio Casualty waived its right to seek reimbursement from West Bend. The court found no waiver. Home & Garden, Target and Ohio Casualty consistently took the position that West Bend was obligated to defend and indemnify them in the underlying lawsuit. There was neither an intentional relinquishment of a known right, nor any conduct inconsistent with their position.[286]

*3.* Navigators Ins. Co. v. Northern Builders, Inc.

Holding: That based on the terms agreed to by the parties in both contracts and in their respective insurance policies, West Bend's insurance coverage procured by subcontractor, Weldex Inc. provided concurrent primary coverage for the general contractor, Northern Builders Inc.[287] Therefore, Navigators Insurance Co. owes a duty to defend the general contractor, Northern Builders, Inc. along with West Bend Mutual Insurance Co.[288]

In *Navigators Ins. Co. v. Northern Builders, Inc.*, a declaratory judgment action was filed by Navigators Insurance Company, which arose out of a personal injury lawsuit that was filed by Darren Beuder and his wife, Krystal Beuder, against the general contractor, Northern Builders, Inc. and subcontractor, Arlington Structural Steel Co., Inc. The Beuders sought damages for injuries Darren Beuder received while he was working on a construction site for his employer and a subcontractor, Weldex Inc. Navigators, sought a declaration that it did not owe primary insurance

284. *Id.* at ¶ 22.
285. *Id.* at ¶ 23.
286. *Id.* at ¶ 29.
287. Navigators Ins. Co. v. Northern Builders, Inc. 2013 IL App (1st) 2145932-U, ¶ 1 (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
288. *Id.*

coverage to Northern Builders under the insurance policy. Weldex, Inc., argued that it provided only excess coverage for Northern Builders.[289]

The subcontract between Arlington and Weldex required that Weldex name both Arlington and Northern Builders as additional insureds under its general liability insurance policy issued by Navigators. Northern Builders notified both Navigators (Weldex's insurance carrier) and West Bend (Arlington's insurance carrier) of the Beuders' lawsuit and that Northern Builders was a primary additional insured under their respective insurance policies and that they owed a duty to defend and indemnify with respect to the Beuders' lawsuit.

Both West Bend and Navigators agree that Northern Builders is an additional insured under the respective insurance policies.[290] The question before the court was which insurance policy had priority on insurance coverage. In Illinois, priority of coverage between two insurance policies was dictated by the terms of the "other insurance" clauses in the policies. The Illinois supreme court has held that, whenever possible, "other insurance" clauses in competing policies should be reconciled to effectuate the intent of the parties. Where one insurance policy contained a primary "other insurance" clause and the other insurance policy contained an excess "other insurance" clause, the insurance company with the excess "other insurance" clause was treated as providing excess coverage. In such an instance, the insurance company providing excess coverage was held liable only after the insurance company with the primary "other insurance" clause has exhausted its policy limits.[291]

West Bend's insurance policy did not contain an excess "other insurance" clause applicable to Northern Builders. The first sentence in West Bend's AI Endorsement stated that "[t]his insurance is excess over: Any other valid and collectible insurance available to the additional insured whether primary, excess, contingent or any other basis unless a written contract specifically requires that this insurance be either primary or primary and non-contributing." This first sentence addressed when the West Bend policy will be excess insurance coverage available to Northern Builders as an additional insured. There existed a contract between Northern Builders and Arlington that requires Arlington to name Northern Builders as an additional insured and required that the coverage be primary.[292]

Under the terms of both the contract between Northern Builders and Arlington and the insurance policy issued to Arlington by West Bend, the

289. *Id.* at ¶ 2.
290. *Id.* at ¶ 6.
291. *Id.* at ¶¶ 8–11.
292. *Id.* at ¶ 24.

coverage provided to Northern Builders under the West Bend policy is primary coverage.[293]

An excess policy will not be triggered until the limits of the primary insurance coverage are exhausted. Neither the West Bend nor the Navigators' policies are true excess policies. They are both primary policies with "other insurance" provisions that contain excess clauses. Both West Bend and Navigators' policies were written as primary policies, not excess policies. Both of the insurance policies had underlying contracts requiring that they provide primary insurance coverage to Northern Builders. Pursuant to the contract between Arlington and Weldex, Weldex was required to procure primary insurance coverage naming the general contractor, Northern Builders, as an additional insured and that "such insurance must be primary and non-contributory coverage." The court determined that this is exactly what the parties intended and that Navigators' insurance policy issued to Weldex provides primary coverage to Northern Builders.[294]

The court was faced with two primary insurance policies that contain similar "other insurance" provisions, specifically excess clauses. The court attempted to reconcile "other insurance" clauses whenever possible. When faced with two primary policies that contain similar "other insurance" provisions, specifically, excess clauses, the policies are mutually repugnant and incompatible. Therefore the clauses must cancel each other out. Here the court determined that the two insurance policies involved were written on the same level as primary policies for Northern Builders. Northern Builders' targeted tender of the defense of the Beuder lawsuit to both West Bend and Navigators was effective.[295]

*4.* General Cas. Co. of Wisconsin Inc. v. Philadelphia Indemnity Ins. Co.

Holding: That the insured's targeted tender of its defense to one of its insurers did not prevail over the "other insurance" clause in the insurer's policy because the insurer provided only excess insurance.[296] In addition, the insurer did not waive any claim for reimbursement by its conduct. Finally, the insurer is entitled to reimbursement for its payment of post-judgment interest.[297]

In *General Cas. Co. of Wisconsin Inc. v. Philadelphia Indemnity Ins. Co*., General Casualty Company of Wisconsin ("General Casualty"), filed a declaratory judgment action against Philadelphia Indemnity Insurance

293. *Id.* at ¶ 25.
294. *Id.* at ¶ 27.
295. *Id.* at ¶ 28.
296. General Cas. Co. of Wisconsin Inc. v. Philadelphia Indemnity Ins. Co., 2013 IL App (1st) 3379142-U, ¶ 1 (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
297. *Id.*

Company ("Philadelphia Indemnity"), seeking reimbursement for damages that General Casualty paid on behalf of their mutual insured, Carmichael Leasing Company. Carmichael leases various commercial trucks to Open Kitchens, Inc. General Casualty issued a $1 million commercial automobile liability policy to Open Kitchens. Philadelphia Indemnity issued a $1 million commercial automobile liability policy to Carmichael. Both policies contained identical "Other Insurance" clauses, providing: "For any covered 'auto' you own, this Coverage Form provides primary insurance. For any covered 'auto' you don't own, the insurance provided by this Coverage Form is excess over any other collectible insurance." Both policies also contained identical supplementary payments provisions, providing that, in addition to the policy limit, the insurer would pay all interest on the full amount of any judgment that accrues after entry of the judgment in any suit against the insured which General Casualty defends. The General Casualty policy also contained an endorsement providing that vehicles that Open Kitchens leased from Carmichael would be considered to be a "covered" auto that Open Kitchens owned. In addition, General Casualty's policy in favor of Open Kitchens included Carmichael as an additional insured.[298]

Emma Taylor filed a survival and wrongful death complaint against Carmichael. The complaint alleged that while the decedent was working as a loader at Open Kitchens, he was struck and fatally injured by a truck that was owned by Carmichael. Carmichael tendered its defense to General Casualty and indicated in its tender that it elected to trigger General Casualty's coverage "to the exclusion of any other applicable policies that may provide liability coverage." General Casualty accepted the tender without a reservation of rights, and reimbursed Philadelphia Indemnity for its prior defense costs. The wrongful death lawsuit proceeded to trial, and the jury's verdict awarded the underlying plaintiff $1.5 million.[299]

At the conclusion of the direct appeal of the wrongful death lawsuit, the amount due totaled $1,906,487.13, consisting of the original $1.5 million jury award and $406,487.13 in post-judgment interest. General Casualty wrote to Philadelphia Indemnity suggesting that General Casualty would pay $1 million (its policy limit) and Philadelphia Indemnity would pay the remaining amount. Philadelphia Indemnity, however, paid $500,000, and General Casualty paid the remaining $1,406,487.13 of the jury award. General Casualty notified Philadelphia Indemnity that it was reserving its right to seek reimbursement from Philadelphia Indemnity and that if General Casualty prevailed "in the declaratory action," it would also seek post-judgment interest.[300]

298. *Id.* at ¶¶ 2–7.
299. *Id.* at ¶ 9.
300. *Id.* at ¶ 11.

The issues before the court were (1) whether General Casualty provided excess coverage to Carmichael, (2) whether General Casualty could seek reimbursement, (3) whether General Casualty waived arguments that its policy was excess and (4) whether Philadelphia indemnity was responsible for post-judgment interest.[301] With regard to the first issue of whether General Casualty provided excess coverage to Carmichael, Philadelphia Indemnity argued that General Casualty was a primary, not excess insurer. The court determined that this contention was without merits. Philadelphia Indemnity never raised this argument before the trial court. Since this argument was never presented to the trial court, it is forfeited.[302]

In regard to the second issue of whether General Casualty could seek reimbursement, the court examined various cases concerning the targeted tender doctrine and "other insurance" clauses. The court noted that the common and determinative elements shared by these cases is that, in each, the insurance issue—that held by the insured and provided by his multiple insurance—originated from primary policies. The court therefore concluded that, since "all the insurers stood in the same position with respect to the potential duty of defense and indemnification owed to the insured," the rule to derive from these cases is that when concurrent multiple policies are primary policies, the targeted tender rule prevails over other insurance clauses and allows the insured to select which insurer will defend and indemnify him. It is clear that Carmichael's targeted tender to General Casualty did not render General Casualty's "other insurance" clause as primary for the vehicles that Open Kitchens "owned" and excess for other vehicles. There was no evidence provided that the vehicle that struck and killed Taylor was listed on the schedule. As such General Casualty was an excess insurer in this case and Philadelphia Indemnity was the primary insurer. Carmichael's targeted tender to its excess insurer (General Casualty) did not prevail over the excess insurer's (General Casualty's) "other insurance" clause.[303]

The third issue before the court was whether General Casualty waived arguments that its policy was excess. The question is not whether General Casualty knew the contents of its own policy, but rather when Carmichael tendered the defense of the underlining litigation, whether a targeted tender trumped General Casualty's "other insurance" provision was not a known right that General Casualty relinquished.[304]

The last issue was whether Philadelphia Indemnity was responsible for the post-judgment interest. Philadelphia Indemnity argued that if the court finds that General Casualty provided excess coverage, the court should

301. *Id.* at ¶ 12.
302. *Id.* at ¶¶ 20–23.
303. *Id.* at ¶¶ 28, 31 35, 39, 47, 51.
304. *Id.* at ¶ 58.

reduce the judgment against Philadelphia Indemnity by the amount of the post-judgment interest that accrued while General Casualty was defending Carmichael. The court rejected this argument on the basis that Philadelphia Indemnity did not cite to any authority in support of its argument. The court determined that Philadelphia Indemnity was responsible for the payment of all post-judgment interest.[305]

## VIII. ARBITRATION AND ALTERNATIVE DISPUTE RESOLUTION

### A. Arbitrator Exceeding Authority

#### *1.* Smola v. Greenleaf Orthopedic Assoc.

Holding: Since the Uniform Arbitration Act is silent with respect to whether an arbitrator may reconsider the merits of an award before the award becomes final, an arbitrator has the authority to entertain such a motion so long as the parties' agreement does not prohibit the arbitrator from doing so.[306] Absent clear language indicating finality, the arbitrator is in the best position to determine when the award becomes final, which necessarily involves construing the parties' agreement. In this case, the agreement was silent as to finality and the arbitrator's conduct reflected that he would review Smola's motion to reconsider and rule upon it in due course.[307]

In *Smola v. Greenleaf Orthopedic Assoc.*, Steven Smola brought an action in which he alleged a person injury claim against Greenleaf Orthopedic Associates, S.C., BQMCC, LLC and Tomassetti Landscaping, Inc. Smola alleged that he slipped and fell on black ice in a parking lot owned and maintained by Greenleaf Orthopedic Associates, S.C., BQMCC, LLC and Tomassetti Landscaping, Inc. which caused injury to his shoulder. Parties agreed to submit their dispute to binding arbitration. The arbitrator entered the Award against Smola. Arbitrator signed the award and delivered it to the parties. Smola's attorney contacted the arbitrator to reconsider. A motion to reconsider was sent, a reply was sent but Smola never responded to the reply. On September 1, 2011 the order was entered that arbitration decision was final and binding.[308]

The court reviewed whether the arbitrator was allowed to reconsider the award he had previously entered and whether the arbitration award was final and binding. Smola's contention rested on his argument that the arbitrator was entertaining his motion to reconsider at the time the court entered its

305. *Id.* at ¶ 59.
306. Smola v. Greenleaf Orthopedic Assoc., IL App (2nd) 111277.
307. *Id.* at ¶ 20.
308. *Id.* at ¶ 1.

order. The parties argued on whether the arbitrator could entertain a motion to reconsider after issuing the award.[309]

The court reviewed the Uniform Arbitration Act and prior case law which revealed little guidance regarding the procedural availability of motions to reconsider before an arbitrator or whether an arbitration award becomes final once issued. With respect to the Act, section 8(a) provides that an award shall be in writing and signed by the arbitrator and that a copy of the award should be delivered to the parties personally, by registered mail, or as provided in the parties' agreement.[310] Section 8(b) provides that an arbitrator shall make an award within the time frame specified by the agreement, "or, if not so fixed, within such time as the court orders on application of a party."[311] Section 9 of the Act provides that, within 20 days of delivery of the award, a party may file an application with the arbitrator to modify or correct the award or to clarify the award.[312] However, the Act does not address whether a party may move for an arbitrator to reconsider his decision.[313]

Accordingly, the court determined that when the parties' agreement is silent with respect to an arbitrator's authority to entertain a motion to reconsider, the decision of whether such a motion may be entertained pursuant to the parties' agreement should be left to the arbitrator in the first instance. In other words, if the parties' agreement to arbitrate does not express the circumstances under which an award would become final, the arbitrator retains the authority to reconsider the award before the trial court enters a judgment confirming the award. The court does not believe that an arbitrator is prohibited from entertaining a motion to reconsider an award before the trial court confirms and enters judgment on the award, merely because the Act is silent regarding this matter. The better rule is to allow parties to express the terms of finality and, if the parties fail to do so, to allow the arbitrator to decide in the first instance whether considering the motion would be consistent with the parties' agreement.[314]

B. Arbitrator's Final Award

*1.* Kenny v. Kenny Industries Inc.

Holding: That the arbitrator's final award addressed all installment payments due under SPA; the merger doctrine did not preclude the holding company from commencing litigation against trust to enforce its contractual

309. *Id.* at ¶ 2.
310. 710 ILL. COMP. STAT. 5/8(a) (West 2010).
311. 710 ILL. COMP. STAT. 5/8(b) (West 2010).
312. 710 ILL. COMP. STAT. 5/9 (West 2010).
313. *Id.* at ¶ 18.
314. *Id.* at ¶ 20.

right of setoff; and sibling shareholders' assignment of their judgment to holding company did not create a debt owed to holding company.[315]

In *Kenny v. Kenny Industries Inc.*, Kenny Industries was formed as a holding company for the Kenny family's business entities. Its shareholders consisted of Gerard and siblings James, Joan, John, Patrick, and Phillip. The shareholders entered into a share purchase agreement (SPA) which governed the purchase and sale of Kenny Industries stock upon the death, total disability or termination of employment with the Kenny Group of any shareholders. Any shares transferred remain subject to the terms of the SPA. Section 4.5 of the SPA also states: "If, at the time payments are to be made under this Agreement to the Shareholder . . . the Shareholder . . . is indebted to any member of the Kenny Group, then [Kenny Industries], in its discretion, may withhold any payment, in whole or in part, and apply such withheld amount to the payment or partial payment of such indebtedness."[316]

On November 2, 1999, Gerard transferred his shares of Kenny Industries stock to a trust. In August 2005, Gerard and his sister, Mary Ann Kenny Smith, each obtained a $3.5 million loan from LaSalle Bank, N.A. for a hotel development project. In November 2005, Gerard's employment with Kenny Industries was terminated and triggered Kenny Industries' obligation to purchase his shares pursuant to the SPA. A letter was sent to Gerard's trust which valued its shares at about $5.4 million. It informed the trust that it intended to exercise its right to set off a $7.6 million debt it claimed Gerard owed. As a result of the setoff, Kenny Industries claimed it owed nothing to Gerard.[317]

The trust initiated arbitration proceedings to dispute Kenny Industries' valuation of the shares and challenged the setoff. The arbitrator issued an interim award which valued the trust's shares at $6,989,626. The arbitrator concluded that Kenny Industries must pay that amount to the trust and for the $7.6 million setoff claimed by Kenny Industries, the arbitrator ruled that it had no right to exercise its setoff option because the debt owed under the agreement was to the siblings individually. A final award was issued on March 25, 2009 for $2,253,041.58.[318]

The trust filed a petition in which it sought confirmation of the final award and entry of judgment. On November 3, 2009, it filed a motion for summary judgment on its petition. Kenny Industries filed a response in which it asked for a stay of enforcement pending the resolution of a separate case filed in 2005 (2005 case) involving Gerard and his siblings.[319]

315. Kenny v. Kenny Industries Inc., 2012 IL App (1st) 111782.
316. *Id.* at ¶ 5.
317. *Id*.
318. *Id.* at ¶ 7.
319. *Id.* at ¶ 9.

The court reviewed whether an arbitrator's final award addressed all installment payments due under the SPA; whether the merger doctrine precluded the holding company's enforcement of its contractual right of setoff against payment due and; whether sibling shareholders' assignment of their judgment to the holding company created a debt owed to holding company so as to allow for a setoff of judgment.[320]

Kenny Industries claimed that the award did not address future installment payments. The court determined that Kenny Industries' argument is without merit. The arbitrator's final award makes clear it contemplated future installment payments as well as the payments due as of the date of judgment.[321]

The trust disputed that Kenny Industries is entitled to a setoff, and argues that the merger doctrine bars Kenny Industries from doing so. The merger doctrine states that once a party obtains a judgment based upon a contract, the contract is entirely merged into the judgment. Therefore, the trust contends that "the SPA [and its setoff provision can] no longer be invoked as a defense to Industries' enforcement of the Trust's Judgment." Kenny Industries did not attempt to attack the underlying judgment but rather sought to enforce its contractual right of setoff against "any payment" due to the trust under the SPA. The merger doctrine is inapplicable.[322]

Kenny Industries may exercise its right to setoff pursuant to the SPA if the assignment created a debt owed by Gerard to Kenny Industries. An assignment operates to transfer to the assignee all the right, title or interest of the assignor in the thing assigned. However, the assignee cannot, merely by virtue of the assignment, acquire a greater right or interest than the assignor possessed. It is clear under the SPA that a debt owed to the Kenny siblings does not qualify as an indebtedness to Kenny Industries that may be set off. Since the Kenny siblings had no right to set off their 2005 case judgment, they could not properly assign that right to Kenny Industries.[323]

*2.* Travelers Property Cas. Co. of America v. The Illinois Workers' Compensation Commission

Holding: The Workers' Compensation Act does not mandate that the insurance carrier be made a party to the proceedings, but merely provides that the insurance carrier may be made a party to the proceedings in the event the employer does not pay the award.[324]

---

320. *Id.* at ¶ 13.
321. *Id.* at ¶ 14.
322. *Id.* at ¶ 15.
323. *Id.* at ¶ 16.
324. Travelers Property Cas. Co. of America v. The Illinois Workers' Compensation Commission. 2013 IL App (5th) 4502822.

In *Travelers Property Cas. Co. of America v. The Illinois Workers' Compensation Commission,* Brian Smith was an independent truck driver who was injured while working for himself. Smith filed an application for adjustment of claims under the Workers' Compensation Act, naming himself as the employer. Travelers Property Casualty Company of America (Travelers) had issued the claimant a workers' compensation insurance policy, but denied coverage. Travelers asserted that the policy excluded coverage for workers' compensation claims made by the claimant. Smith's workers' compensation case was scheduled for an arbitration hearing. Prior to the arbitration hearing, Travelers filed a motion to intervene in the workers' compensation proceeding. In its motion, Travelers alleged that the claimant's lawsuit pending in the circuit court was related to the work accident and his workers' compensation insurance coverage. It requested the arbitrator not to hold the arbitration hearing and defer to the circuit court or alternatively, to allow it to intervene.[325]

The arbitrator denied Traveler's motion to intervene and noted that the whether there was insurance coverage was not an issue to be addressed in arbitration. The issue of coverage was a contractual issue that was for the circuit court to decide. At the conclusion of the arbitration hearing the arbitrator found that Smith had sustained injuries as a result of a workplace accident and awarded him benefits under the Act.[326] Travelers filed a petition to review the arbitrator's decision with the Illinois Workers' Compensation Commission. Travelers alleged that it was seeking review as "a proposed intervening respondent." Smith moved to dismiss Travelers petition and the Commission granted motion to dismiss ruling that Travelers had not standing.[327]

The court reviewed whether Traveler's had standing to seek a review of the Workers' Compensation Commission's decision. The court held that Travelers was not a party to the workers' compensation claim. Smith could have named Travelers as an additional respondent but he was not required to do so. Travelers could have filed a special and limited appearance and defendant the claim under a reservation of rights, but opted not to do so. Nothing in the Act grants it a right to intervene in the arbitration hearing or proceeding before the Commission. Therefore, it has not standing to obtain a review of the decision.[328]

*3. QBE Insurance Co. v. The Illinois Workers' Compensation Commission*

325. *Id.* at ¶¶ 2–3.
326. *Id.* at ¶ 4.
327. *Id.* at ¶ 5.
328. *Id.* at ¶ 13.

Holding: Insurer was not entitled to intervene for purposes of appealing the Commission's award.[329]

In *QBE Insurance Co. v. The Illinois Workers' Compensation Commission,* Ronald Voges filed an application for adjustment of claim, seeking benefits from his employer for repetitive trauma injuries he suffered to his hands, elbows, and upper extremities while employed by the employer. Voges named only himself and the employer as parties in the application.[330] Following a hearing, the arbitrator orders the employer to compensate Voges for (1) medical expenses and (2) medical treatment, including surgical intervention.[331] The arbitrator filed its decision with the Commission and the Commission sent a copy of the decision to Voges's attorney and the employer's attorney.[332] QBE Insurance Company filed a petition for review of the arbitrator's decision for this case. QBE was not named as a respondent on the application of claim and had not participated in the hearing before the arbitrator.[333] On March 23, 2011, the employer filed a petition for review of the arbitrator's decision before the Commission.[334] On April 29, 2011, QBE filed a motion with the Commission requesting that QBE be added as a "named party" in the instant worker' compensation case. QBE stated in support of its motion that when claimant amended his application "at the time of trial," to allege an accident date of October 14, 2010, "it brought the claim into the policy coverage dates of QBE."[335] On July 26, 2011, QBE filed a second motion with the Commission, again requesting that QBE be added as a "named party" in the instant workers' compensation case. A commissioner granted QBE's motion. The employer filed its statement of exceptions to the arbitrator's decision on July 15, 2011, and on July 20, 2011, QBE filed its statement of exceptions to the arbitrator's decision. On October 26, 2011, the Commission affirmed and adopted the arbitrator's decision ordering the employer to compensate.[336] The court addressed the issue of whether an insurer can intervene in a review proceeding.

The court stated that claimant did not name the insurer as a party. It is clear that the only issue properly before the Commission was the employer's liability as the sole respondent. Claimant filed his application for adjustment of claim to establish his rights under the provisions of the Act to recover compensation directly from the employer. For the attainment of that end, it was immaterial to claimant who, as between the employer and its insurer,

329. QBE Insurance Co. v. The Illinois Workers' Compensation Commission, 2013 IL App (5th) 3508932 (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
330. *Id.* at ¶ 3.
331. *Id.* at ¶ 4.
332. *Id.* at ¶ 5.
333. *Id.* at ¶ 6.
334. *Id.* at ¶ 7.
335. *Id.* at ¶ 8.
336. *Id.* at ¶ 11.

was ultimately chargeable with the payment of compensation for his injuries.[337] The plain language of the statute provides that if the employer does not pay the compensation for which it is liable then an insurance company which may have insured such employer against such liability shall become primarily liable to pay the employee. The statute provides the claimant the right to proceed directly against the insurer in the event the employer does not pay the award. However, the Act does not mandate that the insurance carrier be made a party to the proceedings. The statute merely states that the insurance carrier may be made a party to the proceeding in the event the employer does not pay the award.[338]

Voges filed an application for adjustment of claim pursuant to the Workers' Compensation Act, seeking benefits form the employer for injuries. Voges names himself and the employer as parties in the application. Claimant did not name QBE as party. The court found neither a provision in the Act nor any Illinois case which provides for intervention following a section 19(b) award by an insurer who was not a party to the proceedings and where the claimant chose to bring his claim against the employer alone. Thus, the court vacated the Commission's order granting QBE's motion to add QBE as a named party and dismiss this appeal for lack of jurisdiction.[339]

## IX. GUARANTY FUND

### A. Reimbursement from Workers' Compensation Insurer

#### *1.* Illinois Insurance Guaranty Fund v. Virginia Surety Co.

Holding: The Workers' Compensation Act did not require borrowing employer to provide insurance when the employee leasing company provided insurance, coverage under borrowing employer's policy was limited to borrowing employer's employees, and borrowing employer's insurer never collected or retained a premium for borrowed employees.[340]

In *Illinois Insurance Guaranty Fund v. Virginia Surety Co.,* Janusz Szaradzinski was injured on the job while his employer, T.T.C. Illinois (T.T.C) leased him to MGM Company, Inc. (MGM). The workers' compensation insurer for T.T.C. became insolvent, the Illinois Insurance Guaranty Fund (the Fund) made payments to Szaradzinski and then filed this action for reimbursement from MGM's workers' compensation insurer, Virginia Surety Company, Inc. (Virginia Surety). T.T.C. was a temporary employment agency which loaned Szaradzinski and other workers to MGM.

337. *Id.* at ¶ 21.
338. *Id.* at ¶ 22.
339. *Id.* at ¶ 24.
340. Illinois Insurance Guaranty Fund v. Virginia Surety Co.,2012 IL App (1st) 113758, ¶¶ 17–18.

T.T.C. was contractually responsible for paying Szaradzinski's salary and maintaining workers' compensation coverage.[341]

Szaradzinski was at MGM's site, performing MGM's work, when a tire he was inflating exploded. It caused nose and skull fractures which required emergency medical care, surgery, and his hospitalization for about 10 days. Szaradzinski received medical expenses and total temporary disability benefits of about $400 per week for about a year as provided by the Illinois Workers' Compensation Act (Act). Approximately $91,000 of the benefits Szaradzinski received were from the Fund, after T.T.C.'s workers' compensation insurer, Credit General Insurance Company, was involuntarily dissolved by the Illinois Insurance Department. The Guaranty Fund filed suit against MGM and its insurer, Virginia Surety.

The court reviewed whether a borrowing employer's insurer was liable for benefits paid by the Fund after employee leasing company's insurer became insolvent. The Fund had relied on a combination of three statutes: Section 546(a) of the Code, Section 1(a)(4) of the Act and Section 4(a)(3) of the Act. The plain terms of section 546(a) of the Code do not create "other insurance" coverage—the legislation only requires the exhaustion of a policy which covers "the same facts, injury, or loss that gave rise to the covered claim against the Fund."[342]

Section 1(a)(4) of the Act, imposed three key provisions regarding workers' compensation liability in this loaned-employee arrangement: (1) both MGM and T.T.C. were made liable for Szaradzinski's workers' compensation, (2) the lender was given a right of action against the borrower to recover any compensation it was required to pay to discharge this liability, and (3) the employers were authorized to reverse this payment priority. When the Illinois legislature specified that the borrowing employer was primarily liable but the two employers may agree to reverse this payment priority, the legislature ensured that one of the two employers would be financially prepared for employee accidents and that an injured employee would not lose his or her rights to benefits merely because he or she sought compensation from the wrong employer. The Illinois legislature did not require both a lending employer and borrowing employer to procure identical coverage for the same employees. The legislature did not mandate duplicate coverage and premiums in a loaned worker arrangement, because other sections of the Act limit the amount of compensation a worker may receive, bar any common law or statutory right to recovery from the employer except as provided under the Act, and do not allow a worker to receive a second recovery for the same injuries. Furthermore, regardless of which of the two employers pay the workers compensation benefits, the exclusivity provision of the Act

341. *Id.* at ¶ 3.
342. *Id.* at ¶ 18 (citing 215 ILL. COMP. STAT. 5/546 (2000)).

immunizes both the borrowing employer and the lending employer from further claims. Accordingly, the court did not construe section 1(a)(4) of the Act to have required MGM to duplicate the coverage that T.T.C. was contractually obligated to obtain for employees it was lending to MGM.[343]

The terms of section 4(a)(3) of the Act require that an employer's policy "cover all the employees and the entire compensation liability of the insured," or authorizes the employer to split coverage between two insurers or between one insurer and self-insurance, provided "the entire compensation liability of the employer to employees working at or from one location shall be insured in one such insurance carrier or shall be self-insured." Insurance carrier also cannot limit or modify its liability. There was not enough presented to the court to support the proposition that a borrowing employer must duplicate the coverage that a lending employer, in apparent compliance with section 4(a)(3), had procured for all of its employees.[344]

Thus, none of the three statutes that the Fund relied upon shifted liability from T.T.C.'s defunct insurer to MGM's insurer. The court held that the statutory language is clear and unambiguous, and there were no terms which could be construed to require that when a lending employer has workers' compensation coverage, a borrowing employer obtain duplicative coverage, pay duplicate premiums, or increase its self-insured retention to cover borrowing employees. And, given that a double recovery is not permitted, the court found that duplicative coverage over the same workers would not further the purpose of the three statutes or the overall purpose of the Act.[345]

343. *Id.* at ¶ 19.
344. *Id.* at ¶ 20 (citing 820 ILL. COMP. STAT. 305/4(a)(3) (2000)).
345. *Id.* at ¶ 22.

## X. DEPARTMENT OF INSURANCE: REGULATION IN GENERAL

### A. *Burns v. Department of Insurance*

Holding: Producer failed to establish issues of fact or involve agency expertise, so as to qualify as an exception to the exhaustion doctrine.[346]

In *Burns v. Department of Insurance*, an insurance producer filed a complaint for judicial review of the revocation of his insurance producer license.[347] John T. Burns III, alleged that he was employed by USA Retirement from November 2008 thru March 2010. He obtained his insurance producer license in March 2009, but he denied that he ever sold insurance products. In March 2010, USA Retirement was taken into receivership after the Federal Securities and Exchange Commission filed a complaint against the managing partners of the company.[348] The hearing officer determined that because Burns was found by the Securities Department to have committed fraud and other violations of the Securities Act, it was within the Director's discretion to revoke his insurance producer license pursuant to section 500–70(a)(8) of the Insurance Code.[349] On January 10, 2012, the Department adopted the hearing officers' factual findings, conclusion of law and recommendations.[350] On February 14, 2012, Burns filed an action for administrative review in the circuit court. The Department of Insurance filed a 2-619 motion to dismiss the complaint. The Department of Insurance argued that Burns failed to petition for a rehearing or to reopen the hearing pursuant to section 2402.280 of the Administrative Code (50 Ill. Adm.Code 2402.280 (West 2012)) and, therefore, failed to exhaust his administrative remedies as required by the Department's rules.[351]

The court addressed the question of whether the existence of a genuine issue of material fact should have precluded the dismissal or absent such an issue of fact, whether dismissal was proper as a matter of law. Regarding administrative proceedings conducted by the Department, section 2402.280(c) of the Administrative Code provides that: "[a] motion for a rehearing or a motion for the reopening of a hearing shall be filed within 10 days of the date of mailing of the Director's Order."[352] Further, section 3-102 of the Administrative Review Law[353] provides that "[u]nless review is sought of an administrative decision within the time and in the manner herein provided, the parties to the proceeding before the administrative agency shall

346. Burns v. Department of Insurance, 2013 IL App (1st) 5476425 at ¶ 15.
347. *Id.* at ¶ 2.
348. *Id.* at ¶ 5.
349. 215 ILL. COMP. STAT. 5/500–70(a)(8) (2012).
350. *Id.* at ¶ 6.
351. *Id.* at ¶ 7.
352 50 ILL. ADMIN. CODE 2402.280(c) (2012).
353. 735 ILL. COMP. STAT. 5/3–102 (2012).

be barred from obtaining judicial review of such administrative decision." Accordingly, the general rule was that parties aggrieved by the action of an administrative agency cannot seek review in the courts without first exhausting all administrative remedies available to them. Where the administrative rules allow for applications for rehearing, a party must do so in order to exhaust his administrative remedies and preserve his right to seek judicial review. However, the court recognized several exceptions which included: (1) where a statute, ordinance or rule is attacked as facially unconstitutional; (2) where multiple administrative remedies exist and at least one is exhausted; (3) where the agency cannot provide an adequate remedy or where it is patently futile to seek relief before the agency; (4) where no issues of fact are presented or agency expertise is not involved; (5) where irreparable harm will result from further pursuit of administrative remedies; or (6) where the agency's jurisdiction is attacked because it is not authorized by statute.[354]

In this case, Burns admitted that he never filed an application for rehearing pursuant to section 2402.280 of the Administrative Code, but he argued that the exception allowed for judicial review where no issues of fact are presented or agency expertise was involved. He argued that the Department based its revocation on hearsay statements that were improperly admitted and whether evidence constitutes hearsay is a legal issue, not requiring the Department's expertise or fact-finding duties.[355] However, the transcript from the administrative hearing containing the alleged hearsay was not made a part of the appellate record nor have the parties stipulated for its inclusion, there the court can only consider the documents in the certified record.[356] The court therefore rejected Burns' contention since any doubts which may arise from the incompleteness of the record will be resolved against the appellant. Without any transcript of the administrative hearing, the court must presume that the Department's evidentiary rulings conform to the law and had a sufficient factual basis. Further the court stated that if it were to consider the merits of Burns' argument, it would not find that the evidentiary issue fall under the exception since this exception was meant to deal with evidentiary issues that arise during an administrative hearing but instead with novel statutory construction issues. Evidentiary issues are not novel and allowing the Department to reconsider such issues allows it to use its expertise to correct its errors. The purpose of the exhaustion doctrine seems best served by requiring that Burns exhaust all administrative remedies including filing for a rehearing before seeking judicial review of the evidentiary issues he raised.[357]

354. *Id.* at ¶ 11.
355. *Id.* at ¶ 13.
356. *Id.* at ¶ 14.
357. *Id.* at ¶ 16.

## XI. WORK PRODUCT PRIVILEGE

### A. Depositors Insurance Co. v. Canal Insurance Co.

Holding: That the claim files and final file were entitled to protection under the work product doctrine.[358] However, after reviewing all of the documents that Canal refused to turn over, the court concluded that Canal withheld a substantial number of documents with no good-faith basis to believe that they were privileged. However, the reserves it set for the Baumanns' negligence claim and Depositors' subrogation claim. The documents submitted for review do not show that the reserves necessarily reflect the theories, mental impressions, or litigation plans of defense counsel or coverage counsel.[359]

In *Depositors Insurance Co. v. Canal Insurance Co.*, a declaratory judgment action was filed by Depositors Insurance Company against Canal Insurance Co. At issue in the declaratory judgment is the scope of the liability coverage under a motor vehicle insurance policy by Canal to Four Winds Corporation. The coverage dispute related to a collision between a motor vehicle operated by Michael Baumann and tractor-trailer unit negligently operated by an alleged employee of Four Winds. Michael Baumann, whose vehicle was insured by Depositors, sought recovery for personal injuries. Martha Baumann sought recovery for loss of consortium.[360] Four Winds allegedly owned the trailer involved in the accident but Canal denied coverage on the basis that the trailer was not listed on the policy's schedule of insured vehicles. As a result, Depositors paid Baumanns under its uninsured motorist coverage policy. Depositors, as the Baumanns' subrogee, filed a negligence action against Four Winds, the driver of the tractor-trailer, and the owner of the tractor pulling Four Winds' trailer. Canal provided a defense under a reservation of rights. Depositors asserted that Four Winds' liability was covered under an endorsement to the policy providing coverage for vehicles not listed in the policy where such coverage was required under federal law establishing financial responsibility requirements for motor carriers.[361]

Pursuant to Illinois Supreme Court Rule 214, Depositors requested that Canal produce, *inter alia*, "[a] full and complete copy of the electronic and paper claim file created and/or maintained by Canal Insurance Company in connection with the claim filed by Michael and Martha Baumann for injuries or damages allegedly sustained in the April 24, 2006 vehicle accident

358. Depositors Insurance Co. v. Canal Insurance Co., 2013 IL App (2nd) 5509108 (This order was filed under Supreme Court Rule 23 and may not be cited as precedent by any party except in the limited circumstances allowed under Rule 23(e)(1)).
359. *Id.* at ¶ 1.
360. *Id.* at ¶ 3.
361. *Id.* at ¶ 4.

including, but not limited to, that portion of any claim file created and/or maintained for the litigation arising out of [the negligence lawsuit filed by Depositors as the Baumanns' subrogee]." Depositors also requested production of the underwriting file for the policy issued by Canal to Four Winds. Canal produced various documents, which were organized into three files (which have been referred to as the "claim center file," the "underwriting file," and the "final file"). However, Canal withheld documents from each of the files, claiming that the documents were privileged from discovery. Depositors moved to compel production of the withheld documents. However, Canal refused to produce roughly 200 pages of documents. Depositors subsequently moved for sanctions against Canal for its noncompliance.[362]

The issue before the court is whether any of the documents that Canal claims are privileged from discovery are within the ambit of the work product doctrine. Attorney work product is protected under Illinois Supreme Court Rule 201(b)(2), which provides, in pertinent part, that "[m]aterial prepared by or for a party in preparation for trial is subject to discovery only if it does not contain or disclose the theories, mental impressions, or litigation plans of the party's attorney." A major point of contention between the parties is whether work product created by defense counsel in the negligence lawsuit is privileged from discovery in the declaratory judgment action. "It has been held . . . that the work product doctrine protects materials prepared for any litigation or trial so long as they were prepared by or for a party to the subsequent litigation. The rationale for continuing protection, even in unrelated cases, was explained in *In re Murphy*.[363] The court agreed with the rational expressed in *Murphy* and concluded that the work product privilege extended to all subsequent litigation.[364]

The court determined that all material prepared by or for Canal is privileged from discovery if it "contain[ed] or disclose[ed] the theories, mental impressions, or litigation plans."[365] The court further stated that the scope of protected work product was broader in federal courts than in Illinois courts. Canal has claimed the work product privilege against disclosure of the reserves it set for the Baumanns' negligence claim and Depositors' subrogation claim. The documents submitted for review do not show that the reserves necessarily reflect the theories, mental impressions, or litigation plans *of defense counsel or coverage counsel*. Canal also argued that reserve information simply is not relevant to the question of coverage. Canal did not raise a relevance objection when it originally submitted its files to the trial

362. *Id.* at ¶ 5.
363. *In re* Murphy, 560 F.2d 326 (8th Cir.1977).
364. *Id.* at ¶ 7.
365. ILL. COMP. STAT. S. CT. R. 201(b)(2) (2012).

court for *in camera* review. Because the relevance objection was not properly raised below, the court did not consider the issue on appeal.[366]

The court reviewed the documents that Canal contended are privileged against discovery and concluded that some of the material constituted as protected work product. The court next determined whether any of the remaining documents were protected by the attorney-client privilege. To be entitled to the protection of the attorney-client privilege, a claimant must show that (1) a statement originated in confidence that it would not be disclosed; (2) it was made to an attorney acting in his legal capacity for the purpose of securing legal advice or services; and (3) it remained confidential." The privilege applies only where the client has expressly made the communication confidential or where the client would reasonably believe that the attorney would understand the communication to be confidential. The court reviewed the documents that Canal contends are privileged against discovery, and found no documents that met all of the above criteria for privileged status that are not otherwise covered by the work product privilege.[367]

## XII. CONCLUSION

Illinois courts have continued the trend to enforce policy language as written and have refined court interpretations of undefined policy terms. They have continued to view the insurance policy as a contract between two parties that are at slightly different bargaining levels. The legal trends and development of insurance coverage law continues its slow evolution to further define and interpret every word found within a policy.

366. *Id.* at ¶¶ 8 -9.
367. *Id.* at ¶ 11.