D&O and E&O Policy's Interrelated Claims Provisions Create Unique Fertile Ground for Fact Discovery in Coverage Disputes

Corporations and individuals purchase Directors and Officers (D&O) and Errors and Omissions (E&O) policies to insure against professional and corporate claims alleging wrongful acts. D&O and E&O policies are almost exclusively written on a "claims-made and reported" basis. Accordingly, these policies provide coverage for a claim arising out of a wrongful act where the claim is *both first made against the insured and reported to the carrier during the policy period.*

An important feature of "claims-made and reported" policies is the provision of almost unlimited retroactive coverage for wrongful acts taking place prior to the applicable policy period, subject to the requirement that any resultant claim be first made against the policyholder and reported to the insurance carrier during the policy period. Another significant feature and benefit of this form of coverage is the provision of coverage for a subsequent claim reported outside of the policy period so long as the later claim is interrelated to a claim that was previously reported within the original policy period. Similarly, a policyholder can report a *potential claim* (i.e. notice of facts and circumstances which may give rise to a claim) during the policy period and this will constitute timely reporting of future claims arising out of the same wrongful acts, even if the subsequent claim is reported outside the policy period. The limiting factor in this scenario is the subsequently reported claim(s) must be interrelated to the claim(s) or notice of facts and circumstances which were reported within the policy period. In other words, the subsequent claim must arise out of the same wrongful acts as those which gave rise to the initial claim or notice.

The "flip side" to this concept occurs when the insured fails to report a claim, or facts and circumstances, during the relevant policy period. In this circumstance, all subsequent interrelated claims will be barred from coverage as they will be deemed "first made" during the initial policy period but not reported as required by the policy. This provision is favorable to both insurer and insured so long as the insured complies with its reporting obligations. For the insured, so long as an initial claim (or facts and circumstances) is reported when the claim is "first made," all subsequent related actions will be covered under the policy, even if they are not brought against the insured and/or reported to the insurer until a later policy period. The benefit to the insurer is the limiting of the carrier's exposure to a series of claims arising out of related facts or circumstances to a single policy limit.

The typical claims-made and reported policy contains interrelated wrongful acts provisions which state:

All Claims arising out of the same Wrongful Act and all Interrelated Wrongful Acts of the Insureds shall be deemed to be one Claim, and such Claim shall be deemed to be first made on the date the earliest of such Claims is first made, regardless of whether such date is before or during the Policy Period. All Damages and all Claims Expenses resulting from a single Claim shall be deemed a single Damage and Claim Expense.

Related Wrongful Act means a Wrongful Act which is the same, related or continuous, or Wrongful Act which arises from a common nucleus of facts, Claims can allege Related Wrongful Acts regardless of whether such Claims involve the same or different claimants, Insureds or legal causes of action.

Consider the following scenario. On March 1, 2016, a former client, through counsel, writes to the insured asserting professional malpractice against the insured, demanding certain redress and threatening suit. This letter constitutes a "Claim" under most policies. Because the insured believes he or she did nothing wrong, the insured does not report the letter to the carrier. On August 1, 2016, a new policy period begins but the March 1, 2016 letter still has not been reported to the carrier. On November 1, 2016, because the former

client's allegations and demands have not been met, the client files suit with factual assertions and legal theories similar to those raised in the March 1, 2016 demand letter. Upon receipt of the suit, the insured reports the same to its carrier, however, coverage is denied based upon alleged untimely reporting of the claim. The carrier deems the claim was "first made" upon service of the prior demand letter which should have been reported to t he carrier within the prior policy period. The insured files a declaratory judgment action for coverage asserting that the claims described in the malpractice complaint are new and/or different than those set forth in the letter and hence constitute a new claim unrelated to the demand letter.

In the scenario described above, the propriety of the carrier's denial will turn on the factual issue of whether the demand letter is premised upon the same common nucleus of facts as those alleged in the subsequent lawsuit against the insured. In order to resolve the issue, a court will need to make the factual determination whether the prior demand letter (which constituted a claim) was interrelated to the subsequently filed lawsuit. See *G-I Holdings v. Hartford Fire Insurance Co*., 2007 U.S. Dist. LEXIS 19069, at *4 (D.N.J. 2007); *Passaic Valley Sewerage Commissioners v. St. Paul Fire and Marine Insurance Co.*, 2010 N.J. Super. LEXIS 475, at *3-4, 12 (App. Div. 2010).

Comment: This increasingly common scenario is playing itself out in courts around the country compelling insurers and insureds to engage in significant fact discovery into the underlying basis for both of the claims deemed to be interrelated. Simply adding a new legal cause of action, an additional claimant and/or plaintiff will often be insufficient to separate two claims should they ultimately be based upon the same *common nucleus of facts*. On the other hand, courts have been wary to deny coverage to subsequently added defendants who were not identified in earlier claims. Whereas many typical declaratory judgment insurance coverage action(s) require merely comparing the underlying pleadings and sometimes discovery to ascertain coverage, in the above scenario, parties and the court are compelled to drill down into the detailed underlying basis for the claims to ascertain whether the later reported claim is truly "interrelated to the prior." Both insurers and insureds need to be prepared to "roll up their sleeves" and delve into the factual basis of the underlying claims in depth when this issue is raised.