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Policy Conditions, Requirements That Need to Be Met for the Coverage to Be Valid

This article briefly discusses these policy conditions, which may not be well known to insureds, so that a coverage assessment is limited to the merits of a claim and not a failure to satisfy policy conditions.

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Third-party liability insurance policies, whether a standard form CGL policy or a manuscript specialty policy, share common conditions that an insured should remain cognizant of through the claim process to ensure that coverage is not jeopardized. The conditions section of these policies delineates the obligations that must be fulfilled for the contract of insurance to be enforced. While there are conditions obligating both the insurer and the insured, the more common conditions which, if ignored or unknown, can result in the creation of needless coverage hurdles for insureds, are: providing timely notice and reporting of a claim; cooperating with an insurer; and avoiding the assumption of liability. This article briefly discusses these policy conditions, which may not be well known to insureds, so that a coverage assessment is limited to the merits of a claim and not a failure to satisfy policy conditions.

Notice and Reporting Requirements

Notice and reporting requirements across most policies are similar in that they require an insured to provide notice and/or report a claim "as soon as practicable" or in a similar immediate manner to be considered timely. The upshot being that sitting on a known or on a suspected claim is never a good idea. The purpose of the reporting condition is to provide a carrier notice of a claim allowing for an opportunity to investigate the claim as soon as possible and thereby to collect as much information when it most readily available resulting in an accurate coverage analysis. Additionally, in instances where an insurer is obligated to provide a defense, the sooner notice of a claim is received the sooner an insurer can defend its insured against potential liability. Although the duty to timely report a claim to a carrier is important, regardless of the nature of the subject policy, the importance of this duty differs depending on whether the policy is an occurrence- based policy or a claims-made policy.

For occurrence-based policies, such as a CGL policy, where the happening of an occurrence is the triggering event for coverage, a standard form CGL policy's reporting/notice provision reads, "you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim." Disputes often arise as to whether an insured gave notice as soon as practicable, and whether the insurer can deny coverage based on late notice.

Most states, including Pennsylvania, require an insurer to prove that it has been prejudiced by untimely notice of a claim before a denial of coverage premised upon the insured's failure to provide timely notice is permitted. In Pennsylvania, this requirement is commonly referred to as the Brakeman rule and provides that to deny coverage based on an insured's failure to comply with the notice provision an insurer must prove not only that the notice provision was breached but also that it suffered prejudice as a consequence of that breach.

What might constitute prejudice and the manner of which an insurer must prove it was prejudiced by an insured's untimely notice depends on the circumstances of the case. In Pennsylvania, Justice Max Baer, in a concurring opinion in *Vanderhoff v. Harleysville Insurance,* 621 Pa. 429 (2013), wrote to "provide specific guidance regarding how an insurance company can demonstrate prejudice resulting from an insured's failure to comply" that is accomplished when "the insurer provides reasonable proof that its ability to investigate the accident was impaired in the context of both the accident and the delay at issue in the case."

Looking at a claims-made policy, the fundamental distinction between that policy and an occurrence-based policy is that the coverage triggering event in a claims-made policy is the making of the claim and not the happening of the insured event or occurrence. Thus, the Brakeman rule for an occurrence-based policy, requiring a showing of prejudice, does not apply in the claims-made realm, for an insured's receipt of a claim is the triggering event for coverage that is almost always specific to a given policy period making timely

notice crucial. The essential characteristic is that the claims-made policy provides coverage for a claim first made and reported during the subject policy period. Therefore, a failure to report a claim received during the policy period in which it was received can abrogate coverage for an otherwise covered claim.

While the Pennsylvania Supreme Court has not addressed if prejudice must be shown to decline coverage under a claims-made policy, other courts addressing this question under Pennsylvania Law have unanimously concluded that a showing of prejudice from an insured's untimely reporting of a claim is not necessary to deny coverage. New Jersey's Supreme has directly addressed this issue in *Templo Fuente De Vida v. National Union Fire Insurance of Pittsburgh*, 129 A.3d 1069 (N.J. 2016) holding that an insured's failure to give notice of claim as soon as practicable under claims-made policy does not require a showing of prejudice to disclaim coverage.

As such, it is of vital importance for an insured to be aware of the nature of its insurance policies, be it occurrence-based or claims-made, when claims are made against the insured and it begins taking steps to report those claims.

Duty to Cooperate

Virtually all insurance policies impose some form of a "duty to cooperate" on the insured. A common form of this policy condition reads, that "[t]he insured shall cooperate with the [insurer] and, upon the company's request, assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity ..." Breach of cooperation clause may include failure to cooperate with claim investigation or defense of claim or suit e.g., failure or refusal to: provide requested documents, appear for EUO, appear for IME, and appear for deposition or trial.

The purpose of a cooperation clause in an insurance contract is to protect the insurer's interest and to prevent collusion between the insured and the injured party. See 8 Appleman, Insurance Law and Practice Section 4741. Properly and narrowly interpreted, this obligation makes sense, for the insured should not put-up obstacles to prevent the carrier from fulfilling its obligation to fairly assess coverage or to defend the insured. An insured's failure to cooperate, in some egregious circumstances, may excuse the insurer's duty to defend

An example of an insured's failure to cooperate is when the insured neglects to disclose information material to a coverage determination or the preparation of a defense. Also, when an insured does not aid in securing witnesses, refuses to attend hearings, will not provide documents and information, fails to appear and testify at trial, or otherwise does not "render all reasonable assistance necessary to the defense of the suit," this constitutes a breach of a policy's cooperation clause.

A breach of a duty to cooperate will only relieve the insurer from liability under the policy if the failure is substantial and results in prejudice to the insurer because of the breach. In Pennsylvania, whether there has been a material breach of an insured's duty to cooperate has been held to be question for the finder of fact. See *Cameron v. Berger,* 336 Pa. 229, 235, 7 A.2d 293, 296 (1938). Absent estoppel, waiver, or excuse, the failure of an insured's cooperation, if material, can result in prejudice to available coverage. This obligation is one that must be taken seriously and approached in a willing manner.

Avoidance of Assuming Liability

Almost all third-party liability policies contain a provision precluding an insured from assuming liability, incurring an obligation, and making a payment with regard to a claim made against it without the insurer's written consent. The reason for this is understandable; an insurer does not want to be bound to liability and payments stemming from its insured's unilateral actions and wants the ability to defend against and assess a

claim prior to incurring a financial obligation. As a caveat, where insurance coverage is mandated and heavily regulated by statute, such as automobile insurance and workers' compensation insurance, in those instances statute and public policy are the deciding factors.

A violation of this provision can arise for a variety of reasons. For example, when a policy has a significant self-insured retention (SIR) or deductible, an insured may believe that a claim will not overcome that amount making notice of the claim to its carrier unessential to the resolution of the claim. Once the insured has engaged in settlement discussions, it becomes evident that legal expenses, couched as defense costs, and the purported liability will exceed the SIR. At this point, the insured initiates the claim seeking reimbursement after liability has essentially been assumed without the carrier's consent. Despite not having any nefarious motivation for its actions, the insured has compromised its coverage position through the assumption of liability, which could also be in addition to failing to give timely notice of a claim.

These are just a few of the conditions that, if ignored, can negatively impact an insured's entitlement to coverage before the merits of a claim are even considered. However, these conditions are necessary for the proper administration of a claim and are not arduous. An educated and diligent insured can undoubtedly satisfy these conditions.

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