Insurance Update

The Assault And Battery Committed By An Insured Was Not An "Accident" Within The Meaning Of The Insuring Clause Within A Homeowner's Insurance Policy.

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In an opinion styled Delgado v. Interinsurance Exchange of the Automobile Club of Southern California (August 3, 2009) 97 Cal.Rptr.3d 298, the Supreme Court of California held that the assault and battery committed by an insured was not an "accident" within the meaning of the insuring clause within a homeowner's insurance policy.

Factually, Delgado sued Reid, alleging in part that Reid "in an unprovoked fashion and without any justification physically struck, battered and kicked" Delgado and that Reid "negligently and unreasonably believed" he was engaging in self-defense "and unreasonably acted in self defense when [Reid] negligently and unreasonably physically and violently struck and kicked Delgado repeatedly causing serious and permanent injuries." Reid tendered to the Automobile Club of Southern California ("ACSC") the defense of Delgado's lawsuit. ACSC denied coverage and refused to provide Reid a defense, asserting that the assault was not covered because it was not an "occurrence," which was defined in the policy as an "accident," and that the complaint's allegations arose out of Reid's intentional acts, which came within the policy's intentional acts exclusion. After the trial court, at Delgado's request, dismissed the intentional tort claim, Delgado and Reid settled the action by stipulating that Reid's use of force occurred because he negligently believed he was acting in self-defense, and by stipulating to entry of a $150,000 judgment against Reid. Thereafter, Reid agreed to pay Delgado $25,000 and pursuant to California Insurance Code section 11580(b) (2), assigned to Delgado his claims against ACSC; Delgado in turn agreed to give Reid a partial satisfaction of judgment and a covenant not to execute on the remainder of the judgment. Delgado then brought suit against ACSC. The trial court sustained ACSC's demurrer without leave to amend. The Court of Appeal reversed.

In reversing the Court of Appeal, the California Supreme Court found that under California law, the word "accident" in the coverage clause of a liability policy refers to the conduct of the insured for which liability is sought to be imposed on the insured. An injury-producing event, noted the Supreme Court, is not an "accident" within the policy's coverage language when all of the acts, the manner in which they were done, and the objective accomplished occurred as intended by the actor. Consequently, Reid's assault and battery on Delgado were acts done with the intent to cause injury; there was no allegation in the complaint that the acts themselves were merely shielding or the result of a reflex action. Therefore, the injuries were not as a matter of law accidental, and there was no potential for coverage under the policy. It was further noted that in a number of contexts other than those involving claims pertaining to assault and battery, courts have in insurance cases rejected the notion that an insured's mistake of fact or law transforms a knowingly and purposefully inflicted harm into an accidental injury.

In An Excess Workers' Compensation Insurance Policy Providing Indemnification To An Employer For Losses In Excess Of A Self-Insured Retention "Resulting From An Occurrence," An "Occurrence" Was An Event, Either An Accident Or Occupational Disease, Which Caused Damage To An Employee And, In The Case Of An Accident, The Number Of Employees Injured Was Irrelevant.

Note: In the spirit of disclosure, The Roth Law Firm, APLC was trial counsel for TIG Insurance Company in this matter.

In an opinion styled Supervalu, Inc. V. Wexford Underwriting Managers, Inc., et al. (June 3, 2009; as modified June 24, 2009) 175 Cal.App.4th 64, 96 Cal.Rptr.3d 316, the Court of Appeal, Second District, Division 2, California, held that in an excess workers' compensation insurance policy providing indemnification to an employer for losses in excess of a self-insured retention "resulting from an occurrence," an "occurrence" was an event, either an accident or occupational disease, which caused damage to an employee and, in the case of an accident, the number of employees injured was irrelevant.

Factually, Supervalu, Inc. doing business as Albertson's Inc. ("Supervalu") was permissibly self-insured for workers' compensation coverage in California. From 1989 to 1994, TIG Insurance Company ("TIG") provided Supervalu with excess workers' compensation insurance. Supervalu's self-insured retention for each occurrence was $500,000. Subject to certain policy conditions, TIG would indemnify Supervalu "for loss resulting from an occurrence during the contract period on account of [Supervalu's] liability for damage because of bodily injury or occupational disease sustained by employees." The policies further provided that "loss" "shall mean only such amounts as are actually paid by [Supervalu] in payment of benefits ... in settlement of claims, or in satisfaction of awards or judgments." Occurrence, as applied to bodily injury, was defined to mean an "accident." Occupational disease sustained

by an employee was deemed to be a separate occurrence taking place on the last date of the employee's exposure to deleterious work conditions. Thereafter, Continental Casualty Company ("Continental") issued several consecutive excess policies to Supervalu. The self-insured retention and coverage were essentially the same as in the TIG policies. Supervalu alleged that the excess policies provided that TIG and Continental would indemnify Supervalu for loss in excess of the self-insured retention "resulting from an occurrence," and that for the past fifteen years the carriers interpreted "occurrence" to mean a single, overall disability rating until they changed their interpretation to assert that when multiple injuries led to a single, overall disability rating, each injury was an occurrence subject to the self-insured retention. As such, the carriers thereafter refused to reimburse Supervalu for certain disputed claims based on the theory that the self-insured retention had not been reached. The carriers successfully moved for summary adjudication on several issues including the interpretation of the "occurrence" language found in the excess policies.

In affirming the trial court's granting of summary adjudication, the Court explained that the definition of an occurrence does not distinguish between situations in which single employees or multiple employees are injured. This is because an occurrence is an event – either an accident or occupational disease. In the case of an accident, the number of employees injured is irrelevant. It could be one or many and it would still be one occurrence. In contrast, there are as many occurrences – singular or plural – as there are employees who suffer occupational disease.

In rejecting Supervalu's argument that waiver and estoppel were triggered because the carriers paid past claims and settlements without requiring apportionment between events causing damage to employees, the Court found that Supervalu did not identify any evidence that the carriers intentionally waived their rights as to current claims. Further, the policy language did not cover any risks except liability for benefits above the self-insured retention for each accident and occupational disease. As a consequence, Supervalu was asserting estoppel to expand coverage under the policies, which is impermissible, rather than to simply avoid a forfeiture of benefits.

An Insurer May Rescind A Homeowner's Policy When The Insured's Policy Application Executed After Purchased Of The Property Contained Material Misrepresentations.

In an unpublished opinion styled Shokrian v. Pacific Specialty Insurance Company (August 17, 2009) 2009 WL 2488881 (Cal.App. 2 Dist.), the Court of Appeal, Second District, Division 4, California, held that an insurer may rescind a homeowner's policy when the insured's policy application executed after purchase of the property contained material misrepresentations.

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Factually, Shokrian was in the business of buying and managing real property. In December 2004, Shokrian bought property with two occupied residential units: the former owner lived in one of the units and the former owner's tenants lived in the remaining unit. After the purchase, the former owner and his tenants continued to reside on the property. Shokrian never had written rental agreements regarding the units, and he received no rental payments from anyone living on the property. After purchasing the property, Shokrian applied for a policy of homeowner's insurance from Pacific Specialty Insurance Company ("Pacific"). The application forms contained the following question: "15. Is the dwelling presently occupied? If not occupied, risk prohibited." Shokrian answered the question by checking the accompanying box marked "Yes." The forms also asked: "16. If dwelling is tenant occupied, is tenant current with rent payment? If no, risk prohibited...." Shokrian answered the question by checking the accompanying box marked "Yes." Pacific thereafter issued a policy to Shokrian. Sometime later, Shokrian submitted a claim under the policy for damage to the units due to vandalism. After taking Shokrian's recorded statement, Pacific rescinded the policy. As grounds for the rescission, Pacific pointed to Shokrian's answers to questions 15 and 16 on his application. In filing suit for breach of contract and "bad faith," Shokrian alleged that the property had been vandalized by the prior tenants or other parties.

In rescinding the policy, Pacific relied on the following policy provision: "Misrepresentation and Fraud[:] If the insured has concealed any material fact or circumstance concerning this insurance, ... this insurance shall become void and all claims hereunder shall be forfeited." The Court agreed with Pacific that the rescission was authorized under several provisions of the California Insurance Code, including sections 331 and 359, which govern the right to rescind an insurance policy for concealment or misrepresentation. Section 331 provides: "Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance." Section 359 provides: "If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false."

In affirming the trial court's granting of summary judgment to Pacific, the Court found that Shokrian was in the business of buying and managing real property, owning the property at issue at the time he filled out the application and aware the former owner was occupying the property in the absence of any rental agreement. Moreover, Shokrian acknowledged in his deposition that he completed the application without determining whether there were other tenants on the property and, if so, whether they were paying rent. Shokrian nonetheless affirmed that all tenants in the units were current on their rent. He thus misrepresented what he knew about the former owner's status, and otherwise made the affirmations knowing that he had not inquired about the existence of other tenants on his own property.

An Insurer Which Denied Coverage And Refused To Defend The Action On Behalf Of Its Insured Did Not Have A Direct And Immediate Interest To Warrant Intervention In The Litigation.

In an unpublished opinion styled Hinton v. Beck, et al. (August 11, 2009) 2009 WL 2438415 (Cal.App. 3 Dist.), the Court of Appeal, Third District, California, held that an insurer which denied coverage and refused to defend the action on behalf of its insured did not have a direct and immediate interest to warrant intervention in the litigation.

Factually, Hinton commenced a personal injury action against Beck. When Beck's insurance carrier, Grange Insurance Group ("Grange") denied coverage for Hinton's loss and refused to defend, Hinton entered into an agreement pursuant to California Insurance Code section 11580(b)(2) with Beck not to execute any judgment against Beck in exchange for an assignment of Beck's rights against the insurance company. The trial court thereafter entered a default judgment against Beck for approximately $2 million. As assignee, Hinton then filed a separate action against Grange alleging breach of contract, breach of the duty of good faith and fair dealing, and negligent procurement of insurance. Thereafter, the trial court granted Hinton's motion to strike Grange's complaint in intervention.

In affirming the trial court, the Court found that Grange was in is in no position to complain about lack of standing when it consistently denied coverage and refused to provide Beck with any defense. When an insurer denies coverage and a defense, the insured is entitled to make a reasonable non-collusive settlement without the insurer's consent and may seek reimbursement for the settlement amount and for any breaches of the covenant of good faith and fair dealing.