

SECURITIES ARBITRATION COMMENTATOR

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A GUIDE TO PROFESSIONAL LIABILITY INSURANCE FOR THE INVESTMENT PROFESSIONAL

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INTRODUCTION

Whether broker-dealer, investment adviser, registered representative, or investment adviser representative, securities industry professionals in the litigious arbitration environment in which we live today not only have to understand the basic concepts of professional liability insurance and the proto-typical provisions of the policy forms, but most importantly, how to navigate the choppy waters of coverage issues. Policies should be reviewed from the point of view of (1) their scope, (2) the exclusions, (3) the insurer's obligations, (4) the insured's obligations, (5) the definition of terms in the policy, (6) the retention and limits, and (7) coverage issues and disputes. Reading the policy forms closely; carefully negotiating the endorsements; filling out the policy application truthfully and completely; timely reporting a claim or circumstances giving rise to a claim; fully cooperating with the insurer should a claim arise; working with counsel to protect coverage when the insurer disclaims coverage or issues a reservation of rights letter; and, above all, being practical and acting with common sense are the fundamentals for approaching professional liability insurance.

This article will discuss some of the typical provisions in these policies and their potential impact on insureds. We then suggest ways in which

securities industry professionals can improve coverage. In addition, we describe briefly the applicable law, as it relates to the duty to defend, reservations of rights letter, scope of coverage issues, and other areas of possible conflict between insurer and insured. Finally, we examine some practical issues that face securities industry professionals involved in arbitration and litigation disputes from the standpoint of working effectively with their insurers, while preserving their rights as insureds.

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A GUIDE *cont'd from page 1***SCOPE**

Today, most policies are Claims Made Policies, i.e. they cover "any loss arising from claims first made against the insured during the policy period or the extended reporting period (if applicable ...[what is known as a 'tail'])" resulting from the "rendering of or failure to render professional services" in connection with the named insured entity acting as a registered broker-dealer and/or investment adviser and the individual insured acting as a broker-dealer registered representative or an investment adviser representative. The scope provision or a policy endorsement can refer to a "Retroactive Date"; i.e., even though a claim is made within the policy period if the underlying conduct giving rise to the claim occurs prior to a fixed and negotiated date, coverage does not exist. The date assigned can relate to the dollar amount of the premiums charged.

"Professional services" typically means "the purchase, sale, or servicing of securities... on behalf of a customer or client... pursuant to a written agreement between the Broker-Dealer [or Investment Adviser] and its customer [or client]" and means also for the customer [or client] "the purchase or sale of life, accident and health or disability insurance, whether purchased through the broker-dealer or directly from a life insurance carrier if the registered representative is licensed with or in contract with the insurance carrier." Professional services also includes "the purchase,

sale, or servicing of life, annuities or variable annuities, but only with respect to products that have been placed with an insurer that has an A rating." Typically, the insured receives coverage for "providing brokerage services for individual retirement accounts, Keogh retirement plans and employee benefit plans..." and the firm and its Representative are covered as well for "... providing economic advice, financial advice or investment advisory services...[and] financial planning advice." However, what is and is not within the scope of professional services is often unique to the insurer's underwriting policies. Great care should be taken in reviewing the policy in the application process. There is coverage for these products and services if they have been "previously approved by the broker-dealer."

In addition to coverage being limited to "professional services," the claim must relate to "wrongful acts," as defined. "Wrongful Acts" can mean any "[negligent] act, error or omission by the Broker-Dealer or by any director, officer, partner, employee or registered representative thereof [that causes economic harm]¹, solely in their respective capacities as such." As discussed, this wrongful act must occur after the specified "retroactive date," if such exists.

THE EXCLUSIONS

Typical product exclusions involve "advice in connection... [with] commodities, futures contracts,

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forward contracts or any type of uncovered option or futures or option contract... any collectible... or any other tangible personal property...; any equity security which is not traded on a United States National Securities Exchange and is priced under \$5.00 (i.e., "penny stock") at the time that the wrongful act triggering such claim occurred... [and] annuities used in connection with any structured settlement." Policies also exclude viatical settlements. Not only are the foregoing exclusions operative with respect to indemnity coverage but sometimes defense coverage is not provided, i.e., where there are claims "alleging, arising out of, based upon or attributable to transactions" involving the exclusions. (Emphasis Added)

Other exclusions typically involve clearing agency functions, acting in the capacity as an actuary, attorney, accountant, real estate agent, tax preparer, a representative before the IRS and third party claims administrator, as well as acting as a trustee, fiduciary, partner, officer, director, managing general partner of an entity "other than that of the broker-dealer." What if the entity is dually registered as an investment adviser or affiliated with an investment adviser? Is the firm not covered as an investment adviser? This is precisely what the firm's insurance broker and counsel should attend to so that the coverage also includes the organization or its affiliate for investment adviser services.

Other exclusions can involve "alleging"² (and/or) arising out of, based upon or attributable to sexual discrimination and harassment"; "bankruptcy, insolvency, the appointment of a conservator, receivership or liquidation of... any broker or dealer in securities or commodities clearing agency, any bank...any insurance or reinsurance entity", although the exclusion will usually not apply to an investment in the stock of any such entity, diminution in the value of securities other than diminution "due solely to a

wrongful act for professional services"; damages to tangible property other than damage resulting from the loss of client records; employee benefit plans or trusts owned or managed by any insured or in which the insured participates as a fiduciary or where the insured is an administrator or fiduciary under the Employment Retirement Income Security Act of 1974 (ERISA); "any mechanical or electronic failure, breakdown, malfunction or unauthorized access to ...any computer system... or information transmission system in any digital electronic or mechanical system or unit; investment banking activity; management services for entities other than the broker-dealer; express warranties, guarantees or hold harmless agreements; misappropriation for funds or accounts; misusing or aiding and abetting the misuse of non-public information, and infringement of intellectual property; and misappropriation of trade secrets, passing off, plagiarism or unfair competition. (Emphasis Added)

Other typical exclusions that involve described conduct are the following: (1) criminal, fraudulent or dishonest conduct; (2) unjust enrichment; (3) conduct causing bodily injury, emotional distress, mental anguish, sickness, disease or death; (4) money laundering; (5) solicitation or receipt of excessive, additional, undisclosed or improper compensation relating to an offering or compensation greater than disclosed in the prospectus or registration statement; (6) improper solicitations or tie-in agreements and violations of (a) Regulations S-K (non-financial item disclosure), (b) the SEC's Regulation M (which governs the activities of underwriters, issuers, selling securities holders, and others in connection with offering of securities), or (c) NASD Conduct Rules 2110 (Standards of Commercial Honor and Equitable Principles of Trade) and 2440 (Fair Prices and Commissions in the over-the-counter market).

Additional exclusions are for claims or circumstances "which might lead to a claim in respect of which any insured has given notice to an insurer under any other policy in force prior to the effective date of this policy" and claims "arising out of any acts, errors, or omissions which took place prior to the effective date of this policy, if any insured on the effective date knew or could have reasonably foreseen that such acts, errors or omissions might be expected to be the basis of a claim." These exclusions protect the insurer from actual or constructive fraud in the inducement of the policy. Typically, the duty to defend is broader than the duty to indemnify and the presence of one covered allegation can result in the insurer's obligation to provide a defense even if the conduct ultimately proven is non-covered. The mere allegation of criminal conduct should also receive defense coverage.

**INSURER/INSURED
OBLIGATIONS**

Typically, the insurer has the right and duty to defend thus implying that the choice of defense counsel, absent a conflict between insurer and insured, is the sole decision of the insurer. When is the insured entitled to select counsel and not have his coverage prejudiced? The right arises when there is an actual or potential conflict between the insured and insurer, usually evidenced by a reservation of rights letter sent by the insurer to the insured. When this occurs, the insured can usually select counsel with the reasonable expenses thereof to be paid by the insurer.³ However, incurring reimbursable defense expenses (legal, expert or otherwise) and entering into a settlement can usually only be done with insurer's consent.

Policies often have "hammer clauses." These provide that, if the insured refuses to consent to a settlement offer within policy limits that is acceptable to the claimant, and a judgment is then entered exceeding the settlement offer, the insurer is not liable in excess of the dollar amount of

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the prior available settlement offer. In other words, by refusing the available settlement offer, the insured has taken on all liability in excess of that amount of that offer.

The insured also generally has the duty to report in writing and in sufficient detail "complete details of the claim, the exact date the claim was first made, the location, the circumstances giving rise to such claim, the identity of all claimants and a full description of the nature and scope of the alleged damages" and "every demand, notice, summons or other process received by it or its representative." Timely reporting of not merely an actual claim but "circumstances and reasons for anticipating a claim" is obligatory, and if this obligation is discharged "for the purpose of... [the] policy... [the claim when it is eventually asserted will] be treated as a claim made at the time such written notice was given to ... [the] underwriters." Timely reporting of such circumstances locks in coverage. The date of mailing will be the date of notice. In the absence of a timely report of a claim, coverage can be lost.

In the event of payment by the insurer, under the policy the carrier shall have right of subrogation to the insured's rights of recovery that would include other brokers and broker-dealers.

DEFINITIONS

Important and typical definitions are as follows:

The "named insured" is the broker-dealer or investment adviser organization to which the policy is issued. In contrast, the term "insured" generally means "any past, present or future director, officer, partner or employee of the broker-dealer" and any past, present or future registered representative... for acts on behalf of the broker-dealer.

Claims expenses "shall mean those reasonable fees, costs and expenses incurred by outside legal

counsel selected... [by or with the consent of the carrier]." Claims expenses typically do not include reimbursements of expenses for the insured's in-house counsel.

The term "criminal conduct," which is universally excluded from coverage, means "conduct that constitutes (or would constitute) a criminal offense in any part of the world."

Loss means "damages and claims expenses which an insured is legally obligated to pay as a result of a claim" but not (1) "fines, sanctions, taxes or penalties imposed by law"; (2) "salaries, wages, fees, overhead or benefit expenses...;" (3) compliance costs for any settlement or non-monetary award; (4) restitution or return of fees, commissions, and other compensation; (5) civil, regulatory or criminal fines or penalties or punitive damages; and (6) costs automatically assessed by operation of law.

RETENTION

Often, claims expenses may be applied against the limits, which means that the insurer's payment of legal defense costs adjusts the limits downward. Sometimes defense costs do not reduce the limits for indemnity coverage. Higher dollar coverage is generally at a reduced premium because of the retention of a significant dollar amount of the risk by the insured. Membership in an organization (not an insurance carrier) that provides prepaid defenses, coupled with what is in essence catastrophic indemnity insurance, now appears to be the right step forward for the financial services industry and its personnel.

COVERAGE ISSUES

Usually, the named insured has a right to purchase an extended reporting period for an additional premium to cover claims made during a specified period of time after the normal termination date of the policy. Claims made and reported during this period are generally covered as long as the

alleged acts giving rise to the claim occurred prior to the normal termination date.

Notice by the named insured to purchase this coverage, also referred to as "tail coverage," usually must be given at least thirty (30) days after normal cancellation or expiration. The extended reporting period is not available where cancellation or non-renewal is due to non-payment of the premium.

The policy typically is in excess of other applicable insurance, "unless such other insurance is written only as specific excess insurance over the Limits of Liability of ... [the] policy."

Innocent insureds remain covered when the exclusion for fraudulent, dishonest or criminal acts applies. An innocent insured is one "who... did not personally commit or personally participate in committing such act; did not willfully violate the law; did not gain a profit or advantage, and did not personally acquiesce in or remain passive after having personal knowledge or becoming aware" of the misconduct. A showing of intent or willfulness should be required to defeat an insured's status as an innocent insured.

Arbitration to resolve coverage disputes is sometimes provided for in the policy; however, usually the insured is forbidden from instituting any action or arbitration proceeding against the insurer unless as a condition precedent there has been full compliance with all the terms of the policy.

The policy is non-assignable and can be canceled by the "First Named Insured" on written notice and by the insurer typically on written notice not less than sixty (60) days after the insurer's cancellation notice, except when there is non-payment of premium, and then the policy may be cancelled ten (10) days after notice. Some policies have a feature providing

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that if an individual insured continues paying premiums after cancellation of the policy, even if that insured is not the named insured, the policy will not be canceled as to that individual insured.

In sum, as discussed more fully in other sections, coverage issues typically arise when the exclusions in the policy preclude not merely indemnity coverage but also the insured's right to a defense because there is not a single covered claim in the pleadings.

APPLICABLE LAW AND ISSUES

As stated, the typical policy is a claims made policy (as opposed to an occurrence policy) having a "double trigger," meaning that the policy provides coverage as long as the claim is both made against the insured and reported to the insurer during the policy period (with the acts sued upon occurring after the retroactive date, if the policy has a retroactive date). In *Checkwrite Limited, Inc. et al. v. Illinois National Insurance Company*⁵, the Court observed "(t)he term 'claim' as used in liability insurance policies has generally been found by courts to be an unambiguous term that means a demand by a third party against the insured for money damages or other relief owed." When the claim was made during the policy period and the alleged act giving rise to the claim occurred after the retroactive date (because there was "a written demand by a third party for monetary damages...[by] a demand for arbitration"), the policy's coverage was applicable.

The policy's coverage is triggered by the timely reporting of the claim to the insurer. To escape coverage, it is the insurer's burden to dispel any ambiguity in the language of the policy and show facts upon which a court would grant summary judgment in its favor that the acts and omissions are not within the insurer's scope provision and/or squarely within an applicable exclusion. In *General Insurance Company of America v. City of New York, et al.*⁶, it was held

that "...(w)here an insurer seeks to escape coverage by virtue of an exclusion...the insurer will be relieved only where it can 'demonstrate that the allegations of the [underlying] complaint cast the pleading solely and entirely within the policy exclusions, and, further, that the allegations, in toto, are subject to no other interpretation.' " If the insurer disclaims and there is a judicial determination of coverage, the insured is entitled to his or her legal fees incurred in defending against the insurer's disclaimer action.

Some courts have considered an insurance policy to be a contract of adhesion. As noted in *Castleberry, et al. v. Goldome Credit Corporation, et al.*⁷

The rule in question exists within the context of insurance law and reflects the exigencies of insurance situations. '[I]nsurance policies, while contractual in nature, are certainly not ordinary contracts, and should not be interpreted or construed as individually bargained for, fully negotiated agreements, but should be treated as contracts of adhesion between unequal parties...' Courts have interpreted insurance contracts according to the rule of contra proferentem, resolving ambiguities against the insurer... 'Most American Courts apply a rule of construction that coverage terms are construed broadly and exclusions and limitations of coverage are construed narrowly'... In particular, an insurer's contractual duty to defend its insured is read broadly.

The rationale for the application of the traditional rules [of interpreting any ambiguity in the policy in favor of finding coverage] is that the insurance policy is

generally an adhesion contract and therefore the insured has no ability to negotiate for or control the wording of the provisions contained therein. This liberal rule of construction is particularly appropriate in determining the insurer's duty to defend the insured from claims potentially within the scope of the policy coverage....

Thus, '... [a]n insurer's duty to defend is triggered whenever the allegations in a complaint, liberally construed, suggest a reasonable possibility of coverage, or when the insurer has actual knowledge of facts establishing such a reasonable possibility. An insurer may be relieved of its duty to defend only if it can establish, as a matter of law, that there is no possible factual or legal basis on which it might eventually be obligated to indemnify its insured, or by proving that the allegations fall within a policy exclusion.

The duty of defense cannot be denied when "the underlying action against defendants, may be 'within the embrace of the policy ... [the] plaintiff [insurer] must defend defendants therein" (emphasis added).⁸ As a matter of law, it is virtually impossible for an insurer to avoid its defense obligation if the allegations potentially fall within the coverage provided, 'or' when the insurer has actual knowledge of facts establishing a reasonable possibility of coverage."⁹

In *Allianz Insurance Company v. Regina Heimer, et al.*,¹⁰ the United States Court of Appeals for the Second Circuit made it clear that even if the insurer is discharged from its duty to indemnify, it is not excused from the duty of defense. The Second Circuit held in this recent case as follows:

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Thus, for the Insurer to be relieved of their duty to defend, they bore 'the heavy burden of demonstrating that the allegations of the complaint cast the pleadings wholly within the exclusion, that the exclusion is subject to no other possible factual or legal basis upon which the insurer may eventually be held obligated to indemnify the insured under any policy exclusion.

The Court also held there must be a showing that "there is no possible factual basis" for inclusion in the policy's scope. It is universal law in the United States that "an insurer's duty to defend against liability under an insurance policy is surely broad."¹¹

In New York a determination of an insurer's duty to defend is not merely based upon, and is clearly not constricted by, the pleadings.¹² In Burke et al. v ULICO Casualty Company, et al.,¹³ it was held that "under New York law an insurer's duty to indemnify is determined not only 'from the pleadings but from the actual facts' adduced in the course of the litigation." As far as the duty to defend is concerned it is "broader than the duty to indemnify [and the] former duty may arise before facts are sufficiently developed to determine [the] latter duty."

An insurance policy can have a fatal ambiguity that clearly works in the insured's favor. Burke v. Ulico Casualty Company, et al., et al., supra¹⁴ further holds "(i)n the context of an insurance contract ... New York law requires that any ambiguity with respect to an exclusionary clause must be resolved in favor of the insured as a matter of law."

When there is a disclaimer (i.e., an upfront denial of defense, as well as indemnity) or when the insurer sends out a reservation of rights letter (i.e., undertaking the defense but advising there is a significant possibility of a

denial of indemnity coverage because of an applicable exclusion), the language of the policy has to be carefully read not only in terms of the dictionary and plain meaning of the policy language, but in the context of the customs and practices of the securities industry. The law is clear that when there is a reservation of rights because of the conflicts of interest in the insured-insurer relationship, the insured is entitled to choose counsel with the reasonable expense thereof to be borne by the insurer.¹⁵

PRACTICAL ISSUES

Every professional liability policy presents issues because of the practical context in which the professional operates within his industry. It is certainly no different in the securities and financial services industry. What happens when the individual registered representative moves with his accounts from one introducing broker-dealer to another, all within the same clearing system, and the transfer of the accounts occurs merely when a letter of authorization ("LOA") is executed by the customer without the re-execution of new account forms and agreements? Does a written agreement between the customer and the new Named Insured Broker-Dealer exist as the latter's policy requires? If substantial losses occurred at the first introducing Broker-Dealer, does the new broker/dealer's claims made policy preclude the losses, realized or unrealized, that occurred when the account was with the registered representative at the preceding broker-dealer? What is the unambiguous language of preclusion that cuts off a claim for preceding client loss? Is there an "other insurance" or an "excess insurance" clause, and what, if any, effect will that have in respect to the policy's coverage?

If the Statement of Claim appears to allege claims against the insured registered representative that are exclusively within the policy's exclusions, and the registered representative denies offering and

selling the excluded products, is the insured's right to a defense under the policy defeated? If the proposition is that the duty of defense is broader than the duty to indemnify, then how can the duty of defense not exist? How should the insured and his or her counsel approach such an issue? How could a duty of defense not exist in a context where a professional claims his or her innocence of the alleged misconduct? The innocent insured is protected when others within the scope of coverage are clearly implicated in wrongdoing and excluded by the policy. Similarly, a claim of innocence with respect to claims wholly within the exclusions should warrant defense coverage as well.

What happens if the insurer contends that the claim was not timely reported within the policy period? When is a claim reported? When is it transmitted by mail or received, and does it matter whether the insurer can show prejudice caused by the lateness in reporting? Claims and potential claims should be timely reported as coverage can be locked in even if a claim is not yet formally asserted. While absolute comfort cannot be drawn, and the better solution is to report even circumstances that could result in a claim, even though no claim has yet been asserted, the acceptable approach in reliance upon the applicable law is to report the claim "as soon as practicable within the policy period." The law on this point can be summarized as follows:

If the insureds have to "report" claims in writing before the policy expiration, the term "report" should be given its dictionary meaning, i.e., "to give an account of; relate, tell; to serve as carrier of (a message); to prepare or present (as an account of an event)...; ...[and] to make known to...." the insurer. "Report" denotes and connotes the communicator's expression and not the listener's or reader's receipt of the information; it is the point of output and not input. It is well established that reporting occurs

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at the point of mailing.¹⁶ If the insurer has the envelope that transmitted the notice, the post-mark should demonstrate that the “report” was made or not made before the policy’s expiration. If the insurer no longer has the envelope, which is the best evidence, it is not likely that any court or arbitration panel would rule in the insurer’s favor and permit the insurer to contradict the insured’s testimony that the claim was timely reported. The insured should also send all written communications by fax and/or registered or certified mail, return receipt requested, to evidence the time when the notice is given.

Within the policy period, the claim has to be reported “as soon as practicable,” and that standard imports good faith and reasonableness. When written notice is an issue, make sure that the context of the notice demonstrates that a timely report “as soon as practical” was made, especially and even where no losses have, at the time, been realized. Take steps so that the insurer cannot argue that claim was not reported as soon as practicable.¹⁷

It is also important in most states, in order to protect coverage, to establish that there was no prejudice to the insurer as there was no formal claim at the time of the report and that the insurer could not have eliminated or mitigated any cost or harm at this point. In this factual context, New York law, in contrast to other jurisdictions, traditionally does not require an insurer to show prejudice before a late notice claim can prevail. However, reference should be made to the case, *Brandon v. Nationwide Mutual Insurance Company*¹⁸ in which Chief Judge Judith Kaye of the New York Court of Appeals articulated when the “no-prejudice” rule (that it is anticipated the insurer will advocate) does not apply. The Court held:

Generally, ‘one seeking to escape the obligation to perform under a contract

must demonstrate a material breach or prejudice’. By allowing insurers to avoid their obligations to premium-paying clients without showing prejudice ... [this Court in 1972] created a limited exception to this general rule. The rationales for this limited exception include the insurer’s need to protect itself from fraud by investigating claims soon after the underlying events; to set reserves; and to take an active, early role in settlement discussions.... Finding these factors inapposite ... we [decline] to extend the ... no prejudice exception ...

Notwithstanding the above quotation, the law now in New York generally is that coverage can be disclaimed absent a showing of prejudice. Most other jurisdictions, however, require prejudice and this appears to be the trend in New York based on the above-cited case.

For policies written by insurers governed by New York Insurance Regulations, 11 NYCRR §73.3 [e][3][1] accords an automatic sixty (60) day reporting period following termination of a policy, and accordingly the reporting of a claim, when made within the prescribed period of the State’s statute and/or rule setting a time mandate to report, arguably is deemed timely; even if the notice of the potential or actual claim is received on the day after the policy’s expiration. New York Insurance Regulations thus provides for an automatic sixty (60) days window so claims reported after the policy’s termination will receive coverage. Further the exception cannot apply when there were no actual losses and no formal arbitration claim was made until after the point in time when the notice was given, and received by the insurer as there is not even the remotest possibility of any prejudice at this point in time.¹⁹

It is conceivable that a claim can be made shortly before policy expiration, timely reported, and there is language in the policy to the effect that notice of a claim is reported “upon receipt” by the insurer, and not received until after expiration. Construction of a policy, unless the language is manifestly unambiguous, must be made in favor of the insured.²⁰

Under such circumstances, regulators would and should question the disclaimer. Such a policy construction would lead to a practice in violation of Section 2601(a)(1) of the New York Insurance Law (i.e., “knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue”), and (2) (i.e., “failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies”) as it would, without plain English disclosure, possibly constrict the coverage that explicitly exists in the policy. This certainly would be to the detriment of the insured. Litigation, however, in this context has not created settled authority. In all circumstances, however, the earliest possible report of a potential or actual claim is the best practice.

OBSERVATIONS AND RECOMMENDATIONS

If the broker-dealer is dually registered as an investment advisor and if the customer-client has given the investment adviser/broker-dealer more than limited discretion pursuant to a written authorization in compliance with NYSE and NASD Rules, the coverage should not be excluded. In this instance negotiation with the insurer through the insurance broker for an appropriate endorsement should be pursued. Further, a mere “allegation” of the excluded activity or product should not automatically defeat coverage, both defense and indemnity, until arbitrators render a reasoned award specifically describing the product and the activity upon which the award was based. If no

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reasoned award is rendered, as is usually the case, the insurer is in a less defensible position on its denial of coverage, when any allegation has been made that is arguably within the scope of policy coverage.

A policy should also provide for defense coverage for alleged fraudulent conduct and indemnity for non-scienter fraud and/or breach of fiduciary duty, and coverage should not be restricted in essence to negligent conduct. Covered wrongful conduct should not be restricted to negligent acts or omissions, as in the securities context, non-scienter fraud, breach of fiduciary duty, and failure to supervise claims are fairly typical. Coverage should be provided whenever there is an act or omission that causes actual monetary harm – not specifically excluded.

Furthermore, the fraud-criminal conduct exclusions should only be invoked and properly applied when the panel enters a reasoned award that the wrongful conduct was intentional. Negotiate to make the scope paragraph apply to any wrongful conduct except intentional fraud. Otherwise, there is a risk of artificial apportionment of the damages based on the claims asserted.

CONCLUSION

Professional Liability Insurance for the Investment Professional should not be a take-it-or-leave-it proposition for the investment professional. There should be both negotiation of the forms and endorsements as well as effective advocacy on behalf of the insured when a coverage dispute arises with the insurer. Effective advocacy can oftentimes be more readily achieved when brokers and investment advisers have memberships in professional associations that, as part of their member benefits, provide prepaid defenses and attorney referrals utilizing a network of experienced securities counsel. In today's environment this is essential backup for the investment professional, especially where there is a reservation of rights by the insurer. Insurers

working with such associations should also utilize organizations of forensic experts that can conduct periodic mock SEC- and NASD-like inspections to assess risk and manage those risks so that loss experiences can be minimized or prevented.

ENDNOTES

¹ If “negligent acts or omissions” is in the language of the scope provision it is too restrictive. The provision should just refer to an act or omission that causes economic harm. The exclusions then strike a proper balance and the scope paragraph will not be restrictive or deceptive.

² Utilizing an exclusion to preclude defense coverage and not merely indemnification is a substantial dilution of the professional liability insurance policy and the purpose for which the insureds pay their premiums.

³ Public Service National Insurance Co. v. Goldfarb, 53 NY 2d 392, 44 2 NYS 2d 422 (Ct. of Appeals 1981). Allstate Ins. Co. v. Riggio, 125 A.D. 2d 515, 509 NYS 2d 594 (N.Y.A.D. 2Dept. 1986).

⁴ Garay v. National Gange Mut. Ins. Co., 117 Fed. Appx. 785, 2004 WL 2617058 (CA2 2004).

Phoenix Contractors, Inc. v. Affiliated Capital Corp., 273 Wis. 2d 736, 681 NW 2d 310, 2004 Wis App. 2004.

Homsey Architects, Inc. v. Harry David Zutz, Ins., Inc., 2000 WL 973285 (Del. Super. Ct. 2000).

Lexington Ins., Co. v. St. Louis University, 88 F. 3d 632, 110 Ed. Law Rep. 995 (CA 8 (MO) 1996).

Thoracic Cardiovascular Associates, Ltd. V. St. Paul Fire and Marine Ins., Co., 181 Ariz. 449, 891 P2d 916 (Ariz. App. Div.1, 1994).

Dan River, Inc. v. Commercial Union Ins. Co., 227 Va. 485, 317 SE 2d 485, 38 Empl. Prac. Dec. P3J, J75 (Va. 1984).

⁵ 93 F Supp 2d 180; 2000 US Dist. Lexis 62 33 (S.D.N.Y.2000);

⁶ 2005 US Dist. Lexis 35864 (2005);

⁷ 418 F 3d 1267; 2005 US App. Lexis 16472; 18 Fla. L. Weekly C786 (11th Cir. 2005).

⁸ Liberty Mutual Insurance Company v. Ho, et al., 289 A.D.2d 1051; 735 NYS 2d 286; 2001 N.Y. App. Div. Lexis 12764 (4th Dept. 2001).

⁹ International Flavors & Fragrances, Inc. et al. v. Royal Insurance Company of America, et al., 2003 NY Slip Op 51750U; b Misc. 3d. 1024A, 800 NYS

2d. 347, 2003 N.Y. Misc. Lexis 1989 (S. Ct. N.Y. Co. 2003).

¹⁰ 416 F 3d 109, 2005 US App. Lexis 15848 (2d Cir 2005).

¹¹ Miami Battery Manufacturing Co., et al. v. Boston Old Colony Insurance Co., et al., 1999 US Dist. Lexis 23357 S.D.Fla., Miami Division, 1999;

Rosenberg Diamond Development Corporation v. Employers Insurance Company of Wallsall, 144 Fed App. X 122; 2005 US App. Lexis 5261 (2d Cir. 2005).

¹² Burke, et al. v. ULICO Casualty Company, et al., 165 Fed. App X125, 2006 US App. Lexis 1498 (Id Cir 2006).

¹³ Id.

¹⁴ Id.

¹⁵ Public Serv. Mutual Ins. Co v. Goldfarb, Allstate Ins. Co. v. Reggio, Public Serv. Mut. Ins. Co. v. Goldfarb, 53 NY 2d 392, 442, 425 NE 2d 810 (NY Ct. of Appeals 1981);

Allstate Ins. Co. v. Reggio, 125 A D 2d 515, 509, NYS 2d, 594 (2d Dep't 1986).

¹⁶ Aetna Insurance Company of Hartford, Connecticut v. Millard, 25 A.D.2d 341, 269 N.Y.S.2d 588 (Third Dept. 1966).

¹⁷ Romano v. St. Paul Fire and Marine Insurance Company, 65 A.D.2d 941, 401 N.Y.S. 2d 942 (Fourth Dept. 1978);

Public Service Mutual Insurance Company v. Levy, 87 Misc. 2d 924, 387 N.Y.S.2d 962 (S.Ct. NY Co. 1976).

¹⁸ 97 N.Y.2d 491, 769, N.E.2d 810, 743 N.Y.S.2d 53, 2002, Slip. Op. 03289 (Ct. of App.2002).

¹⁹ Naddeo v. Allstate, Ins. Co., 139 N.C.App.311, 533 S.E.2d 501 (N.C.App.2000);

Liberty Mutual Ins. Co. v. Pennington, 141 N.C.App. 495, 541 S.E.2d 503 (N.C.App. 2000).

²⁰ LaPierre, Litchfield & Partners v. Continental Casualty Company 32A.D.2d 353, 302 N.Y.S. 370 (4th Dept. 1969).