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A Review of the Modern General Liability Claims Made Form

Rarely are clients immediately aware of the wrongful or erroneous actions of the "**professional**" they trusted to perform specific duties or services; mainly because "professional" acts or errors do not or only seldom cause immediate injury. A "professional's" wrongful acts or errors may not manifest in client injury until long after the act is perpetrated or the error is committed.

Because of the time lag between the wrongful act or error, the resulting injury and the ultimate claim or lawsuit, Joe D'Alessandro in 1964 deduced that there was a better way to insure a "professional." Secondarily, D'Alessandro postulated that there had to be a way to provide greater actuarial certainty that there would be no further claim activity following the close of the policy period (eliminating the "incurred but not reported" (IBNR) problem). This creative thinking led to the development of the first "claims made" policy wording.

While D'Alessandro's initial thinking was accurate, 45 years of history has shown the goal of achieving actuarial certainty to be elusive at best. The stability and evolution of the "claims made" policy has also been threatened during its history by poor form standardization, court decisions and shoddy policy form draftsmanship.

Profession/Professional Defined

"Claims made" coverage originated in the realm of professional liability. To understand the exposure and the reason for the desire to limit or eliminate the long-tail claim problems, "profession" and "professional" must first be defined.

A "profession" is a **calling** that requires specialized knowledge, has legal and/or educational barriers to entry, requires the practitioner to be dedicated to the vocation itself and necessitates a commitment to continual study and the increase in applied knowledge. This intimates focused attention on the profession's depth and details and surrendering to the fact that the well of the profession's knowledge is infinitely deep and is not adequately explored shy of ongoing, **personal** study.

"Professionals" accept the challenges of the profession's calling, dedicating themselves to studying and understanding the chosen industry, the industry's clients and the mechanism. Receiving pay does not make one a professional, only the result of an individual's membership in a profession.

Professions in antiquity included those that practiced medicine, law, the clergy and engineering. The modern definition of "profession" has been expanded to include architects, investment managers, insurance agents, accountants and others s meeting the above definition who "provide services to others for a fee".

Since its creation, "claims made" wording's use has expanded outside of the "profession" and professional liability realm, finding use in diverse liability coverages. But the roots of "claims made" wording, and its most common use still, is found in covering the exposures created by a "professional's" activities. As seen by the list of true "professions," professionals are individuals who provide a service to society which, if done poorly, could cause extreme or irreparable personal or financial harm.

Expanded Use of the Claims Made Concept – Two Branches

The expansion of claims made policy forms beyond "professions" caused the basic "claims made" concept to diverge and evolve into two distinct forms. One evolutionary branch commenced in professional liability coverages (known also as "errors and omissions" coverages in this series) and the second branch grew out of the financial services industry and the need for directors and officers liability protection, fiduciary liability and employment practices liability (referred throughout this series as "executive liability" coverages).

Although both branches attach to the tree at the same point; greatly different "claims made triggers" have resulted. Additionally, coverage terms, conditions and definitions differ between the two branches.

Developing "Claims Made" and the Problems Defining a "Claim"

"Claims made" policies were designed around a simple idea, "*to indemnify for claims first made against the insured during the policy period.*" This original language has since become known as a "pure claims made" form. There was only one event needed to trigger coverage: a "claim was first made during the policy term." The current complexity evolved from this starting point!

The first problem to arise following the development of this form was the exact definition of a "claim." "Claim" took on more meanings than ever imagined and its use became abused and confused depending on context. Was a claim "first made" when the insured received an angry phone call threatening to sue and/or hold him/her responsible? Was it not until the insured received a demand letter threatening suit; the filing of a complaint or the receipt of the suit papers? Each of these events likely takes place on different dates; this disparity of dates could have profound effect on coverage depending on when coverage incepted or renewed and how "claim" is defined.

Courts wrested with the definition of a "claim" and rendered decisions making the definition and any attempt to narrow it down to one point even more complex. Many of these court-developed definitions actually made things worse. Most current forms specifically define "claim;" and the definitions can be as varied as the carriers that provide coverage (the differences are highlighted in the last post). Forms must be compared to know when a "claim" occurs; the "when" makes a difference since the carrier has to be informed during the policy period to ensure that coverage exists (this necessity and the danger of not meeting this requirement is highlighted in future paragraphs).

Correcting the Perception of Pricing Inequities - Creation of the Prior Acts Date

By 1976, "claims made" policies and the number of carriers offering them flourished. No longer would a professional have to keep boxes of "occurrence form" policies around should an error give rise to a claim, even years after the end of the policy period. But the new form led to pricing questions.

Consider two professionals with the same practice and similar revenues. The first insured has carried a "claims made" policy for several years and is preparing for renewal; the second is buying its first "claims made" policy – and their premiums are - the same.

This didn't seem fair; the insurance carrier was assuming the same risk for both, all prior acts or errors; yet the loyal customer has paid the carrier a large amount of premium for this exposure and the new insured pays only one-year's premium for the same length and breadth of protection.

Beyond the fundamental financial inequity was the concept of potential knowledge. The insured MIGHT already know a claim is coming simply because they are aware of a previously-made error; or perhaps the insured just

believes that in years of practice, something might be lurking in the files. As a result of the pricing difference and the potential the carrier may become responsible for a previous act or error, the first risk/policy modifier appeared on the scene. The new add-on was called the **prior acts date**, retroactive date or retro date (used interchangeably); a now-common feature of the “claims made” coverage.

Introduction of the retroactive date required the insured to meet two coverage trigger conditions:

1) The claim must be first made against the Insured during the policy period (when the claimant supposedly notified the insured); and
2) The insured’s error or wrongful act must be subsequent to a specified date- usually the inception date of their first “claims made” policy (provided there were no coverage gaps). No acts or errors before this prior acts date would be covered by the new policy.

With these two conditions becoming firmly entrenched, the insurance industry’s first inclination was that if an insured wanted to change companies, the new insurer could mitigate it’s exposure by not recognizing the insured‘s current retroactive date, writing the renewal using the date of inception as the new retro date. While a good idea for insurer risk reduction, many quickly found that insured’s would not move their coverage, even for a better price unless the first coverage date was honored, giving prior acts coverage back to the original retroactive date. Thus began the tradition that, in the absence of a gap in coverage, poor claims history (or even multiple predecessor firm history), the new insurer would honor the insured‘s expiring prior act date.

Executive liability insurers did not hold to this tradition. The few directors and officers policies that existed in the 70’s and early 80’s were still written on a pure basis allowing, in essence, any wrongful act dating back to the corporation’s formation to be covered - so long as no insured was aware of any fact or circumstance that a claim might be made (a question that became an actual warranty on the coverage application). Executive liability’s continued use of pure “claims made” wording marks the break in philosophies of errors and omissions underwriters and executive liability underwriters. The separate branches created by this conceptual difference reconnected years later with subtle yet potentially horrendous consequences.

Series to Follow

This is the first part of a five-part series exploring “claims made” policy wording. The remaining installments explore specific policy provisions such as reporting requirements, BERP’s, the prior and pending litigation exclusion, how E&O wording combined with executive liability wording and the seven potential problems with the incident reporting provision.

The series ends with a look at the varied definitions of a “claim” and the three keys to placing the best coverage for the insured.

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‘Claims Made’ Reporting Requirements, BERP’s and Prior Litigation

“I hate my insurer” says the client. “All they ever want to do is settle the claim… after throwing my deductible out the window.” Brokers have heard this for years, and as errors and omissions policy holders, many may even think it themselves. Insureds might even consider handling a “minor claim” themselves to save the deductible and keep the renewal premium in line (since it is assumed that reporting a claim makes the rates go up).

This flawed thinking caused many insureds to delay reporting a claim made during the policy until a trial was looming, perhaps even a year or more after policy expiration; perhaps even after changing insurers. Despite the policy condition that the insured was to report claims or suits immediately or as soon as practical, many appellate courts ruled that the insurer had to show prejudice if the insured didn't comply. In other words, that a "different result would likely have occurred." This means that the insurer could have effectuated a better finding (i.e. the insured would not have been found liable or the amount of the settlement would have been different, etc.); a difficult test to prove.

One New York-based insurer decided in the late 1980's to fix this problem; after all, the "claims made" form was devised to provide actuarial certainty no "incurred by not reported" claims would hit the policy once it expired. The "claims made and reported form" was introduced, intentioned to force insureds to report any claims and not hold on to them for a long period. Rather than placing this provision under the "conditions" section of the policy, the industry choose to make it part of the Insuring Agreement. Being in the Insuring Agreement gave the insurer a better chance the wording would hold up in court.

This change created three coverage trigger conditions:

1) The claim must be first made against the insured during the Policy term;
2) The wrongful act or error must take place subsequent to any Retro/Prior Act Date; and
3) The claim must be reported to the insurer during the policy term.

These conditions would largely become the industry standard for the next several years. Underwriters couldn't copy and paste fast enough; especially after a California Appellate Court upheld the language joining those that had in other States.

Yet, not all of the executive liability insurers followed the crowd in changing their reporting requirements. And those that followed suit did so without applying a prior acts date limitation.

While designed to penalize those who held on to claims for whatever reason, it was quickly determined that the innocent insured might suffer. Questions arose about uncontrolled circumstances such as the last minute suits served on the cusp of a renewal, or the executive responsible for reporting the claim being on vacation, or ill. Would anyone know what to do or even be aware of the policy's reporting provision that, in essence, slammed the window shut at midnight? The industry quickly responded with an automatic reporting provision commonly known as the Basic Extended Reporting Period (BERP) that allowed a short reporting extension following policy expiration:

> "*The* ***Company*** *further agrees that the* ***Insured*** *may have up to, but not to exceed, 60 days (sometimes 30 days depending on the company) after the policy expiration to report in writing to the* ***Company*** *a* ***claim*** *made against the* ***Insured*** *during the* ***policy period****, if the reporting of such* ***claim*** *is as soon as reasonably possible."*

Not every insurer adopted this provision. The duty fell on the agent and the insured to know the policy provisions.

The decade of the 90's and the beginning of the new millennium saw few "claims made" advancements.

Prior and Pending Litigation in Executive Liability & the BERP

Executive liability underwriters, for whatever reason, did not immediately follow their errors and omissions underwriter counterparts' lead in the adoption of a "prior acts"-type (retroactive date-type) requirement. One can only guess what prompted the addition of a risk modifier after years of providing pure "claims made" protection.

Underwriters on the executive liability side eventually enacted a risk modifier; but unlike errors and omissions underwriters, they deciding to not tie the coverage date modifier to the actions of the insured, but rather to the actions of the injured party. For example, if the professional commits the wrongful act or error before the "prior acts date" (as used on the errors and omissions side), no coverage is provided by the policy. In contrast, it does not matter when the insured committed the act if a "prior and pending litigation" form is used, only when the injured party filed suit. If the suit was filed after the prior and pending date, coverage applies.

Prior and pending litigation date is also known as the: "continuity date," "first coverage date," "P/P date" or "administrative proceeding" date - depending on the form and insurer.

Adopting this language into executive liability forms changed coverage requirements. Now:

1. The claim against the insured had to be first made during the policy term;
2. The first notice of litigation or possible litigation, in the form of a service of suit or administrative agency notification, must occur after the specified prior and pending litigation date (often found on the declarations page); and
3. If the policy contained a reporting requirement, the claim must be reported to the insurer during the policy term or any automatic basic extended reporting period.

Institution of this "continuity date" complicated matters for new policy holders. Since the date is referred to as the "first coverage date," the prior and pending date would, absent prior coverage, be the INCEPTION date for the first time executive liability coverage "claims made" buyer. However, like their errors and omissions counterparts' use of a prior retroactive date, executive liability underwriters would honor an existing prior and pending litigation date at subsequent renewals, even if the insured changed carriers.

Executive liability renewal applications using a prior and pending litigation date, oddly enough, did not contain any warranty questions to uncover known claims or litigation that might give rise to a suit. One underwriter once stated that they didn't want to break the chain of continuity" even though they couldn't define the term. In fact, the policy simply defines "continuity" as the date specified on the declaration page and no further explanation is provided.

It's Only Getting Better

To this point, errors and omissions coverage and executive liability protection have remained separate in their application of individual risk modifiers – prior acts vs. prior and pending litigation wording. The

next installment details the problems created when these two separate modifiers collide in one form. Hold on and get ready to review the agency's own errors and omissions policy.

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The Prior and Pending Litigation Exclusion's Convergence into Professional Liability Policies

No one knows exactly when, but at some point, some senior executive liability underwriter must have moved to an errors and omissions division and discovered the professional liability policy contained no "continuity date" limitation. Errors and omissions underwriters soon began using the prior and pending litigation exclusion by endorsing the language onto the policy or inserting it into the policy's exclusion section. The most often used exclusionary language read:

> *"…arising out of … from any **claim**, arbitration, mediation, litigation, administrative proceeding (including disciplinary and licensing), bankruptcy or regulatory proceeding or investigation, pending as of or commenced prior to the **inception date** …"*

Some policies even went so far as to use language as limiting as:

> *"…arising out of … from any **claim**, arbitration, mediation, litigation, administrative proceeding (including disciplinary and licensing), bankruptcy or regulatory proceeding or investigation, pending as of or commenced prior to the **first inception date** …"*

"First inception date" was commonly a defined term in these policies. To clarify the extent of or limitation on coverage, the insured was required to go to the policy's definition section. The definition may have read:

***"First inception date** means the date set forth in Item "X" of the Declarations as the inception date of the first …. Professional Liability Policy that (i) provides or provided the same or essentially the same coverage as this policy, and (ii) was issued by **us** or any other member company of XXXXXX to the **named insured** or its predecessors and was continually renewed by **us** or any other XXXXX member company through the inception date of this policy; or such other date specified in Item "X" of the Declarations as such.*

Some insurers hid similar limitations within their forms without disclosing the prior and pending limitation in the quote. This not only creates claims problems for insureds, it places agents' and brokers' errors and omissions policies in danger; possibly having to respond to an excluded claim.

Note also the conspicuous absence of the term "***known***" from the prior and pending litigation wording. Even unknown suits, administrative proceedings or other such matters would be excluded if they predate the prior and pending date. This potential gap is explored below.

Worse, errors and omissions underwriters, unlike executive liability underwriters, almost always made the prior and pending (continuity) date the same as the inception date of the first policy written with that insurer - even if there was prior coverage. Professional liability underwriters would not "back-date" the prior and pending litigation date, creating a potential coverage gap. This additional provision meant that the insured professional now had to satisfy four coverage triggers:

1. The claim against the insured had to be first made during the policy term;
2. The wrongful act had to take place subsequent to any retroactive date;
3. The claim had to be reported to the insurance company during the policy term or any automatic extended reporting period; and
4. The service of the suit must occur **after** the prior and pending litigation date; even if the insured had no knowledge that it is coming. If the "P/P date" is the inception date, this could cause problems.

The necessity of meeting all four requirements creates a subtle yet potentially devastating coverage gap. Even if the insured has continuous coverage with a many-year past retroactive date, the prior and pending litigation exclusion is absolute and does not require the insured to have actual knowledge that a suit was filed prior to the current policy's inception for such action to be excluded from coverage. If a suit were filed the day before renewal, for example, but not received until after renewal, the prior and pending litigation date may act to exclude coverage for such suit even though the claim is made during the policy term, even if the insured was unaware of any act or error that may give rise to such a suit.

Basic extended reporting periods (BERP's) were created to fill this gap. BERP language in the expiring, non-renewed policy generally allows the insured between 30 and 60 days (most common is 60) to report a "claim." Such an extension should fill the gaps created by the above scenario, but it depends on the definition of a "claim." If a "claim" is defined simply as a "demand for money or services," then the suit might be covered by the prior policy under the BERP provision. If, however, the definition of a "claim" requires the notice of claim or service of suit be received ***during the policy period***, then the claim may be denied by the prior carrier and will likely be denied by the new/current carrier.

Further, there is no chance for coverage from the prior carrier should the claim be submitted after the 30 or 60 days provided by the BERP-allowable extension. This scenario is likely if the insured submits the suit/claim to the current carrier and does not submit it to the prior carrier until denial of liability is received from the new carrier (which may take the entire extension period to receive).

The definition of a "claim" and the basic extended reporting period provisions govern whether or not such a coverage gap exists. A thorough understanding of terms and policy provisions is necessary before coverage is moved from one carrier to another if the prior and pending litigation date is advanced by the new carrier.

Thus far I have seen only three policy forms require the insured to have ***actual*** knowledge of a suit or administrative proceeding in order to be considered a "claim;" unlike the above example which only required the filing of a suit or proceeding. This, having actual knowledge, is the solution that would eliminate all potential gaps in coverage and make the form 100 percent consistent with the warranty contained in the application.

As obvious as it seems to insert the word "***known***" into the definition, some carriers have taken a different path - backdating the prior and pending litigation date to match the prior acts date. While this fixes the coverage "gap" issue, it exacerbates and further highlights the problem created by not simply inserting the term "known." There may be unintended consequences of backdating the prior and pending date without inserting the word "known;"including theoretically covering a claim scenario that could not possibly happen in the real world.

More problems are created when the professional liability underwriter and/or the agent is unaware that their policy contains a prior and pending exclusion that automatically advances to the renewal date at subsequent renewals.

Problems A 'Plenty

Agents are well aware that incidents that may lead to claims should be reported to the carrier once there is knowledge of such incident. "Claims made" policies allow this and certain policy provisions require the reporting of such incidents.

However, the incident reporting provision has developed into a potential trap for the insured; a trap from which a claim denial is possible simply because an incident was not reported in the manner prescribed by the policy.

The next post details common incident reporting provisions and spotlights seven potential problems created by the policy wording. Proof once again that not all "claims made" policies are created equal; and each must be studied to assure there is no coverage gap.

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'Claims Made' Coverage Tripped Up by the Trigger Language

The Incident Reporting Provision

Nearly all "claims made" forms allow the insured to report a fact or circumstance that will likely or may give rise to a claim at some point in the future. If the reported act or error does evolve into a claim at a later date, the insurer to whom the incident was first reported will treat the claim as if it were first made during the policy term of the initial report.

Some insureds abused this provision and submitted a laundry list of "potential claims" to the insurer. The most common reasons for such abuses arose from insureds being non-renewed or changing carriers. Because of such attacks on this liberalizing language, and the industry's attempt to avoid the submission of "possibilities," insureds are now required to provide:

1. The specific details of the act, error or omission **…..** that gave rise to the **Circumstance**;
2. The injury or damage which may result or has resulted from the **Circumstance**; and
3. The facts by which (the Insured)….first became aware of the act, error or omission**….**

The Incident Reporting Provision is not the same as the claim-reporting extension. An "incident" MUST be reported in sufficient detail prior to the expiration of the policy. The insured, absent language to the contrary, does not have any additional time beyond the policy period to report an **incident**. In contrast, a "claims made and reported form" allows the insured an additional 30 or 60 days (as discussed in an earlier section) to report a **claim** "first made during the policy term…." "Claim" and "incident" are not synonymous terms.

The Automatic Claim Reporting Extension and the Claim Reporting Condition

Since the "claims made and reported" wording was first adopted in the early 1990's, it may have become the most common "claims made" wording used. As a result, most insurance practitioners have come to accept that not only must a claim first be ***made*** during the policy term, but to garner coverage, such claim must also be ***reported*** during the policy term (or any extension period if provided). Unfortunately some insurers, in their zeal to force insureds to report their claims in a timely manner, have taken a surprising and unconventional approach that may result in the denial of a claim for unsuspecting insureds. Some policy's Condition sections now state:

> *"The Insured shall, as a condition precedent to the coverage afforded by this policy, give written notice to the underwriters during the policy period of any claim made against the insured, but in no event shall notice to the underwriters be later than 30 (may be 60 or 90 days depending on the insurer) after any insured becomes aware of said claim."*

Not many would expect to find such an unconventional provision in the conditions section when the insuring agreement has already implied it is a conventional "claims made and reported form." Thus an unexpected claim denial might result for an otherwise covered claim.

The Automatic Claim Reporting Extension and Renewal

Most brokers expect a "claims made and reported form" to give the insured some limited amount of time following the end of the policy period to report a claim first made during the policy term (most commonly 30 or 60 days). The purpose of this provision was to not penalize an insured who, in good faith, found it next to impossible to comply with the requirement of reporting the claim during the policy period. The preferred language was akin to:

*"…the **Insureds** shall, as a condition precedent to their rights to payment under this Policy, give to underwriters notice in writing of such **Claim** as soon as practicable provided all **Claims** must be reported no later than the end of the **Policy Period**, in accordance the requirements of the **Optional Extension Period** (if applicable), or sixty (60) days after the expiration date of the **Policy Period**."*

While the above policy language is preferred and relatively unrestricted, new language is popping up with unusual and restrictive language; some is even illogical. New policy wording will only allow the reporting extension: *"In the event of cancellation or non renewal of this Policy, by either the 'Named Insured' or the Company…"*

If the policy is renewed, no last minute claims made against the insured are covered unless the claim is reported prior to expiration of policy. Neither will such claim be covered by the renewal policy since the claim wasn't first made in that policy term. This wording almost behooves the insured to renew elsewhere.

There are still some "claims made and reported" policies in use requiring the claim be first made and reported during the policy term - never allowing for a post-expiration claim report.

The Automatic Claim Reporting Extension and Contradictory Policy Language

Consider a policy's insuring agreement that reads:

"Provides professional liability coverage for those wrongful acts that occur subsequent to the retroactive date stated in the declarations and which are first made against you and reported to us while this policy is in force. No coverage exists for claims first made against you and reported to us after the end of the policy term unless, and to the extent, an extended reporting period applies."

The "Notice of 'Claims'" wording in the conditions section of the above policy reads:

"SECTION VII – CONDITIONS "
Notice of "Claims"

- *"As a condition precedent to our obligations under this Policy, you shall give written notice to us as soon as practicable, but in no event later than 60 days after the end of the "Policy Period" of any "Claim" made against you. …"*

In the same form, the **Extended Reporting Period** language states:
SECTION VIII – EXTENDED REPORTING PERIOD

1) *In the event of cancellation or non renewal of this Policy, by either the "Named Insured" or the Company, for reasons other than non-payment of premium or material misrepresentation in the Application, you shall have the right to an Extended Reporting Period as follows:*
    (a) *Automatic Extended Reporting Period*

Coverage as provided under this Policy shall automatically continue for a period of sixty (60) days following the effective date of such cancellation or non renewal, but only with respect to "Claims" and "Wrongful Acts" committed before the effective date of such cancellation or non renewal.

Claims received during the prior policy term but reported one day after policy expiration have been denied by the renewal carrier (same insurer) because the claim was not reported in accordance with the "Extended Reporting Period" provision since the policy was neither canceled nor non-renewed. Thus, if the policy is renewed, the insured must report even last-minute claims to the insurer prior to expiration. Such interpretation and denial completely ignores **Condition VII – "Notice of 'Claims**.'"

The Automatic Claim Reporting Extension and Confused Policy Language

"Cut and paste" is a quick and expedient way for an insurance carrier to re-draft a policy to its own liking; but it helps to read the finished policy in its entirety once done creating it. A recently reviewed policy's declaration page states:

- ***"Notice of claim must be given no later than 60 days after such claim has been made"***

Yet page one of the Coverage Section reads:

- *All coverage sections in Section I – Liability – cover claims first made during the policy period against the Insured alleging a …'wrongful act' …."* (This is pure claims made wording.)

Going deeper into the form, the policy's Condition Section requires:

- *"As a condition precedent to coverage under this policy, the insured shall give the Insurer written Notice of any claim as soon as practical after…. Become(ing) aware of such claim,* ***but in no event later than 60 calendar days after the termination of the policy period****…."*

Such extended reporting language is usually found in a "claims made and reported" form.

This policy form is obviously a mix of "pure claims made" wording and "claims made and reported" form language. The problem created by such amalgamated wording is deciding which takes precedence and exactly when a claim MUST be reported to avoid denial for not meeting reporting requirements.

The Automatic Claim Reporting Extension and Convoluted Policy Language

How long does the insured have to file a claim considering the following policy language?

A. ***Notice of "Claims"****: As a condition precedent to coverage under this policy, the "Insured" shall provide written notice of any "Claim" made against any "Insured" as soon as practicable, but in no event later than the earlier of:*
   (1) Thirty (30) days following receipt of written notice of the "Claim;" or
   (2) The later of the expiration date of this policy, the Automatic Extended Reporting Period or the optional Extended Reporting Period, if elected hereunder.

To answer the question, the policy and the claim-receipt scenario must be analyzed very closely. This is one of those "it depends" moments with the key phrase being "*the earlier of*…."

Assume, for example sake, that the policy renews January 1 and that the expiring policy has a 30-day automatic extended reporting period (aka "basic extended reporting period" (BERP)) with no Extended Reporting Period. If a claim is received on December 23, what is the date by which the insured must report the claim to avoid denial based on not meeting reporting requirements? January 22!

How is that date deduced? The form states that the insured must report the claim by the EARLIER of: 30 days from receipt or the "the later of" three dates. Looked at in comparison, the relative dates are:

- 30 days from receipt – January 22; or
- Expiration date – December 31;
- Automatic Extended Reporting Period date – January 30; or
- Extended Reporting Period date – not applicable.

The earlier of these two options is January 22 because the latest of the last three dates is January 30. In no event will the insured ever have more than 30 days to file the claim once it has been received; even if received during the supplemental extended reporting period (SERP).

The Automatic Claim Reporting Extension and Limited Extension Wording

The following policy wording only gives the insured 60 additional days to report a claim if the claim was first made against the insured during the last 60 days of the policy period.

"IX. NOTIFICATION

*A. In the event any **Executive Officer** becomes aware that a **Claim** has been made against any of the **Insureds**, the **Insureds** shall, as a condition precedent to their rights to payment under this Policy, give to Underwriters notice in writing of such **Claim** …….no later than the end of the **Policy Period**, in accordance with the requirements of the **Optional Extension Period** (if applicable), or sixty (60) days after the expiration date of the **Policy Period** in the case of **Claims** first made against the **Insured d**uring the last sixty (60) days of the **Policy Period**."*

Agents and insureds cannot confuse this with the idea that the insured has a 60-day BERP. This provision avoids the penalization of an insured whose executive officer does not receive notice of a claim until near the end of the policy period.

The Automatic Claim Reporting Extension and Ridiculous Wording

Some forms don't give the insured any additional time after expiration to report claims made before expiration unless the policy is canceled or non-renewed. The wording below really turns the policy into a 14 month policy; but again only if the current policy is canceled or non-renewed:

> ***C. Extended Reporting Period**:*
>
> ***1.** If **we** or **you** cancel or refuse to renew this policy for reasons other than non-payment of premium; **we** will provide to **you** a 60 day Automatic Extension of the coverage granted by this policy, at no additional charge, for any **claim** first made against **you** and reported to **us** during the 60 day extension period but only as respects **wrongful acts** committed after the **Retroactive Date** (if any) stated in the Declarations and prior to the date of cancellation or non-renewal.*

How can agents and insureds protect themselves from such nonsense?!

It Gets Worse Before it Gets Better

One more problematic definition is left, the definition of a “claim.” Knowing what qualifies as a “claim” is the key for the agent and insured to know when to report an incident to the insurer. The next post provides a chart with eight different definitions of a “claim” to allow the reader to compare and contrast the differences among the carriers.

The series ends with three key recommendations for finding the best “claims made” policy for any client.

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Three Keys to Picking the Best ‘Claims Made’ Form

Over the last two weeks the “claims made” policy has been dissected, revealing its inner workings. But before moving on to the keys for choosing the best “claims made” policy form, the heart of the “claims made” policy must be explored: the definition of a “claim.”

The Definition of “Claim” Scrambles Everything

Defining a “claim” in the context of a “claims made” policy is the first issue when analyzing coverage. Many Appellate courts have ruled that a “claim” is “a demand for money or services.” Sounds simple enough; yet isn’t the filing of a lawsuit, even if un-served, a “demand for money?”

What if suit is filed in one policy term where the definition of claim is “a written demand” yet served after renewal on a policy written by another insurer whose policy defines “claim” as “a written demand received by the insured,” or” a lawsuit served on the insured?” Under these definitions, two insurers could have coverage for the same “claim,” which is not supposed to happen with “claims made” forms.

More complicated is the scenario where an insured moves coverage from an insurer whose definition of “claim” is “a written demand **received** by the insured,” to an insurer that applies a Prior and Pending Litigation exclusion using the policy’s inception date. If suit is filed during the expiring policy term but served after the inception of the new policy, the claim will be denied by both - even if reported to the prior insurer within the 30 or 60 day reporting extension (if applicable). The suit does not meet the extended reporting period requirement as it was not “**received** by the insured” during the policy term. The new insurer will likely deny liability because the litigation commenced (the suit was filed) prior to inception. Thus a gap in coverage is created, which isn’t supposed to happen when the insured has continuous “claims made” coverage.

Below is a chart comparing the various definitions of a “claim” found in “claims made” policy forms. When analyzing an insured’s coverage, knowing that these differences exist can lessen the agent’s own errors and omissions exposure.

Playing the “Claim Game”

Agents and brokers who do not work with "claims made" coverages on a regular basis now should have a much deeper understanding of the intricacies and differences each carrier/policy form offers. Successfully navigating through "claims made" policies requires specific attention to detail, particularly to the policy form definitions.

As has been presented in this series, one "claims made" policy is not just as good as another; and if the insured has been covered by an inferior form in the past, changing to a superior form could create coverage gaps. Knowing how the find the potential gaps makes good agents better agents.

Formulate claims scenarios when/if coverage is being moved to another carrier and policy form. Several may need to be created and run – comparing the scenario to the coverage form wording – to assure that there are no gaps or what gaps there might be.

What to Look for in a "Claims Made" Policy

Placing a "claims made" policy requires the agent to look for certain policy characteristics. Following are a few hallmarks of the "best" "claims made" coverage forms:

- Try to use a company that uses a "claims made" form rather than a "claims made and reported" form. Unfortunately this will prove the most difficult;
- If the only form available is a "claims made and reporting" form, look for one that automatically provides the insured 30 or 60 unrestricted additional days after expiration to report a claim first made prior to expiration. Make sure the definition of "claim" does not require "receipt by the insured;" and/or
- Use a form that does not use the inception date as the prior and pending litigation or continuity date when there is prior coverage in force. Or use one that excludes "known litigation…prior to inception" only.

Use of these simple rules will ensure better coverage for clients and fewer chances for errors and omissions claims for the agent. In addition, by asking for endorsements to clean up the language, fewer underwriters will be heard to say, "You're the only one asking."

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This ends the five-part series on "claims made" coverage forms. Hopefully this has increased awareness of the pitfalls and gaps potentially present in the use of these forms.

About the Author

Frederick J. Fisher, J.D. is the CEO of ***E.L.M. Insurance Brokers*** and is the Executive Vice-President of *Insurance Specialty Group's Professional Liability Practice.* They specialize in insuring Professional Liability risks. For the past 35 years, Fisher has been actively involved in underwriting and placing Professional Liability accounts or in the adjustment, investigation, and resolution of Professional

Liability Claims. He has spent his entire career working with “claims-made” insurance policies and their evolution.

Fisher has lectured extensively on professional liability loss control and authored over 60 articles in trade journals and periodicals. He is the author of ***BROKER BEWARE, Selling Real Estate within the Law***, a loss control program for realtors. He is the designer of a program to assist agents to conduct on site pre-underwriting risk management assessments of a client’s professional liability exposures on behalf of Insurance Producers, Real Estate professionals and Lawyers.

In 1989 Fisher became a founding member of the Professional Liability Underwriting Society (PLUS). He was elected to the **PLUS Board of Trustees** in 1993; and in 1994 he was elected **secretary-treasurer** and a member of the **executive committee** and re-elected to this position in 1995. In 1996, he was elected **vice-president** and moved into the presidency in 1997. In addition to these roles, Fisher was chairman of the finance and budget committee and the communication committee. He previously had been a member of the **PLUS education committee**, and was c***o-chair of the national membership committee***. He remains a member of the industry panel responsible for overseeing and contributing to the Registered Professional Liability Underwriter (RPLU) program guides. He has been the senior technical advisor for ***The Professional Liability Manual*** published by the International Risk Management Institute since 1989. He testifies regularly as an expert witness in cases dealing with the duties and obligations of professionals as well as on coverage and “claims-made” issues.

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Claim means: a) a written demand for monetary damages or non-monetary relief, b) a civil or criminal adjudicatory proceeding or arbitration, c) a formal administrative or regulatory adjudicatory proceeding, or d) a formal civil, criminal, administrative or regulatory investigation, against an **Insured Person**, including any appeal therefrom.
Claim means: 1. a written demand or request for monetary damages or non-monetary relief against any of the **Insureds**, or to toll or waive a statute of limitations; 2. a civil, criminal, administrative, investigative or regulatory proceeding initiated against any of the **Insureds**, including any proceeding before the Equal Employment Opportunity Commission or any similar federal, state or local governmental body, commenced by: a. the service of a complaint or similar pleading; b. the filing of a notice of charges, investigative order or similar document; or c. written notice or subpoena from an investigatory authority identifying such **Insured** as an entity or person against whom a formal proceeding may be commenced; 3. in the context of an audit conducted by the Office of Federal Contract Compliance Programs, a Notice of Violation or Order to Show Cause; or 4. an arbitration or mediation or other alternative dispute resolution proceeding if the **Insured Organization** is obligated to participate in such proceeding or if the **Insured Organization**

agrees to participate in such proceeding with Underwriters' prior written consent, such consent not to be unreasonably withheld."
"**Claim**" means a demand received by any **Insured** for money or services including the service of suit or institution of arbitration proceedings. "**Claim**" shall also mean a threat or initiation of a suit seeking injunctive relief…"
Claim means a demand received by **you** for money or services, including the service of suit or institution of arbitration proceedings involving **you** arising from any alleged **wrongful act**. **Claim** shall also include any request to toll the statute of limitations relating to a potential **claim** involving an alleged **wrongful act"**
"**Claim**" means a written demand for monetary damages arising out of or resulting from the performing or failure to perform "Professional Services."
"Claim" means a demand for money or services naming the **Insured** arising out of an act or omission in the performance of **professional services**. A **claim** also includes the service of suit or the institution of an arbitration proceeding against the **Insured**.
"Claim means: (1) a demand for money or services; or (2) a **suit**;"
"Claim" means a demand or assertion of a legal right made against any **Insured**, even if any of the allegations of the **Claim** are groundless, false or fraudulent. **Claim** also means a **Regulatory Action** or a suit seeking injunctive relief relating to the **Wrongful Acts** specified in **Section I.**, **INSURING AGREEMENT**.