DIRECTORS AND OFFICERS LIABILITY INSURANCE:
A GUIDE FOR DIRECTORS

PROFESSIONAL EDITION

BY
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10.01 INTRODUCTION

"D&O insurance," as directors and officers liability insurance is generally known, is a type of property and casualty coverage similar in many respects to professional liability (malpractice) insurance. D&O insurance is, however, a more complicated structure than malpractice coverage: the individuals it protects are, at least in the case of directors, not so much professionals as fiduciaries of varying backgrounds and abilities. Moreover, the D&O policy serves two purposes: it protects the corporation from some of the sizable losses it could incur because of its indemnification of its officers and directors against liability, and it protects the insured officers and directors directly for certain losses against which the corporation does not or cannot indemnify them. In addition, certain recent policies also will protect the corporation from particular types of claims -- usually securities claims that have been brought against the corporation itself. While it is now clear that D&O insurance often can protect directors and officers against the consequences of conduct for which a corporation cannot legally indemnify them, public policy may prevent an insurance company from paying losses arising out of especially egregious conduct of directors and officers.\footnote{See, e.g., Francis J. Mootz, Principles of Insurance Coverage: A Guide for the Employment Lawyer, 18 W. New Eng. L. REV. 5, 37-38 (1996); Michael Bradley & Cindy A. Schipani, The Relevance of the Duty of Care Standard in Corporate Governance, 75 IOWA L. REV. 1, 33 n.205 (1989); Thomas A. D'Ambrosio, Patricia A. Daniel, et al., Special Project: Director and Officer Liability (Part 2), 40 VAND. L. REV. 599, 777 n.16, 784 n. 51 (1987).}
10.02 A SHORT HISTORY OF D&O COVERAGE

First widely marketed in the late 1960s, when investor unease, public displeasure with corporate officials, and the activism of regulatory agencies such as the Securities and Exchange Commission and the Federal Trade Commission were on a periodic upswing, D&O insurance offered an attractive antidote for the boardroom blues.\(^1\) Because D&O insurance drew on a source of capital independent of the corporate treasury, it could pay the judgments against directors in stockholder derivative actions, which could not, as a matter of public policy, be indemnified against by the company. This very characteristic that made D&O insurance marketable also made it a target for more conservative commentators, who believed such coverage too broad to comport with public policy — an irony for those who lamented the reduction of coverage that occurred later during the 1980s.

To remove doubts about the validity of D&O insurance and the authority of the corporation to purchase it, the drafters of the amendments to the Model Business Corporations Act and the Delaware General Corporation Law\(^2\) in 1967 included in the indemnification Sections of those statutes a provision stating that corporations could purchase and maintain insurance on behalf of directors, officers, and employees for service in virtually any official capacity, regardless of whether the corporation would have authority to indemnify such persons as a matter of state law.\(^3\)

As is always the case with a risk-based system of benefits, D&O insurance flourished as a commercial proposition because the potential calamities which it was meant to prevent were just that — extraordinary events not all that likely to occur in most companies. Though the 1970s, with soaring energy costs, escalating inflation, rising interest rates and languishing profits, were generally a bad time for the insurance markets, the profound malaise created in the corporate boardroom by these conditions was not bad for sales of D&O insurance. As a consequence throughout the 1970s, D&O insurance was viewed in some quarters as a readily available, and not overly expensive, “feel better” item.\(^4\)

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\(^2\) For a general discussion of these amendments, see §4.09 of Olson & Hatch, Directors & Officers Liability: Indemnification and Insurance (Clark Boardman Callaghan, 155 Pfingsten Road, Deerfield, Ill. 60015. Toll-free: 1-800-221-9428) ("Olson & Hatch").


A Short History of D&O Coverage

The D&O insurance market changed abruptly in the mid-1980s. The Van Gorkom\(^5\) and Chase Manhattan\(^6\) cases, with their spectacular, multi-million dollar damage awards against company officials, together with an epidemic of bank failures and the attendant interest of federal regulators in the D&O policy as a source of recovery of institutional assets, awakened insurers to the magnitude of their exposure under then-current policies. The Wyatt Company surveys of D&O liability and fiduciary claims,\(^7\) which are the leading indicators of change in the D&O marketplace, show that from 1974 to 1984, the number of companies reporting liability claims against directors increased from 7 percent to 18 percent,\(^8\) and the probability that one of the top 1000 companies might experience a claim during the ten-year period from 1974 to 1984 was just over 40 percent, and was increasing at an average rate of 15 percent per year.\(^9\)

This sudden change in risk exposure, not surprisingly, resulted in an equally sudden change in D&O insurance availability and pricing. For a time, it became extremely difficult for some corporations, particularly financial institutions,\(^10\) to obtain directors and officers liability coverage in sufficient amount and for what was perceived by the insureds to be reasonable premiums.\(^11\) Ironically, just as in the 1960s, the pundits panned D&O insurance, but this time for completely opposite reasons: the insurance that once seemed to cover too much now covered too little.

Fortunately, the “hard-market” of the mid-80s lasted only a few years. By the 1990s the D&O market had begun to stabilize. Despite the increasing severity and frequency of D&O claims during the first six years of the 1990s, coverage was broadened and pricing for many

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\(^8\) See 1976 Wyatt Survey, supra N. 7, at 7; 1984 Wyatt Survey, supra N. 7, at 22; Romano, supra N.1, at 6-7.


\(^10\) See “Ailing D&O Insurance Market Looks for Cure,” 6 Bus. Law. Update 1 (March/April 1986); Romano, supra N.1, at 14-15. Other types of companies that were not favored by insurers during this period were “high tech” companies, utilities, and companies involved in real estate, petrochemicals, steel and, ironically, insurance. 6 Bus. Law. Update at 1.

\(^11\) In 1984, insurance brokers could reportedly choose from well over 30 carriers, and limits of up to $200 million were available; by mid-1986, the number of insurers had shrunk to a handful and $50 million was a realistic maximum for a large company, while premiums had risen from 200 to 1000 percent. See “Ailing D&O Insurance Market Looks for Cure,” supra N.10; see also Newport, “Protecting Directors Suddenly Gets Costly,” Fortune, Mar. 18, 1985, at 61; Loomis, “Naked Came the Insurance Buyer,” Fortune, June 10, 1985, at 67; Hilder, “Risky Business: Companies Are Finding It Difficult Now to Obtain Liability Insurance for Their Directors,” Wall St. J., July 10, 1985, at 1, col. 6. The Wyatt surveys have found that over 80 percent of firms renewing policies from mid-1985 through 1986 experienced premium increases, and over half of these increases were more than 200 percent, a rate which considerably underestimates the combined impact of higher deductibles and lower limits of liability. See Romano, supra N.1, at 10.
insured companies was reduced. Based on the results of its 1995 Watson Wyatt Directors and Officers Liability Survey, today’s D&O marketplace is characterized as “very competitive, [with] the quality of D&O coverage form having improved every year since 1990 after having seen a steady stream of new restrictions and exclusions between 1984 and 1990.”

Today, the D&O marketplace is very different than it was in the mid to late 1980s. Indeed, 1995 and the beginning of 1996 seemed to bring an unprecedented number of new policies to the marketplace. These policies include Entity Coverage for security claims, and D&O policies specifically designed for private companies, companies that plan to engage in initial public offerings (“IPOs”) and utilities. The 1990s also brought to the marketplace specialty D&O products designed for health care organizations and non-profit organizations.

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12 Of course, not all insureds experienced favorable changes in their policies during this time. For example, it can be assumed that some companies with adverse claims records, material deterioration in financial condition or other material adverse changes in their risk exposures have experienced a narrowing of coverage or higher premiums.


14 See Section 10.09 infra.

15 See Section 10.11 infra.
10.03 ADVANTAGES OF D&O INSURANCE

D&O insurance is widely regarded as a necessary and worthwhile protection for directors and officers and the companies for whom they work. According to the 1995 Wyatt Survey, approximately 86 percent of all companies buy D&O insurance; in the case of the largest companies -- those with assets of over ten billion dollars -- over 97 percent have D&O policies.1 There are several reasons for this:

First, D&O insurance is an independent, contractual source of indemnity, which, at the time a claim is made under a valid policy, is conditioned neither on the economic soundness of the corporation nor the willingness of corporate management to pay the losses of the indemnitee. If the corporation goes through economic troubles or, worse, becomes insolvent, the money for indemnification simply may not be there, regardless of what the bylaws say or the board resolves. In an insolvency, even mandatory indemnification bylaws or indemnity agreements, unless independently funded, merely may entitle the indemnified person to take a place in line with other unsecured creditors.2

Even solvent companies may not be able to indemnify directors and officers under certain circumstances. For example:

1. An Adverse Indemnification Determination: Directors and officers who are determined not to have acted in good faith or in what they reasonably believe to be in the best interests of the company may not, as a matter of state law, be indemnified in most, if not all, jurisdictions.3

2. An Adverse Judgment or Settlement in a Derivative Action: To the extent that directors or officers are found liable to corporations in actions brought by or "in the right of" corporations (so-called "derivative actions"), they may not, as a general matter, be indemnified in any respect, not even for the costs and

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1 1995 Wyatt Survey at 10.
2 At the very least, the filing of a bankruptcy petition places the issue of whether directors and officers may be paid indemnification for defense costs within the discretion of the bankruptcy court, which has the option either to give such payments first priority as "administrative expenses" pursuant to Sections 503 and 507 of the Bankruptcy Code or relegate them to the list of claims of unsecured creditors. See 11 U.S.C.A. §503(b)(1)(A) (1994), 11 U.S.C.A. §503(b)(3)(D) (1994), and 11 U.S.C.A. §507 (1994). There is some authority for treating indemnification of present directors as an administrative expense, provided their continuing services can be shown to be beneficial to the estate pursuant to Code §503(b)(1)(A). See In re Baldwin-United, 43 Bankr. 443, 445, 454 (S.D. Ohio 1984); In re Schatz Federal Bearings Co., 17 Bankr. 780 (S.D.N.Y. 1982). By the same reasoning, however, indemnification on a current basis was denied to former directors and officers of an insolvent corporation because their contracts with the corporation had expired by the time the petition was filed. See In re Baldwin-United, 43 Bankr. at 455.
3 See, e.g., Del. Gen. Corp. Law §145(a). Indemnification laws of various jurisdictions are discussed in detail in Chapter 5 of the Olson & Hatch treatise.
expenses of their defense. In some jurisdictions, it is likely that this prohibition extends also to amounts paid by directors and officers to settle derivative litigation.

3. State or Federal Public Policy Prohibitions: Indemnification of directors and officers may be prohibited by statute or common law in areas of corporate conduct that are heavily regulated because of a substantial public interest, such as the protection of investors or depositors or the conduct of international business.

We will discuss each of these exceptions in turn.

The first exception described above -- an adverse determination with respect to the standard of conduct for indemnification -- may be illustrated in the context of a hostile takeover. Directors who resist such a takeover may well be sued by the would be owners, or perhaps by the company's own shareholders. If the defenses fail and the aggressor is successful in its bid, the outgoing directors could find that the determinations that the indemnification statutes require before indemnification can be awarded and legal expenses reimbursed will be made by new management -- perhaps the representatives of the very plaintiffs who sued them. In such a scenario, it would not be surprising for new management to refuse to indemnify old management, on the basis of a determination that the former directors were not acting in good faith when they sought to defeat the takeover bid.

Another scenario which might cause difficulties for boards of directors looking for an indemnification decision is a claim that is embarrassing to the corporation and its management. In such a case, the board might act to keep the corporate image clean by distancing itself and the company from the alleged putative offender. For example, if a director or officer were publicly

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4 See, e.g., Del. Gen. Corp. Law §145(b). Derivative actions are discussed in Chapter 2 of the Olson & Hatch treatise.

5 See Olson & Hatch at §5.03(4)b)[ii].

6 See, e.g., Globus v. Law Research Service, Inc., 287 F Supp 188, 199 (SDNYSD NY 1968), affd in part, revd in part 418 F2d 1276 (CA2 1969), cert den 397 US 913 (1970); Odette v. Shearson, Hammill & Co., Inc., 394 F Supp 946, 954-55 (SDNYSD NY 1975); Herzfeld v. Laventhol, Kreckstein, Horwath & Horwath, 378 F Supp 112, 135 (SDNYSD NY 1974), affd in part, revd in part on other grounds 540 F2d 27 (CA2 1976). See also Stewart v. American International Oil & Gas Co., 845 F2d 196, 200 (CA9 1988) (indemnification unavailable for violations of the securities laws); Stowell v. Ted S. Finkel Inv. Services Inc., 671 F2d 323, 325 (CA5 1981) (indemnification tends to frustrate the policy of securities legislation), citing Heizer Corp. v. Rosa, 601 F2d 330, 334-335 (CA7 1979) (securities wrongdoing should not be permitted to escape loss by shifting entire responsibility to another party). See also the Foreign Corrupt Practices Act of 1977, 15 USC §78dd-2(8). See also Crime Control Act of 1990 §2523(a), 12 USC §1828(k), prohibiting not only the reimbursement, but any agreement or arrangement to reimburse, any institution affiliated party for any civil money penalty or judgment resulting from any administrative or civil action instituted by any federal banking agency, or any other liability or legal expense with regard to any administrative proceeding or civil action instituted by such agency which results in a final order or settlement assessing a civil money penalty, removing the person from office or prohibiting his or her participation in the conduct of the affairs of the institution, imposing a cease and desist order on such person, or ordering some affirmative act, such as restitution or disgorgement.
accused of sexual harassment, a board might be tempted to determine that no expenses should be advanced to the accused, perhaps on the grounds that such a suit is not brought "by reason of the fact" that the accused was a director or officer, or because the individual could not reasonably have believed that such private conduct was in the best interests of the corporation. Even when circumstances are not so extreme, the right D&O insurance policy may provide some assurance that the presence of such factions or disagreements in the board room will not impair or delay the protection to which the directors or officers are entitled.

With respect to the second prohibition -- actions brought by the corporation or "derivative actions" brought on its behalf -- the prohibition on indemnification arises from the fact that the proceeds of any settlement or judgment go to the corporate treasury. Because the party on whose behalf the suit is brought is the corporation itself, state legislatures have reasoned that indemnification by the corporation would render the judgment meaningless; the proceeds of the judgment would be taken into the treasury with one hand and paid out again to the director or officer as reimbursement with the other.

The third potential problem with indemnification arises out of the fact that the availability of indemnification is not uniform from state to state or from corporation to corporation. Indemnification can nearly always be limited by how each state and each corporation sees its policy interests. For example, some state corporate laws require corporations to indemnify only where the individual has been found to be "wholly successful" in his or her defense, while others may require indemnification to the extent that a director is simply "successful on the merits or otherwise." Bylaws may provide exceptions to the obligation of a corporation to indemnify or, at one extreme, provide that indemnification is at the option of the Company, except where required by statute. Even where statutes or charter documents provide for the broadest forms of indemnification, they do not provide an alternative source of funds for payment. Finally, there are public policy limitations to the ability of a corporation to indemnify its directors and officers.

Even when indemnification is mandatory under state law or corporate bylaws, D&O policies provide an important source of reimbursement for the corporation itself, which would otherwise lose from the corporate treasury any amounts paid in indemnity. For the troubled corporation, possession of adequate directors and officers liability insurance could reduce the

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9 See, e.g., Del. Gen. Corp. L. §145(c).

9a The public policy limitations to corporate indemnification is discussed in chapter 6 of Olson & Hatch.
need to allocate scarce resources to an indemnification fund. For the financially healthy company, insurance frees up corporate resources which can be then used to accomplish other important corporate goals. For this reason, it is not surprising that the Wyatt Survey indicates that more than 86% of all corporations, regardless of financial condition, purchase D&O insurance; in fact, over 97% of corporations with assets greater than $10 billion that participated in the Survey had D&O policies.10

In the mid-1990s, some D&O insurance policy forms have been broadened to provide direct coverage to the corporation in the event that certain types of claims are made against the corporation itself. As further discussed in Section 10.09, it is now possible to purchase “entity” coverage under a policy form insuring against losses from securities claims made directly against the corporation.11

In addition to the basic D&O contract, various insurance companies have designed endorsements or policies with certain industries or types of companies in mind such as utilities or companies going through an initial public offering as well as non-profit companies, financial institutions, privately held companies and companies in the health care industry.12

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10 1995 Wyatt Survey at 10.
11 American International Companies, Directors, Officers and Corporate Liability Insurance Policy Form No. 62335 (5/95) (hereinafter cited as “National Union 1995 Policy Form”)
12 See Section 10.11 infra.
10.04 **Contractual Nature of Insurance**

The benefits of an insurance policy stem from the fact that an independent party has contracted to bear a portion of the insured’s risk. However, this principal advantage of the D&O policy—its independent, contractual nature—has a double edge. Absent bad faith on the part of the insurer or ambiguity in the wording of the contract, the amount of coverage provided in any policy is limited to what has been bargained for, as expressly provided, and the law in effect at the time the bargain was struck between the parties may override subsequent law more beneficial to the insureds.\(^1\) Any of the advantages described in the preceding Section may be restricted or eliminated by exclusion or endorsement, as discussed below. Thus, a great danger for companies which purchase D&O insurance is that they may fail to explore adequately the true scope of the policy before it is purchased, or to communicate that scope to the covered directors and officers. The fact that purchase of a D&O policy in itself may provide a level of psychological comfort for policy beneficiaries makes it important for the company and its counsel: (1) to emphasize and explain to management the areas in which the terms of the policy may not measure up to their assumptions, and (2) to recommend that the policy be backed up with meaningful indemnification.

Moreover, all parties should remain aware that the relationship with the insurer is essentially a business relationship, based upon the insurer’s estimation of the risks involved, the adverse precedents that might be set with respect to other claimants by any deviation from the terms of the policies, and perhaps even the future business that may come to the insurer from the company. For these reasons, among others, it is essential to investigate the insurer before taking out a D&O policy. When evaluating a D&O insurer a number of factors should be taken into consideration, such as:\(^2\)

- Financial strength as evidenced by Moody’s, Standard & Poor and Best’s ratings
- Consistent capacity (meaning maximum limits that can be offered) over several years and high capacity (compared to peers) offered today\(^3\)
- Experienced underwriting and claims staff\(^4\)

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3. This information can be obtained by contacting The Watson Wyatt Company of Chicago, Illinois.
4. Id. A professional insurance broker who specializes in D&O insurance policies can be helpful in answering these and other questions.
Contractual Nature of Insurance

- Flexible and innovative underwriting to respond to the insureds' needs as they change
- Active in loss control
- Fair and expert claims handling including low “bad faith” ratio in D&O claims as compared with its peers
- Quality service and responsiveness
- Global jurisdiction.

Understanding the insurance company’s corporate culture, experience in claims and approach toward the underwriting and claims function becomes critical given the dangers in relying upon judicial interpretation of insurance contracts. Judicial interpretation of insurance contracts has proved to be an inconsistent exercise, not only because each state’s laws and regulations are somewhat different, but because the adjudication of coverage disputes is, by its nature, an interpretive exercise in which courts attempt to balance opposing principles of equity and contract construction. On one hand, the basic principle of freedom of contract dictates that parties should be able to bargain to their own detriment without judicial interference. On the other hand, historically, insurance contracts have been the subject of special consideration by the courts, because of the degree of reliance placed by insured individuals in the coverage provided by insurance and the crucial social welfare role played by insurance. The rule is now well established that ambiguous provisions of insurance contracts should be construed against the insurer. According to this view, in the event of any ambiguity, insurance contracts should be construed to give effect to the “reasonable expectations” of the insured. Nevertheless, it would be the unwise attorney who would counsel his client to rely upon ambiguities in the insurance contract to form the foundation of the protection.

5 Id. One question to ask an insurer is, “What standards do you use to compensate your claims employees?” An answer is based upon how much -- or little -- the claims employee pays out on a claim (sometimes called within the industry “saving on the claim reserve”) might indicate, among other factors, how the claims department is motivated.

6 Because insurance contracts are “contracts of adhesion” -- set forms over which the insured is considered to have little or no bargaining power -- an established legal principle is that ambiguities in such contracts should be construed against the insurer, and exclusions should be narrowly read. See, e.g., Insurance Co. of North America v. Howard, 679 F2d 147, 150 (CA9 1982); Sears Roebuck & Co. v. Reliance Ins. Co., 654 F2d 494, 499 (CA7 1981). The courts of many jurisdictions have further refined this rule to state that, in the event of any ambiguity or dispute, insurance contracts should be construed to give effect to the “reasonable expectations” of the insured. See, e.g., Safeway Stores v. National Union Fire Ins. Co. 64 F3d 1282, 1289 (CA9 1995); Am Cas. Co. v Baker, 22 F3d 880, 889 (CA9 1994); Morgan v. Hanover Ins. Co, 929 F Supp 764 (NJ 1996); Bartley v. National Union Fire Ins. Co., 824 F. Supp. 624, 636 (ND Tex 1992); Nodaway Valley Bank v. Continental Casualty Co., 715 F. Supp. 1458 (WD Mo 1989), aff’d 916 F2d 1362 (8th Cir. 1990); Hubred v. Control Data Corp., 442 NW2d 308, 311 (Minn 1989).
10.05 **STRUCTURE OF THE TYPICAL POLICY**

The D&O policy is an elaborate system of parts, each with a separate function.\(^1\) However, the traditional policy is typically built around two central promises, reflecting the dual purposes of this type of insurance.\(^{1a}\) In older policy forms, the separate promises were treated as separate policies.\(^2\) Most modern policies, however, treat the two promises as two insuring clauses in one policy form.\(^3\) One promise, typically called coverage A or the "individual side" coverage, promises to pay or reimburse officers and directors for losses they have suffered as a result of wrongful acts for which they are not indemnified by the company.\(^4\) The second promise, frequently called Coverage B or "Company Reimbursement" coverage, promises to reimburse the corporation for amounts that it has had to pay as indemnification of officers and directors for losses they have suffered as a result of wrongful acts within the meaning of the policy.\(^5\)

The front page of a typical D&O policy is a "declarations page," which functions as something of a specification sheet for the policy. The declarations usually state:

1. **The policy period**: since the mid-eighties the policy term is most often a year, but in older policies, and in some very recent policies, two or three-year terms are provided;
2. **The name of the parent or "Named Corporation"**: The typical policy will cover the directors and officers of the Named Corporation and its subsidiaries, as defined;\(^6\)

\(^1\) To illustrate the diversity of policy language in the changes in D&O policies over the past decade, the authors have chosen and reprinted as appendices examples of various policy forms, both older and more recent. Forms have been selected for purpose of illustration only and do not indicate any preference of the authors or publisher for any form of policy or any carrier.

\(^1a\) Recent D&O policies also contain a third promise--direct coverage for securities claims made against the corporation. These policies, called Entity Policies, are further discussed in section 10.09 of this work.

\(^2\) See, e.g., National Union Fire Ins. Co. of Pittsburgh, Pa. Directors and Officers Liability Policy Form 8749/8750 (6/85) ("National Union 1985 Policy Form.").


\(^4\) See, e.g., Chubb 1992 Policy Form Insuring Clause 1.

\(^5\) See id., Insuring Clause 2.

\(^6\) Policies generally define "Subsidiary" as a corporation in which the Named Corporation owns more than 50% of the outstanding voting stock either directly or indirectly through other Subsidiaries of the Named Corporation. See, e.g., National Union 1995 Policy Form[\(\,\) 2(1)]. Such provisions generally cover only wrongful acts occurring after the date of acquisition and before any date of sale. Older policy forms, such as the 1985 National Union Form, were not always clear as to whether coverage was afforded for directors and officers of companies that were Subsidiaries prior to the inception date of the policy, but were not Subsidiaries as of that date. However, modern policy forms are generally clear that corporations who were "Subsidiaries" on or before the inception date of the policy will be considered covered under the policy.

[Footnote continues on next page]
3. The limit of liability of the insurer: that is, the maximum combined amount which the insurer is liable to pay in respect to all claims, in the aggregate, made during the policy period or any extended reported period as discussed below;

4. The "retentions" or deductible amounts: the amounts by which the company and the individual insured are agreeing to "self insure" each of their losses;

5. Coinsurance: the amounts, expressed as a percentage, of every loss by which the company and the individual insured are agreeing to "self insure".\footnote{This co-insurance percentage can be expressed either as a fixed amount in the basic policy form or left blank to be filled in on the declarations page. Traditionally, insureds were compelled to pay five percent of every loss in addition to the applicable retention amount. 1995 Wyatt Survey at 21. In the early 1990s it became common for insurers to waive the coinsurance percentage as respects individual nonindemnifiable claims. See, e.g., National Union 1988 Policy Form \S\ 6 & 7. More recently some insurers have eliminated coinsurance in its entirety. See, e.g., National Union 1995 Policy Form.}

6. The premium and any surcharges or installment terms.

For purposes of analysis, it may be helpful to think of the body of the policy as divided into several principal parts, whether or not the policy writer has set these off from one another in the text. The insuring clauses, as discussed above, form the initial principal part of the policy. These are the promises that form the heart of the bargain between the insureds and the carrier. Second, there are the defining terms, which must be reviewed with particular attention, as they materially affect the extent of coverage offered by the policy. Third, an exclusion Section describes broadly those areas of liability to which the bargain does not extend. Next, general terms and conditions of the policy establish important procedures, presumptions and conditions to coverage, including: provisions relating to notice of claims to the insurer, the insured's and insurer's rights with respect to the defense of a claim and subrogation of losses, circumstances in which the policy may be canceled, the right of the insured to elect an extended reporting period or discovery period and sometimes an agreed alternate dispute resolution. A particularly important provision in this section of the policy is one that describes the circumstances in which the insurer would advance costs to the insured. Finally, there are the endorsements - a series of side agreements between insureds and the carrier reflecting points of negotiation and adjustments to the premium; this 'customized' section of the policy has enormous practical impact, as it can either diminish or enhance the value of the policy to the company and insured officials.
10.06 **ANALYSIS OF D&O POLICY PROVISIONS**

Because of the complexity of the policies, and the huge impact on coverage of the exceptions and conditions imposed therein, the best way to understand what D&O insurance offers may be to go through the policy as an insurer would when faced with a claim. The following analysis sets forth some of the requirements or hurdles that typically confront a claimant when submitting a claim on a D&O policy.

There are three preliminary tests that must be satisfied before a claim can be considered for coverage under the policy. These tests arise, logically enough, under the policy's insuring clause. If these preliminary tests are satisfied, then a review of the policy's exclusions and other conditions must be made in order to make a final determination of coverage.

To satisfy these preliminary tests the following must be true: (1) A “claim” must have been made against the insureds during the policy period; (2) the claim must be for a “wrongful act” committed by the insureds; and (3) the insureds must have experienced a “loss.” We will examine each of these terms in turn.

1. **A “Claim” Must Have Been Made During The Policy Period.**

D&O policies, like professional malpractice and other similar liability policies, are “claims-made” policies: that is, they provide coverage only for “claims” that have been made first against an insured during the policy period.¹

Some policy holders may confuse the “claim” on which a claims-made policy is predicated with the “claim” that must be made by an insured when it gives the insurer notice of an insured loss. The “claim” referred to in the term “claims-made” does not refer to the notice by the insured to the insurer, but to a demand by a third party against the insured seeking to hold the insured responsible for the consequences of some alleged wrongful act.

Our first inquiry, therefore, focuses on what constitutes a “claim.” Surprisingly, in the past it was not uncommon for a D&O insurance policy not to contain a definition of claim.² However, without a defining term in the contract, the meaning of the term “claim” became subject to conflicting judicial interpretations.

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¹ See, e.g., Chubb 1992 Form at ¶¶ 1 & 2.

² See, e.g., National Union 1988 Form, Declarations.
For example, in *MGIC Indemnity Corp. v. Home State Savings Ass'n*, the United States Court of Appeals for the Sixth Circuit determined that the term "claim" describes only a demand for some monetary payment. The court wrote that "a claim that a wrongful act has occurred is not the same thing as a claim for payment on account of a wrongful act. In context, it seemed to us, the only kind of 'claim or claims' that could trigger the insured's obligation to pay would be a demand for payment of some amount of money."4

However, other courts have reached different conclusions. In one case, a court found that letters from the Federal Home Loan Bank Board ("FHLBB") to a savings bank constituted a "claim" for the purposes of a bank's directors' and officers' insurance policy, even when such letters did not make any demand for payment of money but instead imposed severe operating restrictions, warned that failure to comply with the FHLBB directive could result in formal enforcement proceedings, expressed dismay at the board of directors' failure to appreciate the seriousness of the agency's concerns, and asked directors to address such problems in light of their fiduciary duties.5

In a similar vein courts have wrestled with when a criminal proceeding could be a claim under the policy. In *Home State Savings*, the court held that a pre-indictment target letter to five officers did not constitute a claim under the policy.6 Possibly a more liberal construction of "claim" was handed down by the U.S. Court of Appeals for the Eighth Circuit in the case of *Polychron v. Crum & Foster Insurance Co.*7 That court found that, in the context of a grand jury investigation, where a bank's records were subpoenaed and the president of the bank was shown to have been a target of the grand jury investigation, although no target letter had yet been sent, the questioning of the bank president by the assistant U.S. Attorney involved allegations of wrongdoing sufficient to constitute "claims" and was not, as the insurer in that case sought to characterize it, a mere "request for information."8

Because of the potential ambiguity and expense associated with judicial interpretations of undefined terms, such as the term "claim," policy holders increasingly have demanded that important terms be defined in the policy. Accordingly, most modern day D&O policies contain a definition of the term "claim."

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4 Id.
6 *MGIC Indem. Corp.*, 797 F2d at. at 287-88.
8 Id. at 463. For a similar line of reasoning in the context of mandatory indemnification by a corporation, see *Stewart v. Continental Cooper & Steel Indus., Inc.* 67 AD 2d 293, 414 NYS2d 910 (1st Dept.1979) (construing Delaware law).
Under some policies, especially those written in prior years for higher risk coverage, the term “claim” is fairly restrictive. Given prior case law, a definition of claim for most risks in the current market should contain four types of coverage:

1. Civil proceedings, such as lawsuits;
2. Criminal proceedings (post indictment);
3. Administrative proceedings (post notice of charges);
4. Monetary or nonmonetary damages or relief for all of the above.

Typical of a definition of “claim” that fulfills all these requirements would be the following:

1. a written demand for monetary or nonmonetary relief; or
2. a civil, criminal, or administrative proceeding for monetary or nonmonetary relief that is commenced by:
   (a) service of a complaint or similar pleading; or
   (b) return of an indictment (in the case of a criminal proceeding); or
   (c) receipt or filing of a notice of charges.

"Claims-made" policies cover only claims that are first made during the policy period. Given the fact that D&O claims are relatively infrequent but are of high severity, the submission of a claim is generally a significant event in the relationship between the insurer and the policy holder. Accordingly, it is in the best interests of both the insured and the insurer to know at the end of a policy period if the expiring policy is subject to a claim. If a claim has been

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9 One such definition, for example, read: "[A]ny adjudicatory proceeding in a court of law or equity brought against any of the Insured Persons which seeks actual monetary damages or other relief and which may result in a Loss under this Policy, including any appeal from such adjudicatory proceeding." See Aetna Casualty and Surety Company, Designated Insured Persons and Company Reimbursement Policy Form, ¶11.(C) found in Appendices. Under such a definition, for example, written demands prior to actual litigation, even though they demanded money and alleged wrongful conduct, would not be covered, nor necessarily would be expenses of defending against administrative proceedings.

10 Unlike corporate indemnification, D&O insurance does not cover "threatened" claims in the absence of a stated intention by the adverse party to hold the insured liable for a violation of law. Therefore, investigations by administrative agencies or self-regulatory organizations prior to the filing of any charges or the announcement of any intention to take action against the insured generally are not included as "claims" under D&O policies. Though it may seem obvious at a certain point to directors and officers that the investigating attorneys are proceeding on a theory that is premised on their participation in a violation of law, there is generally no confirmation of this fact from the investigators and, if the investigation is inconclusive, no record that the individual ever was subject to a potential claim.

11 See, e.g., National Union 1995 Form ¶ 2(a); Chubb 1992 Form ¶ 18 (not covering written demands for non-monetary damages); While, in all probability, arbitration proceedings would fall within the phrase "written demand," an insurer might be asked to clarify this. See, e.g., National Union Securities Plus endorsement; (adding arbitration to definition of Claim).

12 See, e.g., Chubb 1992 Form.

13 Approximately one out of every four companies will experience a D&O loss over a nine year period; yet, if experienced, the average loss is over $5M. 1995 WyattSurvey at 4.
made, both parties will come to the renewal negotiations with knowledge that some legal liability probably will be assumed by the insurer. On the other hand, in the more common situation where no claim has been made during the expiring policy period, both parties will come to the renewal negotiation process with the knowledge that the account has not yet caused any additional liability to the insurance company. The relative certainty of such a process allows both parties to negotiate policy terms and conditions based upon an accurate status of the account as of the inception date of the new policy.

Closely related to the “claims-made” concept is the establishment of a retroactive date. A “retroactive date” or “prior acts date” is a starting point for coverage under the policy -- the first date in which covered wrongful acts may occur. For both the insureds and the insurer, the placement of the retroactive date can be of great significance to the amount of risk covered under the policy. For example, a retroactive date that is concurrent with the inception date of the D&O policy would limit coverage severely. In such a case, in order for a claim to be covered, both the wrongful acts that are alleged as well as the claim arising out of those wrongful acts must occur during the policy period. This concept is so central to many D&O policies that some policies actually have a reference to the retroactive date in the insuring clauses. On the other hand, sometimes policies can be negotiated with no retroactive date. In this case, wrongful acts occurring at any time in the past or during the policy period would be covered subject to the other terms and conditions of the policy.

2. The Claim Must Be Made Against an Insured

The definition of "insured" holds an important part in coverage determination. Until recently, the term insured meant those directors and officers whose acts were protected.14 As discussed in Section 10.09, recent policies have greatly expanded the definition to include the company for designated claims, usually securities claims.

In the past directors and officers had to be listed individually for them to be insured and persons who became directors and officers during the policy period had to be submitted to the insurance company for approval.15 However, almost all modern policies provide blanket coverage for all directors and officers without scheduling and automatically include all directors

14 While most policies use the term "Insureds" to mean those entities or individuals whose wrongful acts are covered under the policy, at least one insurer uses a different term, "Insured Persons," to designate such coverage, using the term "Insured" to include the company-presumably because of the company reimbursement insuring clause. Policy holders with this type of policy should not become confused into thinking that the company's acts are covered under the policy because the company is included in the definition of "Insured." See, e.g., Chubb 1992 Form ¶ 18.

and officers elected or appointed after the inception date.\textsuperscript{16} Note, however, that most applications require a scheduling of directors and officers and care should be taken to complete such applications accurately for reasons described in more detail in Section 10.08[3][d]. As a general matter, the term "director" is meant to describe those individuals who are elected by the shareholders of the corporation; care should be taken to notify the insurer of directors who are appointed to fill vacancies on the board in the case of policies that do not grant automatic newly elected or appointed coverage. Similarly, the term “officer” is meant to describe corporate officers appointed by the board of directors.\textsuperscript{17} It should not ever be assumed without checking the terms of the policy that individuals hired by management and given generic titles such as "vice president" are automatically covered. Most insurers have the ability to add by endorsement divisional officers or other types of managers or supervisors as insureds to the policy upon request of the parent corporation. In addition, policies may contain endorsements automatically adding all employees as insureds in the cases of employment practices coverage or securities claims coverage.\textsuperscript{18}

For companies operating outside of the United States, it is critical that the definition of director and officer also include a description of positions with the foreign company that are equivalent to the position of director or officer in a United States corporation. Extensions of coverage to foreign corporate officials is commonly available by endorsement. Some policies may incorporate such an extension into their basic form.\textsuperscript{19}

### 3. The Claim Must Be for A Wrongful Act

Assuming that one has a claim and that it is against an insured and is made during the policy period, the next question is whether the claim alleges a “wrongful act.” The wording of such definition will vary somewhat from policy to policy. A typical definition reads as follows: “Wrongful Act” means any breach of duty, neglect, error, misstatement, misleading statement, omission or act by the directors and officers of the company in their respective capacities as such, or any matter claimed against them solely by reason of their status as directors and officers of the company.\textsuperscript{20}

\textsuperscript{16} See, e.g., National Union 1988 and 1995 Forms.
\textsuperscript{17} For an extensive discussion of the legal meaning of the terms "director" and "officer," the reader can refer to Olson & Hatch at §1.08.
\textsuperscript{18} See, e.g., National Union 1995 policy with Securities Plus endorsement; American International Companies Directors and Officers Liability and Private Company Reimbursement Insurance Policy Form 63274 (12/95) (hereinafter cited as "National Union Private Company Form"), with Employment Plus endorsements.
\textsuperscript{19} National Union 1995 Form ¶ 2(e)(1).
\textsuperscript{20} National Union 1988 Policy Form ¶ 2(g).
There are a number of issues that can arise out of the definition of "Wrongful Act."

First, caution should be exercised to insure that the definition does not include any restrictive adjective. For example, while not typical, some definitions of "Wrongful Act" only cover "negligent" breaches of fiduciary duty. In such cases, insurers have been able severely to restrict coverage for any allegation of conduct beyond mere negligence.21

Second, note that the definition reproduced above includes so called "status" claims. These are claims that do not allege specific misconduct by a director and officer but rather make claims against them solely by reason of their positions as a director or officer. A definition of "Wrongful Act" that includes status claims is helpful.

Definitions of "Wrongful Act" generally require, as a predicate for coverage, that the directors or officers be acting in "their respective capacities as such." A number of issues arise out of this "capacity requirement." The most common example of a claim that could run afoul of this requirement is a claim made against a director or officer because of his service at the request of the insured corporation on the board of another corporation that is not a subsidiary. While the director in question might view his service on the other corporation's board as a mere extension of his capacity as a director or officer of the insured corporation, no insurer is likely to agree with him. Claims arising out of such "outside directorships" are excluded from the policy unless such coverage is specifically addressed and provided. This restriction in coverage may take the form of an "outside directorship" exclusion or may be inferred from or made explicit in the definition of Wrongful Act. However, outside directorship coverage is commonly available by endorsement to the policy form. Endorsements providing blanket coverage with respect to service to not-for-profit organizations are not uncommon. Many current D&O policies automatically incorporate some not-for-profit outside directorship coverage, typically for entities falling under Internal Revenue Code §501(c)(3).22 This coverage may be incorporated directly into the definition of "wrongful act." Outside directorship endorsements providing coverage for service of directors and officers to non-subsidary for-profit corporations are usually available as well, but must be expressly bargained for on a scheduled basis and may entail more restrictive

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21 Golf Course Superintendents Association v. Underwriters at Lloyds, 761 F.Supp. 1485, 1489 (D. Kans. 1991) (where a wrongful act in a D&O policy is defined as "any negligent act, error or omission, misstatement or misleading statement, etc." intentional conduct consisting of retaliation against an employee for filing a lawsuit against the insured is not covered under the policy). For an example of a clause of this kind, see Aetna Designated Persons Policy Form ¶ II(N).

22 See, e.g., Chubb 1992 Form ¶ 14-02-0951, Outside Directorship Liability Coverage Section ¶¶ 1, 2 & 19 (Definitions "Non-Profit Outside Entity" and "Outside Entity". National Union 1995 Form ¶ 2(j).
terms and greater underwriting requirements. Such "outside entity" endorsements, whether for nonprofit or for-profit service, may require payment of an additional premium.

An interesting question arises with respect to the "capacity requirement" when the director or officer is also rendering professional services to the corporation. Carriers take markedly different views as to whether an officer-attorney rendering professional legal services to the corporation was acting in a covered capacity if he or she is sued as a result of those professional legal services. Other allegations that may fall outside the insured capacity are those which involve conduct by directors and officers that concern acts which are self-interested, such as ventures involving corporate officials, but not corporations, or other acts that are not within directors' and officers' official sphere of responsibility. The position of virtually every insurer will be that at least some, and possible all, of such acts would not be covered by the policy even if such coverage were not already barred by public policy or standard policy exclusions, which is generally the case. Outside directors, who provide legal, consulting or other services to the corporation not directly related to their service as directors, also may find that those activities are not covered.

Finally, of course, the wrongful act must be that of the director or officer and not the corporation. Historically, in policies designed for for-profit corporations, as discussed earlier, only individual directors and officers are insured. While the corporation is a beneficiary of the policy to the extent that it receives reimbursement for indemnification payments made to individual officers and directors, the corporation is not an "insured." Separating wrongful acts of the insured's directors and officers from those of the uninsured corporation can be difficult. This important issue, frequently referred to as the "allocation issue," is discussed in Section 10.07(4).

4. The Insured Must Incur Loss

D&O policies require that, in order to qualify for coverage, the insured must have had "losses." A "loss" with respect to an individual insured is generally defined as any amount for which the insured is legally liable and that arises out of a claim made against him for wrongful acts. With respect to the corporate reimbursement side of the policy, a "loss" may encompass any amount for which the corporation indemnifies its directors and officers for covered wrongful acts by such directors and officers. Further, in the event that the policy provides Entity

23 See Olson & Hatch at 1.08[2][d].

24 Of course, one reason why an insurer might be reluctant to grant coverage for such officer-attorneys in its D&O form is the availability of a separate policy for such capacity, typically called an Employed Lawyers liability policy, which might be available from that same insurer. That policy form would cover not only officers-attorneys, but all employee attorneys within the insured corporation.
Coverage, the corporation may also recover for losses it incurs arising out of securities claims made against the corporation itself.

A typical definition of loss includes all "damages, judgments, settlements and defense costs" incurred by a director or officer in the defense and investigation of a claim. "Losses" covered by the policy thus do not include losses incurred by the corporation unless Entity Coverage is bargained for separately. For example, in the Home State case discussed previously, the court found that even if a claim had been found to exist, there could be no "loss" in that none of the individual officers had received any of the fraudulently claimed commitment fees, and thus the officers could not legally be obligated to return them (thus, there was no loss on the part of the individuals), nor had the company ever been called upon to indemnify the officers (thus, there was no corporate indemnification loss).

It also goes without saying that the directors or officers must have suffered real legal liability for there to be loss on the policy. In the past, some defendants have attempted to settle a claim without the consent of the insurer, with the proviso that the plaintiff could not look to them for payment, but must proceed directly against the D&O insurance policy. Carriers have resisted such attempts to create what they perceive to be an inchoate or artificial loss and courts have upheld the insurers' position.

It is usual for a D&O policy's definition of "loss" to be limited by specific exceptions. One typical exception mentioned above prevents payments made pursuant to settlements without legal recourse to the insured. Other typical exceptions include: punitive and exemplary damages, fines and penalties, taxes, or "matters uninsurable under the law pursuant to which the policy is construed." The historical logic behind these limitations is that fines, penalties and

[Footnote continued from previous page]

26 In this area, as in all areas involving directors and officers policy forms, counsel should inquire as to the specific position taken by his client's D&O insurer.

27 See Entity Coverage for Securities Claims, Section 10.09, infra.

28 For a discussion of who may be a "director" or "officer," see generally Olson & Hatch at 1.08.

29 See, e.g., Chubb 1992 Form ¶ 18.


31 Thus, the court reasons, while there was certainly a loss experienced by the corporation on account of the behavior of the individual insured, the loss was not a loss covered under the D&O policy. Id. at 287-88.

32 In PLM, Inc. v. National Union Fire Ins. Co., DC No. CV-85-7126-WWS, slip op., at 4 (May 31, 1988), reported in Corp. Officers & Directors Liability Lit. Reporter 4519, 4520 (June 22, 1988), the United States Court of Appeals for the Ninth Circuit found that an unapproved settlement in which the defendant directors and officers guaranteed, but never actually had to pay, a settlement amount owed by corporate defendants was simply a "contingent liability," not a legal obligation, and therefore was not a loss covered by the policy.

33 See, e.g., National Union 1988 Policy, definition of Loss.

34 Chubb 1992 Policy Form ¶ 18, Definitions, "Loss", clause (iv).
punitive damages really are designed to be punishment to wrongdoers, not compensation to wronged plaintiffs, and that they are, or should be, uninsurable as a matter of public policy.\textsuperscript{35} It should be noted that the actual public policy of states with respect to punitive damages varies considerably.\textsuperscript{36} Fortunately, as a practical matter, most D&O claims are settled or dropped by the claimants rather than tried,\textsuperscript{37} reducing the impact of the exclusion.

Another issue affecting the scope of covered "losses" is the treatment of interrelated or causally connected wrongful acts. D&O policies typically provide that all claims arising out of interrelated wrongful acts are deemed to arise out of the first such claim.\textsuperscript{38} Arguably, this provision has benefits for both the insurer and the insured. For the insurer it ensures that all risks associated with claims arising out of the same or related wrongful acts will be captured within one policy period and thus will be subject to one liability limit. The danger to the insurer of omitting such a requirement has been well illustrated by cases in which courts have found insurers who fail to include such language liable under separate policy limits for multiple related claims filed over a several-year period.\textsuperscript{39} On the other hand, such a provision may also contain benefits for the insured. First, it may permit the insured to move coverage to another carrier, reserving the argument that any future claims arising out of the interconnected wrongful acts of a previously submitted claim will be covered by the former policy. In addition, most policy forms also indicate that all claims that are interrelated for the purposes of imposing a single limit also

\textsuperscript{35} See Michael A. Rosenhouse, "Liability Insurance Coverage as Extending to Liability for Punitive or Exemplary Damages," 16 A.L.R. 4th 11, 16 (1982). See also discussion of public policy limitations at Olson & Hatch at §4.04 [1]. The applicability of this logic to those states that permit the finding of punitive damages for actions which are not willful or intentional is more difficult to see.

\textsuperscript{36} Compare Northwestern Nat'l Cas. Co. v. McNulty, 307 F.2d 432 (CA5 1962); Country Manors Assoc. Inc. v. Master Antenna Sys., Inc., 534 So.2d 1187 (Fla. Ct. App. 1988); and Beaver v. Country Mut. Ins. Co., 95 Ill. App.3d 1122, 420 NE2d 1058 (Ill. App. 1981) (punitive damages uninsurable because purpose of deterrence would be undermined); with Whalen v. Ou-Deck, Inc., 514 A.2d 1072 (Del. 1986) (punitive damages insurable in absence of contrary legislative intent; insured punished by higher premiums); Skyline Harvestore Sys. v. Centennial Ins., 331 N.W.2d 106 (Iowa 1983) (strong public policy favoring freedom of contract dictates that carriers and their customers should be permitted to decide whether or not to insure against punitive damages); and Harrell v. Travelers Indem. Co., 567 P.2d 1013 (Or. 1977) (insurers free to charge higher premium, so cost of improper conduct not shifted to society).

\textsuperscript{37} Only 25\% or less of all claims against directors and officers are resolved by litigation. Of resolved claims, 59\% were closed by settlement, 16\% dropped by the claimant, and 25\% resolved by litigation. 1995 Wyatt Survey at 45. One interesting counter theory to this argues that with the increasing trend in the securities area toward state court, see section 10.10 (Private Securities Reform Act of 1995), where punitive damages are sometimes permitted, coverage for punitive damages would remove a litigation fear of an uninsured punitive damages judgment that some directors, especially outside directors, might experience. The theory is that such fears might push corporations toward early settlements that they would otherwise not desire. By covering punitive damages, insurers would free corporate defense counsel to litigate claims to trial without being distracted by this fear.

\textsuperscript{38} Sec., e.g., Executive Risk Specialty Insurance Company, Directors and Officers Liability Insurance Policy Including Company Reimbursement Form B21117 (12/95 ed.) (hereinafter cited as "Executive Risk 1995 Policy Form II[K]. Executive Risk Inc. ("ERI"), through its subsidiaries Executive Risk Management Associates, Executive Risk Indemnity Inc., and Executive Risk Specialty Insurance Company, underwrites and issues directors' and officers' liability insurance policies and other professional liability insurance. ERI's subsidiaries market and underwrite substantially all D&O insurance policies issued by the Aetna Casualty and Surety Company in the United States.

obtain the benefit of applying a single retention.\textsuperscript{40} Even when this benefit is not expressed in the policy form, some courts have imposed it by equitable judicial interpretation.\textsuperscript{41}

5. The Claim Must Not Be Excluded Under the Terms of the Policy or by Endorsement

If a claim occurs during the policy period against an insured and alleges wrongful acts of those individuals, creating losses for them or for the corporate policy holder that indemnifies them, then the next avenue of inquiry is whether the claim has been excluded either by the exclusion section of the policy or by endorsement.

Exclusions in a typical D&O policy fall generally under three categories:

1. Exclusions relating to specific conduct of an insured;
2. Exclusions of coverage provided under other policies; and
3. Exclusions relating to issues of public policy or areas of difficult exposure.

Most exclusions are found in the basic policy form, but many also can be added by endorsement. There are also various fairly standard exclusions that for historical reasons are always added by endorsement.

Of the types of exclusions listed above, those concerning “difficult exposures” are the most likely to be negotiable with the insurance company. It should be noted that, because exclusions block coverage under the policy, the insurer bears the burden, in the event of any coverage dispute, of demonstrating that the exclusion applies and that the language of the exclusion is clearly stated.\textsuperscript{42}

a. Conduct Exclusions

Conduct exclusions preclude coverage of acts that the carriers deem to be uninsurable or inappropriate for coverage. Typical conduct exclusions concern claims based on:

1. Illegal remuneration;\textsuperscript{43}

\textsuperscript{40} National Union 1995 Policy Form ¶ 6.
\textsuperscript{43} Typically, this exclusion applies only to remuneration determined by a judgment or other final adjudication to be paid in violation of the law, and remuneration paid pursuant to a settlement agreement, unless the remuneration was approved by the stockholders. See Chubb Group of Insurance Companies Form 14-02-0386 (Ed. 2-84), ¶ 3.2(a). As a leading commentator notes, it is unclear why this exclusion is not
2. Short-swing profits;\(^{44}\) and

3. Criminal or deliberately fraudulent acts;\(^{45}\) or the gaining of any personal profit or advantage to which the insured is not legally entitled.\(^{46}\)

Certain of these exclusions were criticized when they first appeared in the 1960s as being unclear and too draconian because they seemed to deny coverage on the basis of allegations alone.\(^{47}\) As one commentator quipped, if the language excluding claims "based upon or attributable to the gain of a personal profit or advantage to which directors and officers were not entitled" were meant to exclude claims merely alleging self-dealing, the effect would be something like fire insurance for which the insurer had excluded blazes caused by cigarettes, oily rags or deceptive wiring.\(^{48}\)

Accordingly, when reviewing these types of exclusions prior to purchasing coverage, it is essential to verify that they do not apply to claims that consist of mere allegations, but only to claims established by a final adjudication or other finding of fact. Conduct exclusions should contain express language indicating that they are triggered only by an adverse court finding or specifically state they apply only to "in fact" findings and should not contain the word "alleging." If necessary, insurers should be asked to provide "letters of intent" to clarify their position. An example of a conduct exclusion that is not triggered by mere allegations is:

(a) arising out of, based upon or attributable to the gaining in fact of any profit or advantage to which an Insured was not legally entitled (emphasis added).\(^{49}\)

The second essential attribute to look for in the conduct exclusions is severability. Typical D&O policies state that, for the purpose of such exclusions, the conduct or acts of one

\(^{44}\) Short-swing profits are paid in violation of Section 16(b) of the Securities Exchange Act of 1934; see 15 U.S.C.A. § 78p(b) (1994); liability for short-swing profits is discussed in depth in Olson & Hatch at 3.07.

\(^{45}\) Older policy forms may have an exclusion for "active and deliberate dishonesty of the insured person" in lieu of this criminal or deliberate fraudulent act exclusion. However, the ambiguity of the traditional form of the dishonesty exclusion has led in recent times to the creation of a simpler formulation- that of the criminal or deliberate fraudulent act exclusion. In either case, these exclusions, like all conduct exclusions, will require either a judgment or final adjudication adverse to the insured that establishes the prohibited acts or other factual findings. See Eglin National Bank v. Homes Indem. Co., 583 F.2d 1281, 1287-88 (CA5 1978).

\(^{46}\) See e.g. National Union 1995 Policy Form ¶ 4(e).


\(^{48}\) Id at 104.

\(^{49}\) National Union 1995 Policy Form ¶ 4(a).
insured will not be imputed to another insured. If the policy contains such a provision, officers and directors who are found to have negligently supervised an individual convicted of criminal conduct should not be excluded by the terms of the policy under any theory of vicarious liability, since the criminal conduct of the director or officer will not be imputed to another merely negligent director or officer for the purposes of coverage analysis. When purchasing policies with Entity Coverage, care should also be taken to ensure that full severability coverage is granted as between insured individuals and the insured entity.

b. Exclusions Due to Other Policies

There are a number of exclusions in a D&O policy that are meant to protect the policy from being used to cover claims that are, or should be, covered under another type of policy. Such exclusions preclude coverage under the D&O policy of the following types of claims:

1. Claims for bodily injury, sickness, disease or death of any person, or claims for damage to or destruction of any tangible property including the loss thereof (the "bodily injury exclusion");

2. Claims to which an earlier D&O policy was applicable;

3. Claims against fiduciaries for violations of the Employee Retirement Income Security Act of 1974;

4. Claims arising out of litigation pending as of or completed prior to the continuity date (the "pending and prior litigation exclusion").

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50 See, e.g., National Union 1995 Policy Form ¶ 4 (a)-(c).

51 For example, without severability the personal profiting of a chief financial officer would automatically be imputed to the corporation even in circumstances where it was evident that he was acting outside the scope of his office. For a entity policy granting full severability, see e.g. National Union 1995 Policy. For Entity Policies, generally See 10.09.

52 These exclusions also typically exclude "emotional distress" claims, claims for libel and slander, and claims concerning publication of material that violates the right to privacy. See, e.g., National Union 1995 Policy Form ¶ 4(k)), or claims for mental anguish, wrongful entry, eviction, false arrest, false imprisonment, malicious prosecution, malicious use or abuse of process, or loss of consortium. See, e.g., Aetna Independent Directors' Liability Policy Form (Ф-1843) Ed.3-88, at ¶ III(B).

53 See e.g. Executive Risk 1995 Policy Form ¶ III(C)(2).

54 Claims "based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving: . . . any actual or alleged violation of the Employee Retirement Income Security Act of 1974 or any regulations promulgated thereunder or of any similar law or regulation." Executive Risk 1995 Policy Form ¶ III(C)(3). Additional coverage for such claims may be available. For example, both Americ International Companies and Chubb & Son Inc. offer separate coverage Sections or policies for employee benefit plan related claims. See American International Companies Employee Benefit Plan Fiduciary Liability Insurance Policy Form 63854 (12/95); and also Chubb & Son Inc. Fiduciary Liability Coverage Section, Form 14-02-0945 (Ed. 1-92).

55 See, e.g., National Union 1995 Policy Form ¶ 4(e) (excluding prior "litigation"); (Executive Risk 1995 Policy Form ¶ III(C)(I) (excluding an) prior or pending "litigation or administrative or regulatory proceeding"); also see infra. at FN 61.
5. Claims based on wrongful acts of a director or officer of a subsidiary corporation occurring either before it became a subsidiary or after it was spun off as a subsidiary;\textsuperscript{56}

6. Claims based upon or attributable to any failure or omission to effect or maintain insurance;\textsuperscript{57}

7. Claims that are insured against by any other policy or policies, except presumably for D&O policies written specifically to provide excess coverage in addition to the coverage provided by the primary policy.\textsuperscript{58}

While these exclusions are rather straightforward in intent, there are nevertheless issues of interpretation of which a corporation should be wary. Different phraseology can result in radically different coverage. Both the bodily injury and the pending and prior litigation exclusions are good examples of this.

The effect of the bodily injury exclusion is markedly different, depending upon the lead-in phrase that is used prior to the exclusion. In the typical example provided as exclusion number 1 in the list cited above, the exclusion is preceded by the word “for.” This is the most common introductory phrasing and is designed to exclude only those types of direct bodily injury or property damage typically covered by a comprehensive general liability policy. However, older policy forms may begin with the broader introductory phrase, “based upon, arising out of or attributable to” bodily injury or property damage.\textsuperscript{59} In the event that a company suffers mass tort claims such as those brought against pharmaceutical manufacturers for allegedly defective products, “catch-all” introductory language of this kind exclude not only direct bodily injury claims against the insureds, but also subsequent shareholder class or derivative actions filed against directors and officers of the corporation claiming mismanagement or inadequate disclosure under the federal securities laws. However, if the exclusion begins with the word “for,” such indirect mismanagement claims would likely be covered under the D&O policy, while only the direct claims brought by or on behalf of the individuals who suffered the bodily

\textsuperscript{56} See, e.g., National Union 1988 Policy Form ¶ 4(a); this type of provision also may be contained within the definition of “Subsidiary.” See, e.g., Executive Risk 1995 Policy Form at definition (L), National Union 1995 Policy Form ¶ 2(i).

\textsuperscript{57} According to a leading commentator, this exclusion is meant to preclude the use of the D&O policy as a substitute for other corporate liability or property insurance. Such a result might come about if an action were brought against directors and officers by shareholders for failure to maintain adequate coverage on an important facility destroyed by fire. See Johnston, supra N.43, at 2020. Nevertheless, perhaps as a result of the current competitive market for D&O insurance products, very recent policy forms have tended to eliminate the exclusion precluding claims attributable to the failure to maintain insurance. National Union 1995 Policy Form; Executive Risk 1995 Policy Form.

\textsuperscript{58} See, e.g., Chubb 1992 Policy Form at ¶13.

injury would be excluded. For similar reasons, the proper introductory clause for the ERISA exclusion should also begin with the word "for."

The seemingly innocent "pending and prior litigation" exclusion also is subject to varying interpretations, depending on phraseology. In its most acceptable form, the exclusion excludes "claims arising from any pending or prior litigation as of the continuity date, as well as all future claims or litigation based upon the pending or prior litigation or derived from the same or essentially the same facts that gave rise to the pending or prior litigation."

Other broader, and therefore less acceptable, versions of the exclusion might also exclude any "demand, suit or other proceeding . . . decree or judgment entered against any " director, officer or the insured corporation.

In addition to the above exclusions, an exclusion excluding claims arising out of pollution conditions is sometimes listed in this category due to the belief that such claims may well be covered under a standard environmental impairment policy.

c. Exclusions Relating to Issues of Public Policy or Areas of Difficult Exposure.

i. The Insured v. Insured Exclusion.

In the early 1980s, a number of financial institutions thought to turn corporate losses arising out of underperforming loans into D&O insurance recoverables by suing their own officers for negligence in connection with alleged failure to anticipate or respond properly to such losses, or with poor decisions on loan underwriting. If the suit was successful, then the

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60 The last mentioned exclusion is, of course, simply the "flip-side" of the interrelated losses provision discussed in §10.06 [3] supra. This type of exclusion may be found in the policy form or in an accompanying endorsement.

61 See, e.g., Chubb 1992 Form ¶ 5(b).

62 The environmental exclusion was, and remains, very broad. See Monteleone and McCarrick, A D&O Policy Road Map: The Coverage Exclusions, 7 Insights 8, 9 (July 1993). A typically broad exclusion applies to claims "based upon, arising from, or in consequence of (i) the actual, alleged or threatened discharge, release, escape or disposal of Pollutants into or on real or personal property, water or the atmosphere; or (ii) any direction or request that the Insured test for, monitor, clean up, remove, contain, treat, detoxify or neutralize Pollutants, or any voluntary decision to do so " with "Pollutant" defined as "any substance located anywhere in the world exhibiting any hazardous characteristics as defined by, or identified on a list of hazardous substances issued by, the United States Environmental Protection Agency or a state, country, municipality or locality counterpart thereof. Such substances shall include, without limitation, solids, liquids, gaseous or thermal irritants, contaminants or smoke, vapor, soot, fumes, acids, alkalis, chemicals or waste materials. Pollutants shall also mean any other air emission, odor, waste water, oil or oil products, infectious or medical waste, asbestos or asbestos products and any noise." Chubb Policy Form 14–02–0943 ¶15(f) and 18. Some issuers do, however, offer endorsements or separate policies that will cover these risks. See, e.g., National Union Fire Insurance Company of Pittsburgh, Pa. Directors & Officers Insurance and Company Reimbursement Pollution Endorsement, Form 58529SPCMN (9/93) and American International Specialty Lines Insurance Company Directors and Officers Pollution Insurance and Company Reimbursement Policy, Form 54061 (8/92). Some D&O policies expressly carve out from their environmental exclusion claims that are essentially federal or state securities claims or derivative claims alleging environmental violations as predicate "wrongful acts." See Executive Risk 1995 Policy Form ¶ III(B). Other carriers, including National Union and Chubb, provide similar carve-outs by endorsement.
officers would become legally obligated to pay a claim against them based upon their wrongful acts, and the D&O policy would, by its terms, obligate the insured to pay the losses. In response, insurers uniformly introduced an exclusion that attempted to prevent the corporate policy holder from attempting to cash in on D&O policies by suing its own directors and officers.

The purpose of the exclusion, now standard on almost all D&O policies, is easy to understand. The underwriting philosophy behind a D&O insurance policy is to provide coverage for claims brought by third parties against an insured corporation’s management. Providing coverage for a claim brought by an insured against another insured or brought by the company against an insured would support potential collusive arrangements between insiders and put the insurance company in the awkward position where the claimant corporation, the corporate policyholder, inherently had greater access to information and documentation concerning the alleged wrongful act than either the defending directors and officers or the insurance company.

While the reason for the exclusion is understandable, some of the original phraseology of the exclusion was too broad and created considerable confusion. For example, an early broad form of this “insured v. insured” exclusion read as follows:

The Insurer shall not be liable to make any payment for Loss in connection with any claim or claims made against the Insureds . . . which are brought by, or on behalf of, any other Insureds including but not limited to shareholders’ derivative suits and/or representative class action suits, brought by one or more past, present or future Directors and/or Officers including their estates, beneficiaries, heirs, legal representatives, assigns and/or the Company against one or more past, present or future Directors or Officers.64

Because the broad language of such early forms of exclusion might be deemed to exclude even judgments paid in shareholder derivative actions, coverage of which is one of the principal advantages of insurance over indemnification,65 policies subsequently were modified to clarify the exclusion. Newer forms of the exclusion create significant exceptions for shareholder claims that can be shown not to have been made in collusion with an insured or the company and for wrongful discharge complaints against management by former officers. For example:

The Insurer shall not be liable to make any payment for Loss in connection with any claim or claims made against the Directors or Officers . . . which are brought


65 See discussion in §10.03 supra.
by any Insured or the Company; or which are brought by any security holder of the Company, whether directly or derivatively, unless such claim(s) is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of, any Insured or the Company; provided, however, this exclusion shall not apply to wrongful termination of employment claims brought by a former employee other than a former employee who is or was a Director of the Company.66

This form of the exclusion is intended to screen out the possibility of suits by the company, or by individuals acting as proxies for the board or the company, while at the same time permitting most non-collusive shareholder class or derivative actions to be covered.

During the late 1980s and early 1990s, the insured versus insured exclusion had assumed greatest importance in the context of the federal receivership or conservatorship of financial institutions, when a governmental agency sued a company's directors and officers, arguing that it was part of its statutory responsibility to marshal and realize assets of a failed institution on behalf of creditors, depositors, and shareholders.67 A number of courts wrestled with the question of whether the insured versus insured exclusion would bar such actions by the receiver because the receiver is, in effect, “standing in the shoes of the corporation,” exercising rights belonging to the corporation, which rights if exercised directly by the corporation would be excluded under the insured versus insured exclusion.68 Judicial interpretation of the insured versus insured exclusion in this context was mixed, with cases going either way.69

Fortunately, today, the insured v. insured exclusion is much less controversial. The efforts of regulatory agencies to circumvent the exclusion largely were turned aside by the appearance

66 National Union 1988 and 1995 Policy Forms ¶4(i). For a similarly limited provision, see also Executive Risk Policy Form ¶III(D)(1), and Chubb 1992 Policy Form ¶5(e), which also excepts claims for contribution and indemnity arising directly from a claim not otherwise excluded.


69 Gary, 753 F Supp at 1554; Mt. Hawley, 695 F Supp at 481-82. (exclusion effectively bars claims by a federal receiver); see Baker, 758 F Supp 1349-50; Zandstra, 756 F Supp at 431. (exclusion is ambiguous and does not bar claims by receiver claims) and Branning, 721 F Supp at 1184; American Cas. Co., 713 F Supp at 316; Allen, 710 F Supp at 1098; National Union Fire, 630 F Supp at 1151. (receiver not simply "in the shoes" of the corporation and thus exclusion does not apply). Compare FDIC v. American Cas. Co., 975 F2d 677, 681-82 (CA10 1992) (exclusion effectively bars claims by federal receiver) and Mt. Hawley, 695 F Supp at 481-84 (same) with American Cas. v. Santa Fe Federal Sav. Bank, 867 F. Supp. 50, 59 (D Mass 1994) (exclusion does not bar receiver's claims); FDIC v. American Cas. Co., 814 F. Supp. 1021, 1025-26 (D Wyo 1991); Baker, 758 F Supp at 1348-50 (same); Zandstra, 756 F Supp at 431-34 (exclusion is ambiguous and does not bar receiver's claims); Branning, 721 F Supp at 1184 (receiver not simply "in the shoes" of the corporation so exclusion does not apply); American Cas. Co., 713 F Supp at 316 (same); National Union, 630 at 1157 (same).
and then, to some extent, disappearance of the regulatory exclusion discussed below. Thus, the insured versus insured exclusion is now generally regarded by the D&O insurance industry and by policy holders as an acceptable limitation on coverage.\textsuperscript{70}

\textbf{ii. The Regulatory Exclusion}

During the 1980s, due, in part, to their inability consistently to apply the insured versus insured exclusion to claims advanced by financial institution regulators, D&O insurers began adding by endorsement a regulatory exclusion. Typical of the wording of such exclusions is the following:

It is understood and agreed that the Insurer shall not be liable to make any payment for Loss in connection with any claim made against the Directors or Officers based upon or attributable to any action or proceeding brought by or on behalf of the Federal Deposit Insurance Corporation, the Federal Savings & Loan Insurance Corporation, any other depository Insurance organization, the Comptroller of the Currency, the Federal Home Loan Bank Board, or any other national or state regulatory agency (all of said organizations and agencies hereinafter referred to as “Agencies”), including any type of legal action which such Agencies have the legal right to bring as receiver, conservator, liquidator or otherwise; whether such action or proceeding is brought in the name of such Agencies or by or on behalf of such Agencies in the name of any other entity or solely in the name of any Third Party.\textsuperscript{71}

From the insurer’s perspective, this exclusion was viewed as a dike against the vast and rising losses experienced by failed financial institutions - a well-publicized national disaster whose severity was beyond anything contemplated by the insurance industry’s existing policy premium structure.

While the insurers’ point of view that D&O insurance was not written for the benefit of the federal deposit insurance funds is understandable, the attitude of courts toward the regulatory exclusion varied. In many cases, the courts supported the insurer, finding that the exclusion was unambiguous, bargained for, and did not violate public policy.\textsuperscript{72} Other cases, however,

\textsuperscript{70} It should be noted that one remaining circumstance of occasional controversy is the interesting question as to the applicability of the insured v insured exclusion to claims brought by bankruptcy trustees.


determined that the exclusion was either void as against public policy, or ambiguous and to be construed against the insurer. Still other cases argued that there was no public policy issue raised on the theory that the FDIC only had a statutory duty to collect an asset such as D&O proceeds only if the failed bank actually had the asset. According to these cases, the bank had bargained and paid only for a directors and officers liability policy with a regulatory exclusion and, thus, there was no insurance asset for the regulator to reach.

Today, due to the changing economic environment, the need for, and therefore existence of, the regulatory exclusion has been somewhat diminished, although it is always possible that another set of adverse economic events in a regulated industry sector could promote a renewed interest in such an exclusion.

iii. The Antitakeover Exclusion

During the 1980s, in reaction to the massive increase in actual and proposed change of control transactions, and litigation between bidders and resistant corporate managers, policies began to exclude certain types of claims arising from defenses against hostile takeovers. The typical exclusion would exclude claims "alleging, arising out of, based upon or attributable to any attempt, whether successful or unsuccessful, by any person or entity to acquire securities of the company against the opposition of the board of directors of the company, or any action, whether successful or unsuccessful by the company or the board of directors to resist such attempts." Some insurers even sought to exclude claims arising out of any takeover of the company, whether hostile or friendly. Not surprisingly, these exclusions met with opposition from policy holders who viewed hostile takeovers as precisely the type of situation in which directors, in particular, needed the protection of D&O insurance. Responding to the needs of the policy holders, insurers revised its exclusion in 1988 to allow claims where the actions of the

[Footnote continued from previous page]


75 National Union 1985 Policy Form at exclusion (e).

76 See Romano, "What Went Wrong With Directors' and Officers' Liability Insurance?" 14 Del. J. Corp. L. 1, 13-14 (1989); "A view shared by the bar and the press is that [the] merger boom is a primary cause of the D&O crisis. This is because acquisition activities frequently spawn lawsuits against directors by shareholders objecting to the terms of the deal, the disclosure surrounding the deal, or defensive tactics used to thwart the deal . . . . For example, over half of the cases in the most recent supplements to corporate law casebooks involve acquisition transactions." (Citations omitted.)
defending board had been based on the opinions of legal and financial advisers, or restricted the focus of the antitakeover exclusion to claims arising out of going-private transactions by management and the payment of "green mail" to unwanted suitors.

The 1990s were a time of broadening coverage in this area. The same company that had modified the exclusion in 1988 to provide for the business judgment defense previously described, deleted the exclusion in its entirety when it revised its form in 1995. Somewhat surprisingly, however, 1996 has seen the re-emergence of the green mail exclusion in some of the endorsements providing Entity Coverage for securities claims.

d. Endorsements

Most of the exclusions listed above are so generally applied that they have become part of the printed policy form. Sometimes, however, exclusions that are more fitted to the particular circumstances and risks of an individual company are added by endorsement. Endorsements, in fact, unlike exclusions, may be either restrictive or expansive, and thus may best viewed as the result of bargaining or customization on the basic policy form. Unlike many other insurance forms, D&O policies have varied to such an extent in their particulars that the Insurance Service Organization (ISO) has never attempted to file a "standard policy form," and each insurer has continued to use a slightly different policy as its basic form. When one adds endorsements -- many of which are fashioned for one particular client -- to the varieties of different basic policy

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77 "The Insurer shall not be liable to make any payment for Loss in connection with any claim or claims made against the Directors or Officers . . . (e) alleging, arising out of, based upon or attributable to any attempt, whether successful or unsuccessful, by any person or entity to acquire securities of the Company against the opposition of the Board of Directors of the Company . . . or any action . . . by the Company to resist such attempts; however, this exclusion shall not apply if, before taking any such resistive action, the Company or the Board has obtained a written opinion (1) from independent legal counsel that such resistive action is a lawful exercise of the Board's business judgment and (2) from an independent investment banking firm that the price of such acquisition of securities is inadequate, and that any financial transaction approved by the Board which is resistive of such acquisition is fair to the Company and its shareholders." National Union 1988 Policy Form ¶ 4(e). See also "Mergers Pose D&O Threat: Experts," Business Insurance, Feb. 13, 1989.

78 In lieu of a hostile takeover provision, a policy form of Aetna Cas. and Surety Company disallowed claims "based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any plan or proposal to sell the Parent Corporation or any Subsidiary or any of the assets or stock of the Parent Corporation or of any Subsidiary to any directors, officers or employees of the Company" and "any offer to purchase, or purchase of, securities of the Company at a premium over their then-current market value, made by the Company or by any of the Insured Persons, except where such offer or purchase extends to all security holders of the Company." See Aetna Designated Persons Policy Form ¶ IV.(A)(13) & (14).

79 National Union 1995 Policy Form.

80 See, e.g., Chubb's Entity Endorsement 14-02 Ed.12/95. For a discussion of Entity Coverage policies, see §10.09.

81 The exceptions are the Regulatory Exclusion, the Prior Acts Exclusion and the Corrupt Practices Exclusion (also known as the "Commissions Exclusion"), which, for historical reasons, or in the case of the regulatory exclusion, due to its particular applicability to financial institutions, is generally added as an endorsement to policies.

82 Recently, the Surety Association of America also concluded that it should not pursue the development of a standard form of D&O policy for financial institutions or become a statistical agent for the reporting of D&O experiences.
forms, a D&O policy begins to look more like a negotiated commercial agreement than an "off-the-shelf insurance" form. It is important for insured companies and their counsel to realize that the bargain represented by the D&O policy is, in fact, adjustable. Often, elements in the policy form that are objectionable to the prospective policy holder may be traded off by the insurer in return for a higher premium or self insurance at a higher level through the upward adjustment of the retention. On the other hand, some restrictive endorsements represent the only terms on which an insurer is willing to approach an otherwise uninsurable risk.

A sample of some of the restrictive endorsements that might be found in a typical policy include:

1. A nuclear energy liability exclusion, barring coverage for claims arising out of the hazardous properties of nuclear material;
2. Deletions from coverage of specific directors or officers against whom actions or investigations or known claims are pending when the policy is written; and
3. "Reorganization of business" exclusions, which deserve particular attention in that they provide for termination of coverage in the event of a takeover or insolvency.\(^\text{83}\)

Endorsements, of course, are also frequently used to expand coverage under the policy. Examples of such expansive endorsements include:

1. Endorsements amending the term "insured" to include divisional officers, employees or other non-officer or directors;
2. Endorsements expanding the definition of the insured company to include foundations, trusts, partnerships or other noncorporate affiliates;
3. Endorsements obligating the insurer to advance defense costs, if such advancement is not already provided in the boilerplate of the policy;
4. Endorsements expanding or clarifying the worldwide applicability of the policy;
5. Endorsements providing multi-year discovery or run-off periods or making the policy applicable to a particular acquisition that the company is contemplating; and

\(^\text{83}\) Such endorsements may require the insured company to give notice whenever a merger transaction or cessation of business occurs, thus permitting the insurer to revise the policy and adjust the premium, if the transaction is the acquisition by the insured company of a new entity and, more importantly, to provide a terminus for coverage under the policy if the company is acquired or if it becomes insolvent. Particularly in the case of financial institutions, such endorsements may attempt to forestall the kinds of actions by government agencies that have been described above by providing, for example, that if the bank is not the surviving entity in a merger transaction, or if it ceases to engage in an active banking business for any reason, including the appointment by any federal or state banking regulators of a receiver or other liquidator, or to accept deposits, coverage shall terminate as of the date of the transaction or cessation of business. It is important to recognize that such an endorsement may operate to deprive the insureds of yet another of the advantages of a D&O policy over indemnification -- a source of indemnity in insolvency. For a discussion of the more standard "change of control" provisions, see §10-08[2] infra.
6. "State amendatory endorsements" required by state law, which typically expand coverage by providing longer advance notification of cancellation, the ability to elect discovery periods and sometimes other benefits to policy holders.84

6. **The Insurer Must Be Notified.**

Assuming that a claim has been made against an insured during the policy period alleging a wrongful act that is not excluded by any of the exclusions or endorsements to the policy, the policy will require that the claim is submitted on a timely basis to the insurer. As discussed previously, the D&O insurance policy is a "claims-made" contract. A necessary part of the claims-made concept is that both the insured and the insurer know with reasonable certainty at the time of policy renewal whether coverage under the expiring policy has been triggered by a claim. Notification requirements are taken extremely seriously in the claims-made context, and the failure to give such notice may jeopardize coverage.85 D&O policies usually require that insureds notify the insurer "as soon as practicable" of any claims made against them during the policy period (or discovery period, if elected). Higher quality policies might add a small "window" after the end of the policy to facilitate submission of claims made against the insured late in the policy period. A typical provision of that type might read as follows:

The Company or the Insureds shall, as a condition precedent to the obligations of the Insurer under this policy, give written notice to the Insurer of a Claim made against an Insured as soon as practicable and either:

1. anytime during the Policy Period or during the Discovery Period (if applicable); or
2. within 30 days after the end of the Policy Period or the Discovery Period (if applicable), as long as such Claim(s) is reported no later than 30 days after the date such Claim was first made against an Insured.86

Some more restrictive policies however, may require notice to be given within a certain period - such as 30 days - after the claim is first made. 87

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84 While it is not common, state amendatory endorsements sometimes actually restrict coverage. For example, New York law prohibits an insurance company from completely eliminating coinsurance (a form of self-insurance) from a D&O policy. See N.Y. Bus Corp L. §726 (McKinney 1996) (corporations may purchase insurance "to indemnify directors and officers in instances in which they may not otherwise be indemnified by the corporation under the provisions of this article provided the contract of insurance covering such directors and officers provides, in a manner acceptable to the superintendent of insurance, for a retention amount and for co-insurance."); New York Ins. Reg. 110, 11 NYCRR §72.4 (1996).


86 National Union 1995 Policy Form ¶ 7(a).
In addition to the notice of claim provisions, most D&O policies also permit insureds to notify the insurer of circumstances that may give rise to a claim in the future. If such notice is given prior to the expiration of the policy, the insurer will treat any subsequent claims arising out of those circumstances as claims first made within the policy period. A typical provision would read as follows:

If during the Policy Period or Extended Reporting Period (if exercised) an Insured becomes aware of any circumstances which could give rise to a Claim and gives written notice of such circumstance(s) to the Company, then any Claims subsequently arising from such circumstances shall be considered to have been made during the Policy Period or the Extended Reporting Period in which the circumstances were first reported to the Company.

The Insureds shall, as a condition precedent to exercising their rights under this coverage section, give to the Company such information and cooperation as it may reasonably require, including but not limited to a description of the Claim or circumstances, the nature of the alleged Wrongful Act, the nature of the alleged or potential damages, the names of actual or potential claimants, and the manner in which the Insured first became aware of the Claim or circumstances.88

The advantage to the insured of submitting a notice of circumstances is that it preserves the insured’s rights under the existing policy. If a claim arises out of such circumstances after the expiration of the policy period, the policy will treat such claim as if made during the policy period and therefore covered subject to the policy’s other terms and conditions. Of course, such claims likely will be excluded from coverage under subsequent policies due to that policy’s “prior notice” exclusion.89 As a practical matter, the giving notice of circumstances should be approached with caution. Since the giving of notice will inherently trigger potential liability, it may well have an unsettling impact on renewal negotiations, possibly causing more restrictive terms or higher premiums than otherwise would have occurred. On the other hand, if the insurer is proposing to renew coverage on less favorable terms, or the insured is moving coverage from one carrier to another, the giving of notice of circumstances might be the last opportunity to preserve important coverage under the policy. The giving of notice of circumstances when moving coverage from one carrier to another has become such a common event, and such notice

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87 See, e.g., Aetna Designated Persons Policy Form ¶IV(D)(1).


89 See infra §10.06[1].
drafted so broadly, that the giving of notice in those circumstances frequently is referred to as “giving a laundry list.”

7. Loss Must Be in Excess of the Retention Amount and Not Within Any Applicable Coinsurance Percentage

Having properly submitted to the insurer a claim that falls within the scope of the insuring clause, meets the essential definitions of the policy and is not excluded by the exclusion section, the policy holder next will inquire how much of the loss will be paid by the policy.

The first avenues of inquiry are the retention and coinsurance sections of the policy. Typically, the insurer is liable to pay only that loss which is excess of the applicable retention or deductible amount and, in the event of coinsurance, excess of the applicable coinsurance percentage. Both retentions and coinsurance percentages are forms of self-insurance; their effect is generally to lower the amount of premium that the insurer otherwise would require, in exchange for some or all of the insureds’ assuming a portion of the risk.

a. Retentions

D&O policies typically have a split retention with a lower retention amount applying to Coverage A (individual claims) and a higher retention amount applying to Company Reimbursement Coverage or Coverage B. For example, according to Watson Wyatt, the average corporate retention is approximately $1 million, while 84 percent of policies actually contain no individual retention at all. When the individual retention is not zero, it is usually a nominal amount such as $5000 per claim.

A typical retention clause illustrating these attributes is as follows:

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90 The giving of a “laundry list” by no means ensures coverage for subsequent claims. As indicated in the notice of circumstances provision cited above, all policies require a certain amount of particularity in the information given in order to satisfy the provisions of the policy. It can be assumed that the giving of a broad general notice or even a notice describing a particularly risky transaction will be viewed with great scrutiny as to the provisions of the policy when a claim comes in. One possible danger in such circumstances would be for an insured to find that carrier number one denies the subsequent claim on the basis that the particularity requirements of the policy’s notice of circumstances was not fulfilled, and carrier number two denies the claim due to the prior notice exclusion, resulting in no coverage being afforded for a claim under either policy.


92 Wyatt 1995 Survey at 22.

93 At least one state prohibits an insurance company from granting a zero deductible for individual claims. New York Insurance Regulation 110 mandates minimum retention amounts ranging from $100 to $5000 depending upon the type of organization, subject to an overall aggregate cap. 11 NYCRR §72.4 (1996).
The insurer shall only be liable for the amount of loss arising from the claim which is in excess of the retention amount stated in item 5 in the declaration, such retention amount to be born by the company and or the insured and shall remain uninsured, with regards to all loss under Coverage A or B for which the company has indemnified or is permitted or required to indemnify the insureds. A single retention amount shall apply to loss arising from all claims alleging the same wrongful act or related wrongful acts.\textsuperscript{94}

The above provision is also illustrative of another aspect of directors' and officers' liability insurance retentions -- the rule of presumptive indemnification. Due to the huge differences between the individual and corporate indemnification provisions, insurers are naturally quite interested in avoiding a situation where a corporation could refuse to indemnify a director or officer for an act for which indemnification is clearly permitted under the bylaws and its state law, simply to take advantage of the lower retention applicable under Coverage A of the policy. Thus, essentially all D&O policies incorporate the concept that a corporation is presumed to have indemnified an insured whenever it is legally permitted to do so.

There are two important coverage issues regarding presumptive indemnification provisions. First is the issue of where in the policy the presumptive indemnification provision is incorporated. For example, in older policy forms, the presumptive indemnification provision was incorporated in exclusions applicable to the policy's "Coverage A" or "individual insuring clause." An example of this type of provision would be as follows:

The Insurer shall not be liable to make any payment for Loss in connection with any claim or claims made against the Insureds... for which the Directors and/or Officers are indemnified by, or entitled to indemnification by, the Company.\textsuperscript{95}

The same policy form in its corporation reimbursement section would only reimburse the insured company when the "Directors or Officers ... shall have been indemnified by the Company."\textsuperscript{96}

The problem with the above provision is that a claim for which a director and officer is "entitled" to be indemnified, but is not in fact indemnified, does not fall under either insuring clause. This so called "gap" between the insuring clauses results in a claim's not being covered at

\textsuperscript{94} See National Union 1988 Policy Form ¶ 6.

\textsuperscript{95} National Union 1985 Policy Form, Exclusion (a).

\textsuperscript{96} See National Union 1985 Policy Form, Clause 1.
all when, in fact, the real issue should have been, not whether the claim was covered, but whether the corporate retention applied.

In contrast, the following insuring clauses contain no gap. That is to say, whatever is not covered under Coverage A is covered under Coverage B and vice versa.

**Coverage A: Directors And Officers Insurance**

This policy shall pay the Loss of each and every Director or Officer of the Company arising from any claim or claims first made against the Directors or Officers and reported to the Insurer during the Policy Period or the Discovery Period (if applicable) for any alleged Wrongful Act in their respective capacities as Directors or Officers of the Company, *except for and to the extent* that the Company has indemnified the Directors or Officers. The Insurer shall, in accordance with and subject to Clause 9, advance to each and every Director and Officer the Defense Costs of such claim or claims prior to their final disposition. (Emphasis added.)

**Coverage B: Company Reimbursement Insurance**

This policy shall reimburse the Company for Loss arising from any claim or claims which are first made against the Directors or Officers and reported to the Insurer during the Policy Period or the Discovery Period (if applicable) for any alleged Wrongful Act in their respective capacities as Directors or Officers of the Company, *but only when and to the extent* that the Company has indemnified the Directors or Officers for such Loss pursuant to law, common or statutory, or contract, or the Charter or By-laws of the Company duly effective under such law which determines and defines such rights of indemnity. (Emphasis added.)

The lesson here is that the presumptive indemnification rule should be contained in the retention Section of the policy and not in the insuring clause or in an exclusion, so that any violations do not prevent coverage for the claim but only affect the application of the retention amount.

The second important issue regarding the retention clause involves how the retention is applied if a corporate policy holder has becomes insolvent. As discussed earlier, in bankruptcy,
even mandatory indemnification bylaws or indemnity agreements, unless independently funded, merely may entitle the indemnified person to take a place a line with other unsecured creditors. At the very least, the filing of a bankruptcy petition places the issue of whether directors and officers may be paid indemnification or advanced defense costs within the discretion of the bankruptcy court, which has the option either to give such payments first priority as "administrative expenses" pursuant to Sections 503 and 507 of the Bankruptcy Code or to relegate them to the list of claims of unsecured creditors.98 In such circumstances, will the insurer deem that indemnification is still "permitted or required" for purposes of the presumptive indemnity provision, therefore requiring application of the corporate retention amount to payments to the individual directors and officers under insuring agreement A, even though the company is in bankruptcy and unable, as a practical matter, to make the indemnification payments it is "permitted" to make under state law? The preferred solution to this conundrum is a policy provision or a "letter of intent" from the insurer, indicating that in the event the bankruptcy court prohibits advancement of defense costs by the corporation, thus putting the directors and officers in the uncomfortable position of having to pay their own legal costs with the hope of being reimbursed as an unsecured creditor, the insurer will assume the position of the directors and officers as an unsecured creditor and in the meantime pay their defense costs, subject to any applicable individual retention. In such a case, it would not be unreasonable for the insurer to compel the corporation at least to request the bankruptcy court to approve advancement of defense costs as "administrative expenses" pursuant to the Bankruptcy Code, since the granting of such a motion would not be unusual.99

Finally, with respect to recent policy forms granting "Entity Coverage" for securities claims, one insurer has modified the retention clause applicable to such claims to provide that, in the event of a dismissal of the claim against the insureds by reason of a motion for summary judgment or a motion to dismiss or a finding of no liability as a result of a defendant's verdict, even the corporate retention will be reduced to zero.100 This benefit is provided to encourage effective litigation management by creating a reward for a successful defense. In circumstances where the retention waiver applies, the insurer essentially foots the entire bill (subject to any other term or exclusion of the policy) as a "thank-you" for a successful defense. Recently, this

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99 Indeed, there is some authority for treating for indemnification of present directors as an administrative expense, provided their continuing services can be shown to be beneficial to the estate pursuant to Internal Revenue Code §503(b)(1)(A). See In re Baldwin-United Corp., 43 B.R. 443, 445, 461 (SD Ohio 1984); In re Schatz Federal Bearing Co., Inc., 17 B.R. 780, 784 (SDNY 1982). By the same reasoning, however, indemnification on a current basis was denied to former directors and officers of an insolvent corporation because their contract with the corporation had expired by the time the petition was filed. See In re Baldwin-United Corp., 43 B.R. at 455-56.

100 See National Union 1995 Policy Form ¶ 6.
provision has been modified further to remove the retention in the event that a claim is dismissed without prejudice as long as the claim (or a related claim) is not re-filed within a 90 day period.\footnote{See National Union Securities Plus Endorsement Form.} For further discussion of Entity Coverage see §10.09.

b. Coinsurance

As indicated above, coinsurance represents a portion of otherwise covered loss, expressed as a percentage, which is retained by the insureds. For example, assuming five percent coinsurance on a policy with a limit of liability of $1M, it would take an insured loss of $1,052, 631.58 to obtain the full $1M in coverage. Traditionally, D&O insurance policies would have the same coinsurance percentage applicable to both Coverage A and Coverage B under the policy. Sometimes this coinsurance percentage was left blank to be filled out on the declarations page.\footnote{See, e.g., Chubb 1992 Policy Form, Declarations at Item 3.} Sometimes it was a fixed percentage in the policy form itself, typically five percent.\footnote{See e.g. National Union 1988 Policy Form ¶ 7.} During the 1990s, it became quite common to amend the policy form by endorsement to delete the coinsurance clause with respect to individual claims under Coverage A to the extent permitted by state law.\footnote{For example, Regulation 110 of the New York State Insurance Code of Regulations indicates that a policy must contain a coinsurance percentage ranging from .1 percent to .5 percent for individual nonindemnifiable claims. See New York Ins. Reg. 110, 11 NYCRR §72.4 (1996).} Finally, some recent policy forms have eliminated coinsurance in its entirety under all insuring clauses.\footnote{National Union 1995 Policy Form.}
10.07 Defense of Litigation

Our last section concluded with a claim being filed with the insurance company for which coverage is being granted and for which loss is being incurred in excess of the applicable retention and coinsurance amounts. The next series of policy provisions that come into play are those regarding the defense of the claim. Of all the terms of D&O insurance policies, probably none comes under closer scrutiny in the event of a claim than the provisions that describe how the policy operates with respect to the handling of litigation and attendant expenses. Typically, six problems arise:

1. Does the insurer have a duty to defend claims as well as pay losses?
2. Who chooses counsel and how early can the insurer's consent to choice of counsel be obtained?
3. Is the insurer obligated to advance litigation expenses as they occur or to pay only after the final resolution of the claim?
4. How should expenses be allocated among the parties?
5. Who has the right to settle claims?
6. In the event of a dispute between the insured and insurer on coverage, how is that dispute resolved?

We will discuss each of these issues in turn.

1. The Duty to Defend

The duty to defend litigation against an insured is said to be a matter of contract -- either such a duty has been bargained for by the parties, or it has not, and courts generally have not found such an obligation in the absence of an express policy provision.1 It might be assumed that insureds would prefer a duty to defend policy since that duty, if it exists, is comprehensive -- it has been held that an insurer with a duty to defend must take on the defense of all counts of any lawsuit that contains a single count falling within the duty to defend.2 The duty to defend applies

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to the defense of claims that are patently without merit, and includes any appeals. However, corporations historically have taken a different view when it is their own directors and officers who are sued, since the directors and officers are personally liable for damages caused by their breaches of fiduciary duty. In such cases, corporations and their directors and officers who are subject to the lawsuit desire to control the litigation themselves, especially with respect to choice of counsel and settlement decisions, and such control is generally not an option in a duty to defend policy form. In response, directors’ and officers’ insurance policies historically have been written without duty to defend provisions. Of course, turning the defense of a claim over to the policy holder does not mean that the insurer will relinquish all rights in connection with the defense of the claim. This is especially true since some judicial decisions and the terms of modern D&O policies often compel the insurer to advance defense costs for some or all claims.

As further discussed in Section 10.11, the assumption that D&O insurance should not place the insurer under a duty to defend recently has been reexamined by the insurance industry and policy holders alike, especially in light of the difficulty that some small, privately held companies have in mustering the resources and know-how to provide an effective defense. Some recent D&O insurance policies designed for such companies have reverted to a duty to defend format. Other insurers have ventured to leave the choice of defense up to the private company by giving the policy holder the option to elect a duty to defend or non-duty to defend format on a claim by claim basis.

It is important to note that, unlike general liability insurance policies, D&O policies provide that defense expenses count against the policy’s general limit of liability, and that retentions apply to such expenses.

2. Choice of Counsel


5 See, e.g., Chubb 1992 Policy Form ¶11.

6 See §10.06(3) infra.

7 National Union Private Company Policy Form.

8 ‘Defense Expenses shall be part of and not in addition to the Limit of Liability as shown under ITEM 3 of the Declarations, and Defense Expenses shall reduce such Limit of Liability.’ Aetna Designated Persons Policy Form IV.(B)(5). ‘Defense costs are not payable by the insurer in addition to the limit of liability. Defense costs are part of Loss and as such are subject to the limit of liability of Loss.’ National Union 1988 Policy Form ¶5.
While D&O policies generally disclaim a duty to defend, they do require that defense costs be reasonable and that the insurer consent to them. As a practical matter, this means that the insurer will be involved in, and must consent to, choice of counsel to defend the claim against the insureds. Until recently, insurers were quite reluctant to approve choice of counsel in advance. While the lack of discussion on choice of counsel at the time of the negotiation of a policy avoided a potentially contentious issue, it tended only to delay the day of reckoning. Worse, it forced an important issue to be raised at the time of the claim when deadlines are tight and emotions may run high.

A D&O insurer will likely agree to the insureds’ choice of counsel if such counsel is free from conflicts and generally regarded as highly qualified with respect to the type of claim made against the insureds. Questions of reasonableness may arise if individual insureds desire separate counsel or if the corporation desires counsel separate from the directors and officers, unless, as discussed below, conflicts of interest make such representation necessary or desirable.

Closely aligned with the choice of counsel issue is the issue of the reasonableness of specific defense tactics and expenses. D&O policies generally provide that only those charges, costs, expenses and settlements reasonably consented to by the insurer will be considered losses under the policy and that defense costs be “reasonable and necessary.” Although, as a legal matter, whether an insurer can ever unreasonably withhold consent is debatable, the provision does bring the insureds and the insurer into a dialogue in the beginning of the litigation, with hopes of arriving at a joint defense plan. Some of the concerns with which an insurer might approach the issue of defense costs will include: degree of expertise represented by defense counsel, control of unreasonable or unnecessary costs, limitation of the insurer’s liability under the policy, and avoidance of conflict of interest that could expose the insurer to liability for bad faith. If the policy is not advancing defense costs during the pendency of a claim, this dispute may not emerge until the bill, many years after the commencement of the litigation, is presented by the corporation to the insurance company for reimbursement.

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9 See, e.g., Aetna 1995 Policy Form ¶ II(D) and IV(B)(1).
10 See, e.g., Chubb 1992 Policy Form at ¶ 18 (requiring that Defense Costs be reasonably incurred).
12 See, e.g., Aetna 1995 Policy Form at ¶ II(D) and IV(B)(1).
10a See e.g. National Union 1988 Policy Form at definition (d).
13 One commentator has called this requirement “virtually meaningless,” noting that such approval may not, under the terms of the policy, unreasonably be withheld. See Howard, “Apportioning an Insurer’s Liability Between Covered and Noncovered Parties and Claims,” 38 Fed’n of Ins. & Corp. Counsel Q. 317 (1988).
14 Such problems may arise, for example, in the perceived disparate treatment by the insurer of different insureds under the policy, agreement to unfair partial settlements to the disadvantage of other beneficiaries, or the failure to preserve the benefits of the policy for claimants.
Given the importance of choice of counsel and the possibility of disputes over legal bills, it is often advisable to attempt to reach an agreement with the insurer even prior to incurring a claim. Some of the larger D&O insurers now make this approach standard for certain types of claims by attaching at the time of policy inception a list of law firms that both the insureds and the insurers have agreed to use in the ordinary course to defend such claims made during the policy period.\footnote{Thus, for example, the 1995 National Union Policy Form, which provides direct coverage for securities law liabilities of the corporation, requires that the insureds select defense counsel for such securities claims from a list pre-authorized by the insurer, but gives the insurer discretion to waive the requirement in part or in whole. See 1995 National Union Policy Form ¶ 9.}

In cases of multiple defendants, cost of legal counsel becomes a even more delicate issue for insurers. On the one hand, concern over cost would dictate that, whenever possible, there be a joint defense of all insureds, especially in light of directors’ natural interest in obtaining the best available defense. On the other hand, particularly prior to the advent of Entity Coverage,\footnote{See discussion of Entity Coverage for Securities Claims, infra at 10.09.} separate legal representation might make the allocation of costs between covered directors and officers and the uncovered corporation easier. In addition, if there are any apparent distinctions between the various defendants as to potential culpability, then separate representation probably will be necessary. As a practical matter, many insureds as well as their insurers may suggest under some circumstances that separate counsel be engaged to represent those insured defendants who are felt to have a higher degree of potential liability or a different level of involvement in the facts of the complaint, as is sometimes the case with inside as opposed to outside directors. If all defendants are jointly represented in circumstances where the insurer believes one particular defendant might be found liable for dishonesty or another excluded act, the insurer, like any other person paying legal bills, may request that itemized statements for legal services be provided, distinguishing among the costs incurred on behalf of the various parties represented.\footnote{See Howard, 38 Fed’n of Ins. & Corp. Counsel Q. at 334.}

Where both insured and uninsured parties (e.g., directors and officers on the one hand and the corporation on the other in policies that do not provide Entity Coverage) are jointly represented, and the policy either requires that defense costs be advanced, or the insurer has opted to do so, the insured often will insist on an interim allocation agreement, which sets forth, usually on the basis of a mathematical formula, the percentage of litigation expenses which the insurer is willing to advance, subject to an eventual reconciliation of amounts on the basis of a final judgment.\footnote{In the event that the parties agree to such an interim allocation, it may be important for both parties to establish for the record that they are not thereby waiving their rights to a different allocation when the facts as to the claims have been established at the conclusion of the litigation.} One powerful argument for the Entity Coverage discussed below in section 10.09 is that providing coverage for the corporation in the event of certain claims brought against both the
corporation and its directors and officers substantially defuses this issue, as respects claims covered by the Entity Coverage provisions.

An insured should expect at the time a claim is submitted to receive a letter from the insurer outlining, in general terms, the extent and limitations on coverage including possible application of exclusions under the insureds’ policy. While such a “reservation of rights” letter can be extremely irritating to the insured, if the original policy properly was understood by the insureds, the letter should contain few surprises. Nonetheless, it should promptly and carefully be reviewed by the insured’s legal counsel. For example, discussed in Section 10.06(5)(A), exclusions relating to allegations of dishonesty, personal profiting or other excluded conduct should be triggered only upon a final adjudication or other “in fact” findings of such conduct and, thus, coverage should be available for defending such allegations subject to the requirement of reimbursing the insurer in the event such allegations prove to be truthful.

Most insurance carriers keep an eye on their obligations arising from the policy, as well as the limitations of coverage incorporated into the policy, by hiring the services of a "monitoring counsel." Monitoring counsel will review the defense arrangements and generally represent the insurer in its dealing with defendants and their counsel. In addition, however, monitoring counsel also can provide assistance in defending plaintiff’s allegations. What may be the insured company’s first D&O claim is certainly not the first claim for the insurer or its counsel. A primary goal of reputable insurers is to maintain a productive business relationship with policy holders, and the insurer and its monitoring counsel often can provide assistance to insureds and their lawyers.18 Because of the value a D&O insurer can bring to the successful resolution of a claim as well as the insurer’s practical need to monitor the defense of any claim that could result in a loss payment, most policies contain language granting the insurer certain rights of association in the claim and obligating the insureds to provide certain cooperation. A typical provision reads as follows:

The Insurer shall have the right to effectively associate with the Company and the Insureds in the defense and settlement of any claim that appears reasonably likely to involve the Insurer, including but not limited to effectively associating in the negotiation of a settlement. The Insureds shall defend and contest any such claim. The Company and the Insureds shall give the Insurer full cooperation and such information as it may reasonably require.19

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18 As discussed in §10.04 and N.5 thereof, an insurer’s business attitude and expertise in claims, are important factors to be considered in evaluating D&O insurers.

3. The Duty to Advance Expenses

The existence or nonexistence of a contractual duty to defend has proven to be irrelevant\textsuperscript{20} to the issue of central interest to D&O policy holders, which is, does the policy require payment of defense expenses as incurred? During the course of protracted litigation, attorney fees may build to gigantic levels, creating stress on the individual insureds and a strain on the good conscience of any company that has decided to advance defense expenses pursuant to an existing indemnification agreement. Yet, from the insurers’ perspective, D&O policies historically have been considered “duty to pay” rather than “duty to defend” policies, as discussed above.\textsuperscript{21} The lower premium paid for such policies presumably in part reflected the fact that insurers had no obligation to pay expenses associated with a claim until the final resolution.\textsuperscript{22}

During the late 1980s and early 1990s, however, insurers began to realize that compelling individual directors and officers to pay their own defense costs up front was not the same thing as requiring a corporation to pay the director’s and officer’s defense costs as a part of its corporate indemnification obligations. The claims departments of most insurers concluded that it was in the insurers’ best interest to advance defense costs to individual directors and officers when failure to do so meant that the director and officer could not afford to mount a competent defense. Eventually, this practical consideration led to policy provisions that gave the insurer the option to advance defense costs. This option, of course, did the individual director or officer little good when the insurer, for whatever reason, decided not to exercise it.

In 1985, such a provision giving the insurer the option to advance defense costs was the subject of a decision by the United States District Court for the District of Hawaii, \textit{Okada v. MGIC Indem. Corp.},\textsuperscript{23} which, to the surprise of the insurance industry, granted summary judgment for the insureds on the issue of their entitlement to advancement of expenses. The court held that: the lack of a duty to defend under the policy did not mean that the insurer did not have a duty to pay defense costs as incurred, and the existence of an express clause giving the insurer the option to advance defense costs did not preclude the existence of an outright obligation to pay expenses as incurred. In support of its position, the court reasoned that the definition of “losses” — amounts that the insureds were “legally obligated to pay” — included

\textsuperscript{22} See, e.g., the Aetna Designated Persons Policy Form ¶ IV.(C)(2), providing that, in the event that the insurer consented to the defense costs incurred by the insureds, “[t]he Underwriter shall be required to reimburse Defense Expenses covered under this Policy only on the final disposition of the Claim from which the Defense Expenses resulted.”
legal fees. Therefore, the use of “expenses” in the clause giving the insurer the option to advance made the policy ambiguous and liable to be construed against the insurer; thus, in the court’s view, “[a] directors’ and officers’ policy which did not provide, in the event of suit, for payment of the insureds’ attorney fees until final judgment when such suits can last for years and cost astronomical sums to defend would be virtually impossible to sell to reasonable officers and directors, for it would not truly protect the insured from financial harm caused by suits against them.”

On appeal by the insurer, the United States Court of Appeals for the Ninth Circuit affirmed the lower court holding with respect to the insurers’ duty to pay contemporaneous expenses that, because the policy promised to pay “any amounts which the Directors and Officers are legally obligated to pay . . . for a claim or claims made against the Directors and Officers for Wrongful Acts,” the insureds had a reasonable expectation that they would not have to expend their own funds. Since Okada, a number of courts have held that defense expenses must be advanced as incurred. However, probably a greater number have held that, absent a contractual provision requiring advances, the insurer has no obligation to pay litigation expenses until the conclusion of the action, suit, or proceeding. In response to the Okada decision and its progeny, many insurers clarified provisions in their policy forms either to state expressly that the insurer had no obligation to advance defense costs, or to more clearly provide that advancement of defense costs was at the option of the insured. Other insurers sensed that the reasoning of the Okada decision, if not its holding, accurately reflected the expectations and needs of individual directors and officers. Accordingly, some policies began to provide for automatic advancement of defense

[Footnote continued from previous page]


24 Okada, 608 F Supp at 387.

25 823 F2d at 278, 281.


costs to individual directors and officers when their corporation could not legally advance those costs. Typical of such policy provisions is the following:

Under Coverage A, except as hereinafter stated, the Insurer shall advance Defense Costs prior to the final disposition of the claim, unless such Defense Costs have been advanced by the Company ... Notwithstanding the foregoing, if the Company is required or permitted to advance such Defense Costs in accordance with the fullest application of law, common or statutory, or contract, or the Charter or By-laws of the Company, then the Insurer assumes no duty to advance Defense Costs prior to the final disposition of the claim ... 28.

Some recent policy forms have gone one step further by granting advancement of defense costs under both the individual and corporate reimbursement sides of the policy and regardless of whether such advancement is being made or can be made by the corporation. A typical example of such a provision, which also includes advancement of defense costs for direct securities claims against corporations, 29 is as follows:

Under both Coverage A and Coverage B of this policy, except as hereinafter stated, the Insurer shall advance, at the written request of the Insured, Defense Costs prior to the final disposition of a Claim. Such advance payments by the Insurer shall be repaid to the Insurer by the Insureds or the Company severally according to their respective interests, in the event and to the extent that the Insureds or the Company shall not be entitled under the terms and conditions of this policy to payment of such Loss. 30

4. Allocation

Unless specifically provided, D&O insurance does not insure against loss resulting from the corporation’s own liability, as opposed to that of the directors and officers. While a D&O policy typically reimburses the corporation for amounts it has paid in indemnification of the directors and officers with respect to covered claims, such policies generally will not cover damages, defense costs or settlement amounts to the extent these losses are attributable to the conduct or fault of the corporation.

29 See ¶10.09 for a fuller discussion of Entity Coverage.
30 National Union 1995 Policy Form ¶ 8.
This limitation of D&O coverage can leave corporations that rely on D&O policies alone with significant exposures in certain complex litigation, such as securities class actions. Such litigation usually involves claims against both the corporation and individual officers and directors. Allocation of the losses among the company and the individual defendants for purposes of coverage can become a difficult and high stakes exercise for both the corporation and the insurer, particularly when, as is usually the case, some or all defendants choose to settle prior to any findings of liability.

According to Watson Wyatt, the average negotiated apportionment or allocation, as it is better known, among the corporation and the individual directors and officers results in a 40% allocation to the corporation. Not surprisingly, efforts to arrive at a “fair and proper” allocation can dismays corporate policy holders, who may believe that they were covered for more than the 50 or 60% that the insurance company initially may offer to pay. Nevertheless, allocation among the corporation and the individual directors and officers is a natural consequence of the limitation of the definition of “insured” in a D&O insurance policy. It forms a central part of the premium calculation made by the insurer and is an established practice in the industry and, as a general matter, one recognized by the courts.

Thus, in the typical case, the question for the insurer and its policy holder is not whether an allocation must be made between the corporation and its directors and officers in a policy that does not grant Entity Coverage, but rather how the allocation will be made. While broadly supporting the idea of allocation, the courts have not reduced the percentage of appropriate allocation to an exact mathematical formula. One of the first and certainly one of the best known decisions to address the allocation issue between directors and officers and the corporation was PepsiCo, Inc. v. Continental Casualty Co. The PepsiCo court held that each party should be allocated loss in accordance with its relative exposure to the loss.

A year earlier than PepsiCo, however, another court, dealing only with the allocation of defense costs, as opposed to settlement amounts, took the approach that, where the defense of the corporation was "reasonably related" to the defense of the individual insureds, all of the costs should be allocated to the insurance policy, since the defense of each of the parties benefited the defense of the others. Thus ensued the battle between the “reasonable relationship” test and...

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31 Wyatt 1995 survey at 47, Exhibit 9.
34 640 F Supp 656 (SDNY 1986).
the “relative exposure” test with respect to the issue of defense costs, with each side being able to cite at least one case supporting its position.\textsuperscript{37} Over time, the reasonable relationship test became fairly popular with respect to defense costs; however, with respect to the usually larger losses arising out of settlements, the “relative exposure” test became fairly well accepted.\textsuperscript{38}

In the 1990s courts began to wrestle with the relative exposure test even with respect to settlements. The first major departure from history occurred in \textit{Nodaway Valley Bank v. Continental Cas. Co.},\textsuperscript{39} when the Eighth Circuit, while technically looking at the “relative exposure of the parties” in determining the allocation of a settlement, determined that an allocation to the corporation based upon its vicarious liability for the acts of the insured directors and officers would frustrate the insureds’ reasonable expectations of coverage:

Merely derivative corporate liability should not cause an apportionment between the primary wrongdoer and a vicarious wrongdoer, where both are joined in litigation. [This] conclusion would not expand the insurance policy to unfairly create corporate coverage; it simply gives full effect to the D&O coverage.\textsuperscript{40}

Not all courts agreed with this derivative liability theory. In \textit{First Fidelity Bankcorp. v. National Union Fire Ins. Co. of Pittsburgh, PA.},\textsuperscript{41} the court concluded:

[Both] the directors and officers as well as the corporate entity faced liability in the underlying litigation. The mere fact that liability arises exclusively from the conduct of the insured . . . does not provide a basis for the insurer to be responsible for the liability of those who are uninsured . . . . In this instance, First Fidelity would contend that the D&O insurer should pay the damages on behalf of the issuing corporation, who is not insured under the policy. Such a result would be contrary to the purposes of the parties’ intent under the policy.\textsuperscript{42}


\textsuperscript{38} An example of a court that used both these tests is \textit{Federal Realty Investment Trust v. Pacific Ins. Co.}, 760 F. Supp. at 538 n.3, which held that as respects settlement, the allocation rule of “relative exposure” should be used, while as respects allocation of defense costs, the “reasonable relationship” standard is appropriate.

\textsuperscript{39} 916 F2d 1362, 1367 (CA8 1990), aff'd, 916 F2d 1362 (CA8 1990).


\textsuperscript{42} \textit{First Fidelity}, 1994 WL 111363 at 12 (footnote omitted).
Some recent cases dealing with the allocation of settlement payments have totally rejected the relative exposure test in favor of the so-called "larger settlement rule." According to this rule, allocation of losses to the corporation is allowed only to the extent that conduct of uninsured third parties is shown to have increased the amount of the settlement independent of the actions of the directors and officers. This rule was expressed in the leading case of Nordstrom, Inc. v. Chubb & Son, Inc. as follows:

[A D&O insurer is] responsible for any amount of liability that is attributable in any way to the wrongful acts or omissions of the directors and officers, regardless of whether the corporation could be found concurrently liable on any given claim under an independent theory. . . . Accordingly, [the court] will allocate only if there is some amount of corporate liability that is both independent of and not duplicated by liability against directors and officers.

After Nordstrom, the Seventh Circuit reiterated its adoption of the larger settlement rule as originally set forth in the Harbor decision in Caterpillar, Inc. v. Great American Insurance Co. In Caterpillar, the court emphasized that the policy indicated it would cover "all Loss which the Directors or Officers shall be legally obligated to pay" on account of "any claim for a Wrongful Act." The court was careful to indicate that it was interpreting a particular insurance contract and deciding what method of allocation, if any, that contract envisioned.

While these cases suggest that the policy holder may receive a more favorable interpretation of coverage in some courts than under the policy, the costs of litigating, rather than negotiating, coverage disputes is high and the results ultimately uncertain. In litigation with the insurer, the corporate policy holder generally will find an adversary that is knowledgeable about

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43 Note, however, that efforts by insurers to allocate part of a settlement to persons, such as the corporation's accountants, who were not named defendants, have been rejected by courts as tantamount to reopening the case to consider claims that did not play a part in the settlement. See Raychem Corp. v. Federal Ins. Co., No. C-91-200850-RMW, slip op. at 25-26 (ND Cal Nov. 29, 1993); Caterpillar Inc. v. Great American Ins. Co., 864 F Supp 849, 855-57 (CD Ill 1994), aff'd, 62 F3d 955 (CA7 1995).


45 54 F3d 1424 (CA9 1995). See also Safeway Stores, Inc. v. National Union Fire Insurance Co. of Pittsburgh, Pa., 64 F.3d 1282 (9th Cir. 1995).

46 Nordstrom, 54 F3d at 1433 (citations omitted).


48 62 F3d 955 (CA7 1995).

49 Id. at 962 (emphasis added).

50 Id. at 961.
the company's financial health, knows all the prior claims or wrongful conduct against the company, and conducts insurance litigation as part of its daily business.

Moreover, litigation over D&O coverage often comes at an awkward time, when the policy holder is already slugging it out with the plaintiffs over the very same issues in the underlying litigation or attempting to maintain the equilibrium on a proposed settlement. Because allocation issues often arise on the onset of complex litigation, the coverage dispute, with the attendant dangers of collateral estoppel, may be fought out in advance of related cases that await trial on the same issues. Especially when the underlying litigation is still active, squabbles among the defendants and their insurance carriers over the allocation of liability among the corporation and its directors and officers must encourage the plaintiffs in the underlying litigation. As is any good litigator, plaintiffs' attorneys are adept at the art of "divide and conquer." As a result of the difficulties described above, policy holders and insureds both are looking to address the allocation issue through modifications of the D&O insurance contract.

Historically, the D&O insurance policy has either not addressed the issue of allocation at all, assuming that it was implied as a result of the definition of insured, or simply has stated that "both the insured and the insurer shall use their best efforts to determine a fair and proper allocation of the amounts as between the company and insureds and the insurer." More recently, however, policies have sought further to define the allocation process by one of three methods:

1. Use of an allocation formula;
2. Agreement on a pre-set allocation percentage amount; or
3. Providing coverage to the corporation as an insured.

Each of the above approaches has its advantages and disadvantages. The first example, the allocation formula, inserts into the policy a provision stating the particular rule -- for instance, the relative exposure test described above -- by which allocation between the D&Os and the corporation shall be made. The advantage of this approach is that it creates maximum flexibility, allowing the parties to allocate depending upon the facts of the case. However, this flexibility

51 National Union 1988 policy form at clause 9.
52 "[With respect to non-securities claims, the] company and the directors or officers and the insurer agree to use their best efforts to determine a fair and proper allocation of the amounts as between the company and the directors or officers and the insurer taking into account the relative legal and financial exposures, and the relative benefits obtained by, the directors and officers and the company." National Union 1995 policy form at clause 8.
53 See, e.g., Chubb endorsement form 14-72 Ed. 12/22/95.
54 National Union 1995 Policy Form.
also creates uncertainty as to whether the parties can agree upon the proper application of the formula to the facts of the claim.

Method two -- agreement on a set allocation percentage -- has the advantage of greater certainty. Of course, whatever percentage is agreed upon might end up being either too high or too low as compared with the theoretical “proper” allocation for the facts of the case. Nevertheless, it can be argued successfully that such uncertainty is true of insurance in general, which always deals with each party’s estimate of how much coverage is underwritable by the insurer, affordable for the insured and desirable for both. In any insurance buying decision, an insured might discover, based on its actual claims experience that, in retrospect, it purchased too little or too much insurance.

Method three, as further discussed in detail in section 10.09, has the certainty benefits of method two, but also has other advantages. When looked at from the viewpoint of a litigation manager, a standard D&O policy may seem somewhat perverse -- on the one hand, the policy is designed to protect the interests of the individual directors and officers; on the other hand, the presence of coverage can make the dismissal of those very directors and officers from a claim more difficult. In a securities claim, both the corporation and its directors and officers are often named defendants. In many cases, the directors and officers may have valid independent defenses that theoretically could result in their dismissal. Yet, if litigation defense counsel seeks to dismiss the directors and officers, he does so at the risk of losing the benefits of the insurance policy for the joint defense effort. Plaintiffs' attorneys know this as well and presumably make every effort to ensure that the directors and officers are kept in the case. It is this litigation management conflict that has led some insurers to forego a pre-set allocation approach and instead simply add the entity as an insured under the D&O policy, as discussed in section 10.09 of this work.

a. Settlement Issues

As discussed in section 10.07[2], modern D&O policies attempt to create a partnership between the insured and the insurer in the defense of the claim. Never does the value of this partnership evidence itself more strongly than at the time of settlement. D&O policies generally provide that the insureds may not settle claims against them without the insureds’ consent, although such consent will not unreasonably be withheld. D&O policies allow the insureds to

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55 See, e.g., Section 11, Securities Act of 1933, 15 USCA §77k(n)(1) (1996) (providing a "due diligence" defense for directors and certain officers signing a registration statement); see also First Fidelity Bancorp, 1994 WL 111363 (ED Pa Mar. 30, 1994). Also see 10.10 infra. for unique defenses available to individual defendants under the Private Securities Reform Act of 1995.

56 See, e.g., 1988 National Union Form ¶ 9.
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conduct their own defense, but obligate the insurer to pay the bills, including the costs of a judgment or settlement. Permitting the defendants to settle without the insurer's consent would not only obligate the insurer, perhaps, to pay an unnecessarily large settlement, but might encourage the parties to attempt to structure the settlement in a way that unreasonably would disadvantage the insurer. A recent Ninth Circuit opinion57 strongly hinted that the insureds and attorneys for the plaintiffs might have done exactly this:

A presumption that the parties have reasonably allocated a settlement amount... should be reserved for a settlement by parties with truly adverse interests in the allocation. Where the parties have purported to settle an imaginary dispute over allocation, that allocation should be given no special treatment in an indemnity action. [citation omitted]. This is exactly our case. Slottow [the defendant director/officer and his co-defendant, the bank holding the D&O policy] didn't have adverse interests; on the contrary, each had a strong incentive to structure the settlement precisely as it did. The bank... knew it could avoid costly liability and public ignominy by allocating 0% of the liability to itself and 96% to Slottow. And the bank knew it could indemnify Slottow -- who also sat on the bank's Board -- while being fully reimbursed by American [Casualty Company of Reading, Pa.] under the terms of the policy. Slottow and the bank thus crafted a win-win solution for themselves, with the insurance company footing the bill. Far from deferring to allocations such as these, we view them with considerable suspicion because of the risk that liability may have been allocated for strategic reasons, as almost certainly happened here.58

Plaintiffs naturally have an interest not only in achieving settlement, but in collecting the amounts due thereunder. Thus, the requirement of the insurers' consent may keep the insurers' "deep pocket" and "ready money" from being traded by the defendants for a dismissal of claims, or the uncovered allegations or losses. For these reasons, courts at times have excused the insurers from reimbursing insureds for settlements obtained without the carrier's consent, even when the insureds had kept the insurer informed of the claim, the progress of negotiations, and the decision to settle, and even in instances when the insurer might have given its consent if asked.59

57 Slottow v. American Cas. Co. of Reading, Pa., 10 F.3d 1355 (CA9 1993).
58 Id. at 1359.
Given the practical importance of determining who pays how much in the settlement process, settlement agreements often contain provisions allocating settlement proceeds among the various parties or claims, thus establishing a record of the allocation and heading off future quarrels between the insurers and their policy holders over the amounts of recovery under the policy. At least one court has held, however, that an insurer may not withhold its consent even if the insureds refuse to cooperate in this type of approach in circumstances where there is a great risk that such refusal will lead to a plaintiff recovery beyond policy limits so that the most reasonable manner of disposing of the claim is a settlement within those limits. In these circumstance, the failure to accept such a settlement may result in insurers’ being held to have violated its implied covenant of good faith and fair dealing and thus be liable for the amount in excess of the aborted settlement that the defendants must later pay by judgment or subsequent settlement. For this reason, an insurer may consent to the form of the settlement agreement, but reserve its rights under the policy with respect to the amounts actually payable. Nevertheless, this is a dangerous course of action for most insured corporations who, as a result of their own desire to know their net liability after recovery of insurance proceeds, should be willing to reach an agreed upon allocation of the settlement payments with the insurers, who also desire finality as to their ultimate liability, as part of a joint decision to make a settlement offer. Then, if the settlement offer is accepted, each party knows its own net liability without further haggling.

Interestingly enough, the issue of settlement without an insurer’s consent has a flip side. Some insurers concerned about the problem of never-ending defense costs have inserted what is known in the insurance industry as a “hammer” clause seeking to limit their liability in cases where the insured refuses to consent to a claim that the insurer believes it can settle. A typical provision reads as follows:

The Insurer may make any settlement of any Claim it deems expedient with respect to any Insured subject to such Insured’s written consent. If any Insured withholds consent to such settlement, the Insurer’s liability for all Loss on account of such Claim shall not exceed the amount for which the Insurer could have

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60 "The insurer, in deciding whether a claim should be compromised, must take into account the interest of the insured and give it at least as much consideration as it does to its own interest. When there is great risk of a recovery beyond the policy limits so that the most reasonable manner of disposing of the claim is a settlement which can be made within those limits, a consideration in good faith of the insured’s interest requires the insurer to settle the claim. Its unwarranted refusal to do so constitutes a breach of the implied covenant of good faith and fair dealing.” Commale v. Traders & Gen. Ins. Co., 50 Cal. 2d 654, 659, 328 P.2d 198, 201 (1958). See also Crisc v. Security Ins. Co., 66 Cal. 2d 425, 431, 58 Cal. Rptr. 13, 426 P.2d 173 (1967) (“An insurer should not be permitted to further its own interests by rejecting opportunities to settle within the policy limits unless it is also willing to absorb losses which may result from its failure to settle.”); National Union Fire Ins. Co. v. Continental Illinois Corp., 658 F. Supp. 775, aff’d, 673 F. Supp. 267 (N.D. Ill. 1987).

settled such Claim plus Defense Costs incurred as of the date such settlement was proposed in writing by the Insurer.\textsuperscript{62}

While a provision such as this might be understandable from the insurer’s point of view, it has, not surprisingly, met with a great deal of resistance from the community of insureds. Indeed, one insurer that had included such a provision in its standard policy recently deleted it by means of an endorsement making various enhanced coverage changes to its policy form.\textsuperscript{63}

A different and more perplexing problem may occur under D&O policies when plaintiffs propose to settle with certain of the defendant directors and officers and the amount of such settlements would exhaust or substantially deplete the amount of coverage available under the policies. This may be a particular danger when there are multiple plaintiffs employing separate counsel. No consistent viewpoint has emerged from the courts as to any duty of insurers to consent to settlement in these circumstances. For example, with respect to the somewhat analogous issue presented by multiple third-party claims against the same defendant, some cases would suggest that an insurer in control of litigation may not safely refuse to settle with certain claimants in an effort to achieve a more comprehensive settlement.\textsuperscript{64} Other cases seem to stand for the proposition that efforts to achieve a prorated, comprehensive settlement with respect to

\textsuperscript{62} National Union 1995 Policy Form. A more subtle but possibly as effective form of hammer clause might state. "[I]n the event of a Claim, the Insureds will do nothing that may prejudice the Company’s position of its potential or actual rights of recovery." See, e.g., Aetna 1992 Policy Form. Presumably, an insured’s failing to consent to a settlement might be considered a violation of this clause.

\textsuperscript{63} See National Union Securities Plus endorsement form.

multiple claims may, depending on the circumstances, excuse the insurer's reluctance to settle with less than all the claimants. In one decision dealing squarely (albeit in the context of a duty to defend policy) with the issue of settling claims to the policy limits against less than all of the insured defendants, the New York Supreme Court, Appellate Division has stated that it is bad faith for an insurer to choose to pay claims against certain policy holders up to the limits of liability and leave other insureds completely exposed. The most viable alternatives open to the insurer in this situation may be either negotiation with the plaintiffs and defendants to achieve a comprehensive settlement, proration of claims, or the filing of an interpleader action (though the costs to the insured parties of a decision to interplead must be considered carefully).

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10.08 DISCOVERY, CHANGE OF CONTROL AND CANCELLATION

Discovery, or the extended reporting provision as it is sometimes known, change in control provisions and the cancellation provisions of a D&O policy all relate to a discontinuation of coverage due to an external event. It is therefore appropriate to discuss them together.

1. Discovery or Extended Reporting

As discussed above, D&O insurance policies are claims-made policies. In order to trigger coverage, the claim must be made against the insureds during the policy period.\(^1\) One of the greatest fears of those insured under a claims made policy is that the insurer, sensing that a claim soon may be made against an insured, will refuse to renew, or, even worse, cancel the policy before the claim can be made, thus robbing the insureds of their reasonable expectation of coverage. Drafters of D&O policies, long aware of this problem, have inserted a number of provisions in the policy to eliminate, or at least greatly reduce, the possibility of this harm.

One such provision already has been discussed. Under most D&O policies, the insureds need not wait until the actual claim is made against them before reporting the problem to the insurance carrier. D&O policies generally permit the advance reporting of facts and circumstances that they reasonably believe might lead to a claim.\(^2\) The reporting of such circumstances according to the requirements of the policy may anchor coverage and require that any claim arising from the reported circumstances subsequent to the policy period will be deemed to be reported during the policy period, even if the insurer has, in the meantime, canceled or failed to renew the policy. As previously discussed, as a practical matter, this type of notice is used most frequently by insureds when changing carriers or when notified by the incumbent carrier that renewal coverage will be renewed only at a drastically reduced level or a greatly increased premium.

The second major tool in the insureds’ arsenal against unwanted cancellations or nonrenewals by the carrier is the ability to elect “discovery” or an extended reporting period. In its most common form, the right to discovery permits the insured, upon a cancellation or nonrenewal by the insurer, to elect an additional fixed period of time, usually from 90 days to one

1 See §10.06[1].
2 See §10.06[6].
year, to report claims alleging wrongful acts that occurred prior to the end of the policy period.\textsuperscript{3} Thus, if an insurance carrier, sensing that a claim is about to be made against an insured, suddenly cancels or fails to renew the policy, the insureds may, for a fixed percentage set forth in the policy (most commonly 75\% additional premium for a one-year discovery period),\textsuperscript{4} insure that if the claim is made months after the end of the policy period, coverage still will be triggered. Of course, the D\&O policy typically will provide that the limit of liability for claims reported during the discovery period is part of and not in addition to the limit of liability for claims reported during the policy period.\textsuperscript{5}

While the discovery clause originally was designed to eliminate harm arising out of a sudden cancellation or nonrenewal by the insurer, insureds frequently have requested that discovery be available no matter who cancels or refuses to renew. There are a number of practical reasons for such a request. First, D\&O policies typically provide that a renewal on different terms or for a higher premium will not constitute a "nonrenewal" for the purposes of electing discovery.\textsuperscript{6} Policies of this nature understandably will prompt insureds to worry that an insurer can effectively eliminate their right to discovery simply by quoting outrageous terms and renewals. A simple way around this problem would be to request the insurer to amend the discovery provision to permit the election of discovery no matter who cancels or refuses to renew. Thus, if the insurer quotes different terms on renewal that are unacceptable to the insured, the insureds can refuse to renew and elect discovery.

A number of states already have reached this conclusion and mandated, as a matter of their state insurance law, that D\&O policies permit election of a discovery period, no matter who cancels or refuses to renew.\textsuperscript{7}

Perhaps as another sign of the times, the most recent D\&O policies have been drafted to permit the election of discovery no matter who cancels or refuses to renew. A common example of this "bilateral" discovery provision is as follows:

Except as indicated below, if the Insurer or the Named Corporation shall cancel or refuse to renew this policy, the Named Corporation shall have the right, upon payment of an additional premium of 75\% of the "full annual premium," to a period of one year following the effective date of such cancellation or nonrenewal

\textsuperscript{3} See, e.g., Chubb 1992 Policy Form ¶4; Executive Risk 1995 Policy Form ¶(IV)(H); National Union 1995 Policy Form ¶10.

\textsuperscript{4} Id.

\textsuperscript{5} See, e.g., The Power ¶IV(A)(1).

\textsuperscript{6} See, e.g., Chubb 1992 Policy Form. Also see §10.08(3)(C) infra.

\textsuperscript{7} See, e.g., New York Code of Rules and Regulations, Title 11, Insurance Department, §73.3 - Terms and Conditions of Claims-made Policies, 11 NYCRR §73.3 (1995).
(herein referred to as the Discovery Period) in which to give to the insurer written notice of Claims first made against the Insureds during said one-year policy for any Wrongful Act occurring prior to the end of the Policy Period and otherwise covered by this policy.\(^8\)

A special mention should be made of the interaction between discovery and the change of control or bankruptcy of the insured corporation. In such cases, it is routine for the merger or acquisition agreement or plan of reorganization to require that the “surviving corporation” indemnify the directors and officers of the target corporation or bankrupt corporation, as the case may be, for acts that occurred prior to the acquisition or bankruptcy. Such provisions also usually require, logically enough, the purchase of a directors' and officers' insurance policy with terms no less favorable than those of the policy in existence at the time of the acquisition or bankruptcy. Such provisions generally have their origin in the fears of incumbent directors and officers that, once the reins of the corporation are handed over to a new group of individuals, indemnification, regardless of how mandatory at the time of the acquisition or bankruptcy, may no longer be made available. Typically, the merger agreement or plan of reorganization will mandate purchase of insurance for a period no less than the period provided by the statute of limitations for all possible claims against the directors and officers. For this reason, multi-year discovery periods or “run-off policies” commonly are purchased in 3- or 6-year periods. The premium for such a policy may be and usually is prepaid and the policy usually provides that it cannot be canceled by any of the parties. The policy premium usually is treated as an expense of the acquisition or bankruptcy proceedings.\(^9\)

In the current D&O market, some insurers have included such a “multi-year run-off” period in the basic policy form. One such policy states:

In the event of a Transaction, as defined in Clause 12, the Named Corporation shall have the right, within 30 days of the end of the policy period, to request an offer from the Insurer of a Discovery Period (with respect to Wrongful Acts occurring prior to the effective time of the Transaction) for a period of no less than three years or for such longer or shorter period as the Named Corporation may request. The Insurer shall offer such Discovery Period pursuant to such terms, conditions and premium as the Insurer may reasonably decide. In the event

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\(^8\) National Union 1995 Policy Form ¶ 10.

\(^9\) The tax ramifications of the premium payment may depend upon the facts of their particular case and go beyond the scope of this chapter. As in all instances where there may be tax ramifications, a quality tax professional should be consulted.
of a Transaction, the right to a Discovery Period shall not otherwise exist except
as indicated in this paragraph.\textsuperscript{10}

2. **Change of Control**

Of similar origin are the provisions of D&O policies relating to a change of control of the
corporation. When the corporate policy holder is acquired by another corporation and does not
survive the transaction, the incumbent directors and officers may fear that, once they lose control
of the insured corporation, the acquiring corporation may terminate or refuse to renew their
insurance coverage. In a worst case scenario, the acquiring corporation would cancel the
insurance policy immediately after the acquisition and be entitled to any return premiums due
under the policy.

To guard against this possibility, drafters of D&O policies have inserted certain
protections for the insured officers and directors in the event of a change of control. D&O
policies generally provide that if the insured organization is taken over by either an asset or stock
purchase, the policy cannot be canceled. To prevent the acquiring corporation from accessing the
limit purchased by the target corporation and using those limits to insure the wrongful acts of the
acquirer, D&O policies generally provide that the policy will not insure acts occurring after the
date of acquisition. A typical “change of control” provision is as follows:

If (i) the **Parent Organization** merges into or consolidates with another
organization, or (ii) another organization or person or group of organizations
and/or persons acting in concert acquires securities or voting rights which result in
ownership or voting control by the other organization(s) or person(s) of more than
50\% of the outstanding securities representing the present right to vote for the
election of directors of the **Parent Organization**, coverage under this coverage
section shall continue until termination of this coverage section, but only with
respect to **Claims** for **Wrongful Acts** committed, attempted, or allegedly
committed or attempted, by **Insured Persons** prior to such merger, consolidation
or acquisition. The **Parent Organization** shall give written notice of such
merger, consolidation or acquisition to the **Company** as soon as practical together
with such information as the Company may require.\textsuperscript{11}

\textsuperscript{10} National Union 1995 Policy Form ¶ 10.

\textsuperscript{11} Chubb 1992 Policy Form ¶ 15.
Counsel should be advised to review carefully the change of control provisions of D&O policies. While rarely found in the current era of D&O coverage, some older forms provided that the policy would be canceled at the time of a change of control without coverage of any claims made after that date, even if those claims related to alleged wrongful acts occurring prior to the date of the change in control.

Regardless of whether the policy contains a multi-year run-off provision of the type discussed in the previous section, insureds should be entitled by provisions such as that quoted above to a "run-off" to the end of the policy period following a change of control. Even if the policy does not contain such provisions, corporations undergoing a change of control should inquire of their D&O insurer as to availability of a multi-year run-off period with appropriate credit to be given for whatever remains of the policy period. For example, if a change of control occurs with six months left to the policy period, an insured organization might request a multi-year run-off clause for an additional five and one-half years. This premium may be paid prior to the effective time of the change of control and, once paid, the coverage can be guaranteed and not cancelable.

3. Cancellation or Rescission

a. Cancellation at Discretion of the Parties

D&O policies generally provide that the policy may be canceled upon notice by either party. The right to cancel provides the insurer with an important means of exiting a situation in which the risks underwritten have altered dramatically and for the worse. On the other hand, the right to cancel also may create substantial hardship on policy holders by thwarting their expectation of coverage for which they have paid. In the 1980s, when claims against directors and officers were escalating both in size and number, insurers sometimes canceled policies on the very eve of the events against which the policy holders had intended to be covered. The most celebrated litigation contesting the insurer's right to withdraw from the contract in this fashion was that between Unocal Corporation and its D&O insurer, Harbor Insurance Co. The Harbor policy purchased by Unocal provided coverage in the amount of $20 million for any "wrongful act" of a Unocal officer or director, including "any breach of duty, neglect, error, misstatement, misleading statement, omission or other act done or wrongfully attempted by the directors or

12 See, e.g., National Union 1995 Policy Form § 11.
13 Unocal Corp. v. Superior Court (Harbor Ins. Co.), 244 Cal. Rptr. 540(Cal App 2d Dist. 1988).
officers." The policy contained a fairly standard provision permitting the policy to be canceled at any time by either party, and requiring that, if the insurer canceled, it must first give 60-days written notice. One day after a partnership headed by T. Boone Pickens and Mesa Petroleum publicly announced that it had purchased a significant number of Unocal shares, Harbor mailed a notice to Unocal canceling the policy. It also concurrently offered Unocal a new policy that excluded coverage for losses arising from directors' and officers' attempts to defend against hostile takeovers and increased the deductible by over 3000 percent. Unocal filed an action against Harbor alleging breach of contract, fraud and bad faith, and later, after discovering five other alleged instances in a two-year period in which Harbor had canceled policies after learning of hostile takeover attempts, amended its complaint to allege a RICO cause of action. During the course of discovery, Unocal discovered a telexed message written by Harbor's senior underwriter which stated that Harbor had taken a "groundbreaking stand" on the current wave of merger activity by playing "hard ball" with respect to the increase of retentions and the cancellation of "dozens of accounts" in an effort to protect reinsurers.

In reviewing the decision of the trial court that Unocal's complaint did not allege facts sufficient to constitute a RICO action, the California Court of Appeals for the Second Appellate District held that the covenant of good faith and fair dealing overrode the policy's mutual cancellation clause, so that Harbor might be held liable for concealing its intent to cancel at the first sign of a hostile takeover.

The Unocal action was settled prior to final disposition, and the California Supreme Court ordered that the opinion not be officially published, thus substantially limiting the precedential value of the ruling. Although the case is therefore of limited use as a guide to future decisions, the opinion remains illustrative of how the implied covenant of good faith and fair dealing and other equitable doctrines may be applied to limit the ability of an insurer to cancel. For example, it has been held that insurance companies cannot cancel a policy to avoid liability where the loss has commenced or is imminent, just as a fire insurance company cannot

14 244 Cal Rptr. at 542, 198 Cal. App. 3d at 1259.
15 Id.
16 Id. at 542-43.
17 Id. at 543.
18 "An insurer breaches the implied covenant of good faith and fair dealing when it cancels coverage because of circumstances that were reasonably foreseeable at the policy's inception and the risk of loss has developed to the point where it is unavoidable by the insured." 244 Cal Rptr. at 548; see also PepsiCo Inc. v. Continental Cas. Co., 640 F Supp 656, 664 (SDNY 1986).
19 See Unocal Corp. v. Superior Court of the County of Los Angeles, 1988 Cal. LEXIS No. 135 (Cal June 1, 1988).
cancel fire insurance when it learns that a forest fire is approaching the insured property.\textsuperscript{21} The \textit{Unocal} court distinguished cases offered by the insurer for the proposition that an insurer may cancel a policy when the risk of loss from a hazard has increased, finding that such cases were predicated on facts showing that, while overall risks had increased, there was no imminent or impending danger facing the insured.\textsuperscript{22} Moreover, the court found that Harbor had taken "unconscionable advantage" of Unocal by remaining silent about its intent to cancel and in attempting to coerce Unocal into entering into a less favorable successor policy, banking on the fact that Unocal would not be able to find a replacement policy elsewhere at a reasonable cost.\textsuperscript{23}

Cancellation by the insurer also may be limited by statute. A number of states have insurance codes that restrict the ability of insurers to cancel certain types of coverage.\textsuperscript{24}

b. Cancellation on Bankruptcy of Insured Corporation

Still another limitation on the ability of the insurer to exercise its rights under the cancellation clause may be found in bankruptcy law. The filing of a bankruptcy petition has been held to stay automatically any action by an insurer to cancel a D&O policy, on the theory that the policy is a corporate asset that becomes the property of the estate.\textsuperscript{25} Section 362(a)(3) of the Bankruptcy Code imposes an automatic stay on "any act to obtain possession of property of the estate or of property from the estate or to exercise control over property of the estate."\textsuperscript{26} The Code defines "property of the estate" as "all legal or equitable interests of the debtor in property as of the commencement of the case."\textsuperscript{27} Thus, courts have reasoned, even though the policy benefits directors and officers individually, it also benefits the company by affording it protection against claims for indemnification by those directors and officers, and thus constitutes a legal or

\textsuperscript{21} \textit{Home Life Ins. Co. v. Heck}, 65 Ill. 111, 114 (Ill 1872).
\textsuperscript{22} \textit{Unocal}, 244 Cal. Rptr. at 548.
\textsuperscript{23} \textit{244 Cal. Rptr. at 549-50}.
\textsuperscript{24} See, e.g., \textit{Ohio Rev. Code Ann. 3937.25 (Anderson 1996)} (mid-term cancellation of commercial property, casualty or fire insurance policies is prohibited unless the cancellation is based on nonpayment, discovery of fraud or misrepresentation, discovery of willful acts, etc.). But see \textit{PepsiCo}, 640 F Supp at 664 (D&O policies not within scope of N.Y. Ins. Law §3425 preventing cancellation of specific sorts of insurance policies).
\textsuperscript{25} See \textit{In re Minoco Group of Cos., Ltd.}, 799 F2d 517, 519 (CA9 1986). Citing \textit{Minoco Group}, a bankruptcy court more recently has reasoned that the automatic stay should prevent the insurer from going to court to enforce its "insured v. insured" exclusion against claims by the estate against directors and officers. See \textit{In re Pintlar Corp.}, 175 BR. 379, 382-83 (D Idaho 1994). For a more extensive discussion of the effects of D&O insurance on the automatic stay, see \textit{Olson & Hatch} at §6B.03[1][a].
equitable interest of the corporation within the purview of the Bankruptcy Code. While the insurer may not be able to cancel the policy under these circumstances, it is possible that third-party claims against the directors or officers also would be stayed as attempts "to obtain possession of property of the estate" if such actions would activate unconditional rights of the directors to draw on corporate indemnification.

Application of the concept of "property of the estate" to a D&O policy is not without contradictions. Under certain circumstances, courts have made a distinction between the proceeds of the insuring clause covering the claims of directors and officers individually and the proceeds of the corporate reimbursement part of the policy, holding that the former belong not to the estate but to the officers and directors themselves. Yet, once it is decided that even a portion of the policy constitutes "property of the estate," one must confront the reality that the typical D&O policy does not allocate policy proceeds separately to the individual and corporate insuring clauses. If indemnification payments cannot be made by the insolvent corporation to the individual officers and directors, the corporate reimbursement insuring clause will not operate, and the individual insureds should be able to claim under the individual insuring clause. Such claims will, of course, draw down the aggregate indemnity available under the policy and deplete that undivided portion which constitutes the "property of the estate." For this reason, some courts have taken the dismal view that even the individual insuring clause is property of the estate and that claims on such proceeds are subject to the automatic stay.

In an attempt to puzzle through this conundrum, the United States District Court for the District of New Jersey analyzed and criticized (while affirming on other grounds) a decision of the Bankruptcy Court that had held all D&O policy proceeds to be property of the estate. "An insurance policy," the court wrote, "is only an asset to the extent that it increases the debtor's worth or diminishes its liabilities. If the policy, although paid for by the debtor, fails to meet this


Louisiana World Exposition, Inc. v. Federal Ins. Co., 832 F.2d 1391, 1400 (CA5 1987). This case involved a situation in which a creditor's committee brought suit against several directors in the name of the debtor corporation. The corporation's bylaws, however, required that the insolvent corporation advance litigation expenses to the directors. The company had a D&O policy which, pursuant to its individual insuring clause, obliged the insurer to begin to pay such litigation expenses directly. Of course, the net effect of these payments was to decrease the amount of insurance available under the policy to pay a judgment to the company on behalf of the creditors committee, not to mention fueling a defense by the directors. Nonetheless, the court refused to find the individual insuring clause proceeds a part of the estate of the debtor.

See §10.05 supra. Complicating this matter is the "presumptive indemnification" rule of a D&O policy which indicates that corporate indemnification has taken place whenever the corporation is legally permitted to indemnify. As discussed in §10.06 supra, this rule may or may not apply in a bankruptcy scenario depending upon the language of the policy. Further, whether the presumptive indemnification rule applies in the insuring clause or the retention clause of the policy also may impact the "property of the estate" issue since the placement affects which insuring agreement is paying the proceeds of the policy.
test, it cannot be said to be a debtor asset." Even in the court’s view, this test, with respect to D&O policies, turns on state law questions of indemnification. If the corporation’s bylaws require the corporation to indemnify its officers and directors unconditionally, then it is more likely that the corporate reimbursement Section of the policy could be said to “diminish the liabilities” of the corporation and thus constitute “property of the estate.”

On the other hand, if the bylaws give the corporation discretion, as in the case before the court, over whether to indemnify the directors, then the company’s liabilities would be executory and unable to be diminished, and the D&O policy consequentially would not be considered “property of the estate.” Even though state law might require the corporation in such a case eventually to pay the defense expenses of the directors and officers if they are “successful on the merits or otherwise” in the court’s view, a claim for such a potential liability probably would be disallowed under Section 502(e)(1)(B) of the Bankruptcy Code, as a contingent claim for reimbursement or contribution by an entity that is liable with the debtor.

c. De Facto Cancellation — the Kemmerer Case

As discussed above, discovery or extended reporting options may be exercised to extend the policy period in the event that the insurer cancels or fails to renew the policy. In the case of Kemmerer Engineering Co. v. Continental Casualty Co., the court held that an offer to renew a policy at a 650 percent higher deductible and a 200 percent higher premium amounted, in fact, to a nonrenewal enabling the insured to exercise its rights to a discovery period. Kemmerer has not been without its impact on policy language. In an attempt to avoid the argument of Kemmerer,

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[Footnote continued from previous page]


33 Id.

34 Id. at 665-66.

35 Id. at 666.


37 In re Zenith Laboratories, Inc., 104 BR at 666.

38 See supra §10.06(5).

most insurers now include a provision which states that the offer of different renewal terms, conditions, limits of liability, or premiums “shall not constitute” a refusal to renew.39

d. Rescission on Account of Misrepresentations by Insured

The previous sections have attempted to navigate some of the more treacherous shoals of D&O coverage, including some of the problems of obtaining a suitable policy, understanding the limits of coverage, and realizing the benefits of the policy once the need for insurance proceeds arises. These difficulties usually may be overcome by a combination of prudence and perseverance. More fundamental and less easily cured is the problem to which we now turn: a misrepresentation in the application for coverage that is arguably sufficiently significant to give the insurer a legal right to rescind the contract.

A basic, almost intuitive principle of contract law provides that a person may rescind a contract that he has been induced to enter into by another party’s fraud or material misrepresentation on which he justifiably has relied.40 Though thoroughly fair-minded, this right of rescission can pose serious problems for the beneficiaries of D&O coverage. Rescission is a severe remedy, which differs from mere cancellation by being retroactive in effect: that is, rescission renders the contract void from its inception.41 For all intents and purposes, there never was any coverage and no benefits are payable.

For D&O policy holders, the potentially fraudulent inducement or misrepresentation that may provide the insurer with the right to rescind usually will take the form of an answer to one of the questions posed by an application form. The typical application for D&O coverage requires answers to questions regarding: previous D&O insurance history, current and historical financial condition of the company, including copies of the company’s current audited financial statements; a description of any prior securities, class action, intellectual property or other extraordinary litigation involving the company or any of its directors or officers; a description of any pending and publicly announced mergers and acquisitions, and a complete description of pending claims and of any events and circumstances that might give rise to future claims. For depository institutions, the application forms may be considerably more complex, requiring detailed statements as to the safety and soundness of the institution.


i. The Case of the Innocent Insured

The most dangerous part of the application for the unwary beneficiary-to-be is usually the "cognizance representation"—a statement contained either separately or as part of the above questions, that the applicants know of no other facts or circumstances that might give rise to a claim under the terms of the policy, routinely referred to in the industry as the "warranty statement". The problem that this statement presents the individual applicants is that the policy application usually is filled on their behalf by the company’s counsel or its risk manager or by an inside officer or director. While the outside directors and officers covered by the policy sometimes may (and always should) be given a chance to review the application, too often they will not be walked through the provisions of the application with care by a knowledgeable guide. Thus, they either may not pay sufficient attention to the application’s demands, or, in the case of outside directors, simply may not be aware of a misrepresentation or omission made by the management official filling out the form, particularly with respect to the answer required by the "cognizance" or "warranty" representation.

Fortunately, the "warranty" representation should only be contained in the initial application for insurance, the first time the buyer is requesting insurance from a particular carrier for a particular "layer" of liability (sometimes known as the "main form" as opposed to a "renewal" application). Unfortunately, however, for such directors and officers, if such misrepresentation in the "main form" application is significant enough to increase the insurer’s risk under the policy, all of the insureds, the innocent along with the guilty, may lose their coverage. Courts long have held that, because an insurer has a right to determine what risks it will accept, is it also entitled to learn all of the facts relative to the applicant or applicants, to rely on them as true, and to determine its coverage on the basis thereof. While the result is difficult for the innocent individual, the insurer is in even less of a position to know of the misrepresentation than they, and yet would suffer substantial penalties if it were made to insure the risk that had been concealed from it. As one court put it, "While we sympathize with [the

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42 See, e.g., American Insurance Companies, Directors & Officers Insurance and Corporate Reimbursement Application Form §1456 (4/91) ¶ 9; Chubb Group Ins. Co., Executive Liability and Indemnification Policy Application, § 10—Prior Knowledge. Note while the "cognizance representation" may not be the only representations made in an application, due to its all encompassing nature, it has developed the short hand reference of the ‘warranty statement’.

43 Thus, for example, where a staff attorney at the corporation filled out a D&O application on behalf of the beneficiaries and did not reveal facts known to him that constituted "knowledge or information of any act, error or omission which might give rise to a claim under the proposed policy," the court summarily dismissed a policy holder’s claim that the insurer’s rescission was "vexatious and unreasonable." Automotive Wholesalers v. National Union Fire Ins. Co., 501 F Supp. 1205 (ND Ill 1980).

innocent insureds'] position and recognize that innocent officers and directors are likely to suffer if the entire policy is voidable because of one man’s fraudulent response, it must be recognized that plaintiff insurers are likewise innocent parties.”45

For many years, the issue of an innocent beneficiary’s responsibility for a misrepresentation made by another beneficiary on a policy application was addressed only obliquely or preliminarily by the courts.46 In 1972, the United States District Court for the Eastern District of Pennsylvania refused summary judgment to directors and officers suing an insurer over its rescission of a D&O policy on the basis of a cognizance misrepresentation by one insured.47 In so holding, the court advanced the theory that the person who fills out a D&O policy application functions as the agent of the other policy beneficiaries, who are therefore liable for his actions taken within his agency.48

In 1984, Shapiro v. American Home Assurance Company,49 a decision of the United States District Court for the District of Massachusetts, finally dealt directly with the problem of the innocent insured in the context of application fraud. Shapiro, the president of a Massachusetts retail chain, executed an application for a D&O policy and, in the process, answered “no” to the following “cognizance” question, “Does any Director or Officer have any knowledge of any act, error or omission which might give rise to a claim under the proposed policy?” The application very forthrightly went on to state, “It is agreed that if such knowledge or information exists any claim or action arising therefrom is excluded from this proposed coverage.”50

Five years after Shapiro had completed the policy application and obtained D&O coverage, the United States Attorney brought indictments against Shapiro and other corporate officers for securities fraud. Shapiro was convicted of having deliberately submitted financial statements that grossly overstated the company’s earnings for the fiscal year in which the insurance application was filed.51 Unsurprisingly, the company’s directors and officers found


46 Oblique references were made to the possibility of rescission as to all beneficiaries based on one director’s application fraud in Schlenzy v. Dorsey, 574 F2d 131, 148 n.11 (CA3 1978) and American Employers’ Ins. Co. v. King Resources Co., 556 F2d 471, 475 (CA10 1977), as a reason for the beneficiaries in question to accept settlements of less than the full amount of their potential claim under the policy.

47 (Bird), 334 F Supp at 296.

48 341 F Supp. at 294-95.


50 Id. at 1247.

51 Id. at 1247, 1249.
themselves the targets of five civil actions for securities fraud. They gave notice of claims under their D&O policy, were told that the policy had been rescinded, and brought an action in federal district court, requesting a finding that they were, in fact, insured.

To justify the extreme remedy of rescission of the policy, false statements or misrepresentations in an application must be material. Generally, they must either be made with the actual intent to deceive the insurer or they must be sufficiently misstated to increase the insurer’s risk of loss: that is, to have reasonably affected the insurer’s determination to enter into the contract, its evaluation of the risk, or its calculation or the premium. Massachusetts has an insurance statute to this effect, and the court had little trouble deciding that Shapiro’s omission was material on both counts: the general financial condition of the corporation was among the factors an insurer issuing a D&O policy was most likely to consider in making an underwriting decision; moreover, the filing of a false financial statement exposes a company and its officers to civil liability by investors and stockholders under common law and federal securities law—the very risks against which the company was seeking insurance.

Though troubled by the plight of the outside directors and lower level officers who would be victimized by a rescission of the policy, the Shapiro court found no alternative to a decision to relieve the insurer of its liability. Finding the agency theory advanced by the Bird decision “somewhat fictional”—Shapiro, the company president, surely was not the “agent” in any real sense of outside directors and officers lower in the corporate hierarchy than he—the court used principles of contract construction to reach its conclusion. The cognizance representation had inquired about the knowledge of any officer or director of facts from which claims might arise, and the application stated that such claims were excluded from coverage; the misrepresentation made by Shapiro was material not only to his potential liability, but to the liability of any other director or officer who might be held jointly and severally liable with him, and thus misrepresented the risks with respect to all insureds. Moreover, the court noted, if the parties

52 See generally 12A Appleman, Insurance Law and Practice §7294.
53 “No . . . misrepresentation . . . made in the negotiation of a policy of insurance by the insured or on his behalf shall be deemed material or defeat or avoid the policy or prevent its attaching unless such misrepresentation . . . is made with actual intent to deceive or unless the matter misrepresented . . . increased the risk of loss.” Mass. Gen. Laws ch. 175 §186 (1996). Other state statutory insurance codes also have materiality formulations. See, e.g., Cal. Ins. Code §330-34, 356-60 (1996); Haw Rev Stat 421:10-209 (1996).
55 Id. at 1251.
56 Id. at 1251-52.
57 Id. at 1252.
had intended another result, they could have negotiated a contract that specifically would have protected “innocent” insureds.58

A final theory advanced on behalf of the plaintiffs in the case was that the contract was actually a series of separate contracts between each individual officer or director and the insurer: thus, the misrepresentations of one officer should result in the rescission of the contract only with respect to him.59 Such a theory, the court held, did not square with the fact that the policy was negotiated by the company as a single unit and one premium was paid by the company for all the coverage, or with the fact that viewing the application as the statement of only one director would leave the insurer inadequately protected against the joint and several liability of all of the insureds.60

Because of the extreme nature of the rescission remedy and the comprehensiveness of the cognizance representation required on some (i.e. “main form”) D&O applications, courts as well as legislatures have intervened to define more closely the circumstances in which the insurer may rescind. In particular, courts have scrutinized the timing of the alleged misrepresentations, to assure that they in fact speak as of the date they actually were made.61 For example, the United States District Court for the Southern District of California granted summary judgment against an insurer who attempted to rescind its D&O policy because the insured corporation, Oak Industries, had failed to disclose in its application either the material inaccuracies in a recent securities prospectus of the company (which inaccuracies were known to its executives) or the several class actions commenced against the company in connection therewith.62 To market its services to Oak Industries, the insurer had offered and sold to Oak a “continuity of coverage” (or “renewal application”) policy that essentially insured against future claims for wrongful acts committed during a prior carrier’s policy term. Prior to issuing the new policy, the insurer did not require Oak’s directors and officers to make new cognizance representations.63 On these facts, the court held that, in order for there to be material misrepresentation or concealment, the insured must be

58 Id.
59 Id. at 1252-53.
60 Id.
61 This concern merely articulates the common law with respect to misrepresentations and warranties. See, e.g., National Union fire Ins. Co. v. Continental Ill. Corp., 643 F Supp. 1434, 1442 (ND Ill 1986) (under Illinois law, representations speak as of the date made, and a reaffirmation of a prior representation reaffirms its truth only as of that date). Note, however, that California’s Insurance Code specifically provides that representations in insurance policy applications are presumed to refer to the time of completion of the contract. Cal. Ins. Code 3356 (1996).
63 Id. at 93,119.
under a duty to disclose the information withheld or misrepresented, and that this duty arises only when the insured must answer a specific question actually asked by the insurer.\(^{64}\) The insurer could not justify rescission by the fact that Oak had made misrepresentations in public statements and filings made prior to the application for insurance (presumably, even though the insurer reviewed and relied upon such statements and filings in reaching its underwriting decision).\(^{65}\)

Another United States District Court has held, in a similar vein, that when forms of applications to renew D&O insurance incorporate by reference the cognizance representations made in the application for the original policy, such incorporation by reference is effective only with respect to the applicant's knowledge at the time of those earlier applications.\(^{66}\) Any reaffirmation of the prior representations in the renewal application merely reaffirms the truthfulness of the statement as to that earlier date.\(^{67}\)

The lessons to be drawn from these cases are important. Insurance applications should be reviewed by the company's counsel, who carefully should brief the beneficiaries on the implications of the cognizance representation and the remedy of rescission. The dangers inherent is such provisions become an important factor when considering changing carriers if the "replacement" carrier is insisting upon a "main form" application. Directors and officers should not permit the application to be executed and filed before they have reviewed it carefully and might consider requesting the corporation to negotiate a policy that expressly provides for severability as to non-signing innocent insureds (or, at least, outside directors). Whether an

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\(^{64}\) Id. at 93,119-93,120.

\(^{65}\) Id. at 93,120.


\(^{67}\) Id. at 1443.
insurer would be willing to do this might depend upon the length of time the insurance was in place or other factors.

In the end, of course, "severability" as to insureds who do not sign the application form becomes one factor among many in the negotiation process of a policy and should be viewed in that light.\textsuperscript{68}

Where applications call for the attachment of previously prepared financial statements or regulatory filings, it has been held that material inaccuracies or misrepresentations in such statements do not in themselves provide a ground for voiding the policy, because such misrepresentations have not been made at the time of the application with actual intent to deceive or materially affect either the acceptance of the risk or the hazards assumed by the insurer.\textsuperscript{69}

\textsuperscript{68} See generally §10.06 supra on how to analyze the elements of a D\&O insurance policy.

\textsuperscript{69} Id.
10.09 ENTITY POLICIES FOR PUBLICLY TRADED COMPANIES

As discussed in section 10.07 [4] (Allocation), it can be argued that a directors' and officers' insurance policy, at least with respect to securities claims, has an inherent flaw. The definition of "insureds" includes only the directors and officers, despite the fact that the corporation itself also is almost always named as a defendant in such suits. Studies have shown that, when both the corporation and one or more of its directors and officers are named in a securities claim, around 40 percent of the losses resulting from that claim are on average allocated to the uninsured corporation and therefore not covered by the policy. Entity coverage was devised as a solution to the problem of this substantial gap in coverage.

The first Entity Coverage form for securities claims appeared in late 1993, as an endorsement that would provide coverage for the corporation only if it and one or more of its directors or officers were named defendants in securities actions. Since these early endorsements were designed as a response to the allocation problem, they provided coverage for the corporation only as long as at least one director or officer was maintained as a co-defendant in the claim.

It wasn't long, however, before policy holders became frustrated with the "co-defendant requirement" of these early endorsements. The problem with the requirement was that it presented obstacles to the insured's successful resolution of the lawsuit against him personally. Because the Entity Coverage for the corporation would terminate if the directors and officers were dismissed from the claim, the policy, as endorsed, still fell short, from both the plaintiff's and defendant's point of view, of the critical role that insurance should play in the successful resolution of litigation. The threat of losing coverage upon dismissal of the claims against directors and officers could put defendants in a "catch 22" situation. To reach one goal -- dismissal of all directors and officers from potential personal liability -- meant to give up another goal, continuing coverage of defense costs and the potential for insurance to make a contribution

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1 Entity policies for privately held companies are discussed in Section 10.11[3]. Also note that Entity coverage has been a standard feature of the D&O policies of not-for-profit entities. See, e.g., Chubb & Son (Federal Insurance Company) Association Liability Policy Form 14-02-284 (Ed. 1-82) ¶ 8.1 (Definition of "Insured"); National Union Not for Profit D&O policy forms. However, Entity Coverage for for-profit corporations was unknown until the emergence of these recent policy forms, discussed in this section.

2 1995 Wyatt Survey at 47, Exh. 9.

3 The 1993 coverage endorsement was a National Union form that provided coverage for the company only to the extent that directors and officers were "first named and continuously maintained" as defendants in the actions.
to a final settlement or judgment. It is not surprising, therefore, that the first modification to the original Entity Coverage endorsement was a provision stating that coverage for the entity would continue even if all claims against the directors and officers were dismissed. However, even this second generation of Entity Coverage endorsements provided no coverage of claims against the corporation as an initial matter unless a director or officer were named. This situation no doubt motivated some plaintiffs to name individual officers and directors in order to trigger the insurance coverage.

While policy holders were seeking greater coverage for the corporation against securities claims that were becoming more frequent and more severe, Congress took significant steps to reduce the exposure of the corporation and its management to federal securities class actions. As more fully discussed in section 10.10, in late 1995, Congress enacted over a Presidential veto a wide-ranging piece of federal legislation, the Private Securities Litigation Reform Act of 1995. In anticipation of the Reform Act, a directors' and officers' insurance policy providing full Entity Coverage for securities claims was introduced in May of 1995. That policy provided:

Coverage B: Corporate Liability Insurance:

This policy shall pay the Loss of the Company arising from a:

(i) Securities Claim first made against the Company, or

(ii) Claim first made against the Directors or Officers, during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy for any actual or alleged Wrongful Act . . .

Under this policy form, Entity Coverage would be triggered without an individual director or officer's ever being named in the suit. While at present only AIG offers a policy form containing these benefits, such enhancements should be requested from other insurers by endorsement to their basic policy form.

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4 National Union Endorsement Form 59430 (1/94); National Union Endorsement Form 55996 (1/94). These 1994 endorsement forms dropped the "continuously maintained" language present in the insuring clause of the 1993 endorsement described just above.

4a The reform act is also discussed at some length in Olson & Hatch at section 3.07(3).

5 National Union 1995 Policy Form. As an enhancement to the 1995 form, in June 1996, American International Companies introduced Securities Plus™, a wide ranging series of coverage benefits which included: expanding Entity Coverage to cover many claims arising out of proxy contests and other changes or attempted changes of control for which such coverage was not previously available, amending the term Claim to include arbitration proceedings, amending the term Insured to include coverage for all employees in Securities Claims, and expanding the application of the retention waiver provision to refund the corporate retention in the event a Securities Claim is dismissed without prejudice and not brought back. Money is refunded in 90 days after dismissal upon promise to repay if a claim is ever reinstated after that point. See National Union Securities Plus Endorsement Form, at App.10-7-9 et seq. Under the standard policy form, the retention would be returned only in the event the dismissal was with prejudice or there was a final finding of no liability of all insured defendants.

6 See, e.g., Chubb & Sons Entity Coverage Endorsement 14-02 Ed.(12/95) (1/94).
10.10 THE PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995

The Private Securities Litigation Reform Act of 1995,\(^1\) legislation that strives to control certain abusive practices in securities actions brought on behalf of private litigants, was enacted into law on December 22, 1995. With provisions aimed at making it easier for defendants to obtain early dismissal of badly pleaded complaints, restricting the imposition of joint and several liability, and creating a "safe harbor" for corporate disclosures that are appropriately qualified, the Reform Act seems certain to alter the contours, and affect the marketing, of D&O insurance. Although it is too early to analyze the impact of the Act in this area, the following discussion attempts to identify some aspects of this type of coverage that seem likely to be affected.

1. Effect of the Reform Act on D&O insurance Rates

Whether the Reform Act will affect insurance rates is currently unknown. In the long term, the legislation's sponsors clearly hoped that the higher pleading requirements and safe-harbor provisions would reduce some litigation costs by reducing the number of complaints filed and increasing the probability that non-meritorious complaints could be dismissed on motion, thus resulting in downward pressure on rates. The provisions of the Act that limit damages payable by "non-knowing" defendants\(^2\) eventually may reduce the magnitude of claims brought under the provisions of the Reform Act and thus also have a positive effect on premiums. However, other provisions of the Reform Act may adversely affect premium calculations. For example, the participation of institutional investors as the "most adequate plaintiffs"\(^3\) actually may increase settlement costs -- to the extent that those more knowledgeable and well heeled institutions determine to become involved, they may seek more substantial recoveries for their constituents than perhaps the so-called "professional plaintiffs" had in the past. Of course, institutional investors (who are more likely to have a significant long-term investment in a company) also will be less likely to take a leading role in actions that are essentially strike suits. In addition, the requirement that parties publish a notice to class members detailing specific

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\(^1\) Pub L No. 104-67, 109 Stat 737 (1995) (the "Reform Act" or "the Act"). The reform act is also discussed at some length in Olson & Hatch at section 3.07[3].

\(^2\) See, e.g., Reform Act 201 (a), 1934 Act 21D(g)(2), codified at 15 USCA 78u-4(g)(2), more specifically discussed in Olson & Hatch at 3.07[3][d].
information regarding the terms of any proposed settlement may result in demands for higher settlements as shareholders become more aware of the historically low percentage of their alleged damages they actually have received. The net impact of these changes should be fewer unmeritorious claims to defend, but a risk of greater insured losses on claims that do have merit.

The discouragement of slender federal claims by the provisions of the Reform Act may send would-be securities fraud plaintiffs in the direction of state courts. There are preliminary indications that this is already occurring. In California, the November 1996 general election ballot contained a proposition that would drastically amend state law in an attempt to make California a particularly hospitable forum for national securities fraud class actions.

Whatever the long term effect of the Reform Act on insurance premiums, in the short term, one can assume that litigation costs will rise as courts struggle to interpret the new Act's provisions. For example, the Reform Act's safe harbor allows a complaint alleging misrepresentations or omissions involving forward-looking statements to be dismissed, if such disclosures are accompanied by "meaningful cautionary statements identifying important factors that could cause actual results to differ materially from those in the forward-looking statement." In fact, there has already been significant litigation about one effect of the Reform Act's pleading standard and discovery stay provisions.

2. **Effect of the Reform Act on D&O Policy Terms and Conditions**

Perhaps the more interesting question, and certainly a more immediate one, is what can a policy holder do to modify his or her D&O policy so as to take full advantage of the Reform Act? Given the possible volatility of the law during the period in which the effects of the Reform Act are fully worked through and understood, and state laws also may undergo change, insureds

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3 See, e.g., Reform Act 101(a), 1933 Act 27(a)(3), codified at 15 USC 77z-1(a)(3), and 1934 Act 21D(a)(4), codified at 15 USC 78u-4(a)(3), more specifically discussed in Olson & Hatch at 3.07[3][c].

4 See, e.g., Reform Act 101(a), setting forth new Section 27 of the 1933 Act, codified at 15 USC 77z-1 and 1934 Act 21D(a)(7), codified at 15 USC 78u-4(a)(7), more specifically discussed in Olson & Hatch at 3.07[3][c].

5 See "Retirement Savings and Consumer Protection Act" (renamed "Attorney-Client Fee Arrangements. Securities Fraud, Lawsuits"), Proposition 211 on the ballot for the November 5, 1996 California General Election. This proposition was defeated by the California voters 74% to 26%. At the time of publication, efforts had begun to put a similar proposition in the state of Colorado as well as more the debate in California to the legislature.

6 See, e.g., Reform Act 102(a), 1933 Act 27A(c), codified at 15 USCA 77z-2(c) and more specifically discussed in Olson & Hatch at 3.07[3][b].

should review D&O insurance contracts carefully in light of current developments and attempt to modify provisions that might reduce the effectiveness of the Reform Act's changes.

At this time, the Reform Act's effects on D&O insurance terms seem likely to be of four types:

1. The impact of the Act's state of mind requirements on individual versus corporate defendants;
2. The effect of large corporate insurance retentions on the Act's provisions which permit early dismissals of individual defendants and early settlements;
3. The effect of the Act's proportionate liability provisions on policy exclusions; and
4. The effect of the Act's "damage cap" on the need for public relations services.

a. **State of Mind Requirements**

A key component of the Reform Act is the requirement that a plaintiff adequately plead a defendant's state of mind. The new pleading requirements state that complaints alleging a violation of the 1934 Act must now "specify each statement alleged to have been misleading [and] the reason . . . why the statement is misleading . . .". For every such alleged misleading statement, the complaint also must "state with particularity facts giving rise to a strong inference that the defendant acted with the required state of mind." Similarly, the safe harbor provisions indicate that there will be no liability for either written or oral forward-looking statements if the statements were not made with actual knowledge that they were false or misleading. It is axiomatic that pleading a corporation's state of mind is different from pleading an individual's state of mind. A corporation's state of mind may be pieced together, in some circumstances, from the knowledge and perceptions of its individual constituents, but the state of mind of each individual is often a frontier without so many vantage points. Indeed, the Reform Act specifically states that in the case of the safe harbor provisions, corporate knowledge may be proved by reference to the individual knowledge of any executive officer.

The added difficulty in pleading an individual's state of mind -- especially in light of the higher pleading standards imposed by the Reform Act -- would seem almost certain, absent

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8 Reform Act 101(b)(1), 1934 Act 21D(b)(1), codified at 15 USC 78u-4(b)(1).
9 Reform Act 101(b)(2), codified at 15 USC 78u-4(b)(2).
10 See, e.g., Reform Act 102, 1933 Act 27A(c)(1), (2), codified at 15 USC 77t-2(c)(1),(2) and 1934 Act 21E(c)(1), (1), codified at 15 USC 78u-5(e)(1),(2).
insurance implications, to result in more frequent dismissals of individuals in federal securities cases. Indeed, those pleading standards may, if they function as intended, discourage many suits from even naming such individuals. A well known securities plaintiff attorney recently commented: "The Reform Act's pleading requirements, particularly with respect to scienter, will affect a plaintiff's choice of defendants. It may very well prove easier to name only a corporate defendant to avoid the difficulties of alleging the state of mind of any individual corporate officer or director." Thus, corporations weighing the purchase of Entity Coverage should consider the advantages such coverage might have in reducing the likelihood that directors or officers will be named or held hostage in a suit subject to the Reform Act.

b. The Relationship Between the Reform Act and the Corporate Retention

The D&O policy contains a self-insured retention or deductible amount. The "corporate" retention that applies to claims in which the corporation has indemnified, or is permitted or required by law to indemnify, the directors and officers can be very large. The Watson Wyatt Company reports that the average defense costs incurred by defendants in the effort to dismiss a claim against directors and officers is over $600,000, while the average corporate retention is over $1,000,000. Accordingly, in the average case, the cost of obtaining a complete victory on the behalf of the directors and officers is borne totally by the policy holder.

Because of its higher pleading requirements and safe harbor provisions, the Reform Act may increase the frequency of dismissals of directors and officers in the early stages of litigation. Even when those individuals are not dismissed, the uncertainties for plaintiffs created by the

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14 Unless and until entity coverage becomes universal, directors or officers may be named to assure that D&O coverage is triggered; however, the developers of entity coverage believe that, in some of these cases where such coverage is purchased, the individuals may be dropped once the nature of the policy is discovered, especially if the plaintiff is having difficulty meeting the particularity requirements of the Reform Act for each defendant.
15 See Section 10.06(7)(a) supra.
16 Wyatt, table 34 at 48.
17 Wyatt, table 12-14, at 24.
18 This assumes that the individuals are being fully indemnified by the corporation and that the claim falls under the corporate indemnification clause of the policy, a likely event in both cases.
Act's pleading provisions may give force to the threat of a pending motion to dismiss and encourage early settlement.

While from the insurer's point of view the amount of the corporate retention is an important factor in determining the size of a premium, corporate policy holders and their officials may be disheartened to learn that the cost of their litigation victories — whether manifested by a dismissal or an early and inexpensive settlement — fall within the corporate retention amount and must be totally self borne. In reaction to unhappiness with such a built-in disincentive and perhaps also to encourage effective litigation strategies, some policies have begun to insert provisions that waive the corporate retention in the event of a dismissal or early settlement. If such a retention waiver provision is triggered, the total cost of the case is likely to be paid by the carrier.

c. The Effect of the Proportionate Liability Test on Policy Exclusions

The Reform Act seeks to eliminate joint and several liability for securities action defendants who are not found to have "knowingly committed a violation of the securities laws" under the 1934 Act and for outside directors in cases under Section 11 of the 1933 Act. In general, D&O policies cover claims alleging knowing or intentional violations of the securities laws. Policies differ, however, as to whether securities claims that result in a jury finding of a knowing violation are covered. One relevant type of exclusion reads as follows:

based upon, arising from, or in consequence of any . . . willful violation of any statute or regulation by such Insured Person, if a judgment or other final adjudication adverse to such Insured Person establishes such . . . willful violation.

It is possible that such an exclusion would preclude coverage under the very circumstances in which the Reform Act maximizes liability. Since not all policies contain the exclusion, policy holders should review their policies and attempt to negotiate the removal of this type of exclusion if one exists.

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19 As discussed in Section 10.09 supra, retention waiver provisions can be attached to dismissals with or without prejudice; however, counsel is advised to read their policies carefully before assuming that dismissals without prejudice trigger the retention waiver provision.

20 See Section 10.06(7)(a) supra.

20a Assuming the policy also grants entity coverage and the cost of defense doesn't exceed the limits of the policy, a likely assumption in both cases.

21 Reform Act 201(e), 1934 Act 21D(g)(10), codified at 15 USCA 78a-4(g)(10); Reform Act 201(b), amending 1933 Act 11(f), 12 U.S.C. 77k(f).

22 See Chubb 1992 Policy Form ¶ 6(b).
d. The Effect of the Damage Cap on Coverage for Crisis Communication Fees

The Reform Act provides that, in any private action in which the plaintiff seeks to establish damages by reference to the market price of a security, the award of damages to the plaintiff shall not exceed the difference between the purchase price paid (in the case of a purchase) by the plaintiff for the security and the mean trading price of that security during the 90-day period beginning on the date of the corrective disclosure.23 The expressed purpose of this provision was to limit damages when the stock of the subject company bounces back within three months after the initial drop in the price of the stock. Today, many companies hire “crisis communication” firms, or do the work internally, to advise them on how best to communicate a negative event, such as a disappointing revenue release, to the investing public, hoping quickly to restore confidence in the company’s stock. From the D&O insurer’s perspective, such restoration efforts may reduce its ultimate exposure on the subsequent D&O claim. Because of this, coverage for outside “crisis management” fees recently has become available in some D&O policies.24

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23 See Reform Act 201(b), 1934 Act 21D(e), codified at 15 USCA 78u-4(e).
24 See, e.g., National Union CrisisFund Endorsement Form 66083 (8/96).
10.11 Industry Specific Policy Forms

Unique needs of various types of business concerns have prompted the insurance industry to develop variations of their basic D&O insurance policy more specifically tailored to the needs of certain industries or types of business organizations. This Section will deal with a few of the better known of these D&O policy variations, namely policies covering not-for-profit companies, health care companies and, most recently, privately held companies. Insurers who do not have such forms often will endorse their basic policies to provide these types of coverage if requested.

1. Not-for-Profit Entities

While Entity Coverage for for-profit corporations is a recent innovation, not-for-profit entities have enjoyed broad Entity Coverage in their D&O policies for many years. A coverage grant in a not-for-profit D&O insurance policy form typically provides the following:

[OPTIONAL COVERAGE] If there is a premium charge in ITEM 5(b) of the Declarations, the Underwriter will pay on behalf of the Insured Entity Loss from Claims first made against it during the Policy Period.1

Such policies also alter the definition of "insured" to cover trustees and governors of not-for-profit entities.2 Many not-for-profit policy forms may also offer additional enhancements, such as combined D&O and errors and omissions coverage, a less expensive and/or longer discovery period.3

2. Health Care

Some policies are specifically designed for health care companies. These policies provide optional Entity Coverage but also state that the Underwriter may not cancel the policy

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1 See Directors, Officers and Trustees Liability Insurance including Non-Profit Organization Reimbursement Policy, Executive Risk Indemnity, Inc. form C21108 (1996 ed.) ("Aetna 1996 Non-Profit Organization Policy Form") ¶ 1(C). Also see Directors, Officers and Organization Reimbursement Insurance, National Union Fire Insurance Company of Pittsburgh, Pa. A more extensive discussion of the particular liabilities and needs of not-for-profit organizations is provided in Chapter 11 of Olson & Hatch.

2 See, e.g., Aetna 1996 Non-Profit Organization Policy Form at definition (F).

3 See, e.g., Aetna 1996 Non-Profit Organization Policy Form at clause IV(E) (40% of total premium for a one year discovery period in lieu of standard 75%).
except for failure to pay premium when due.\textsuperscript{4} As in the case of all industry designated policy forms, insurers who do not have such forms will usually endorse their basic policy forms to provide similar or identical coverage if requested.

3. Privately Held Companies

Privately held companies have been purchasers of D&O insurance for many years. According to the Watson Wyatt 1995 Survey, approximately 65\% of all companies with less than 500 shareholders purchase D&O insurance\textsuperscript{5} and the average cost of each piece of litigation against directors and officers of privately held companies was in excess of $1.8M.\textsuperscript{6} Though privately held companies often have relatively little securities claim exposure, privately held companies until very recently purchased the same policy form as their publicly traded brothers, although at much reduced prices.\textsuperscript{7}

In the mid 1990s, general D&O forms began to be revised to increase coverage for publicly traded companies -- the most obvious example of such revisions being the introduction of Entity Coverage for Securities Claims.\textsuperscript{8} Because these provisions were of less interest to private companies, underwriters and policy holders alike felt the need to design a separate policy form that would meet the needs of the privately held companies. Today, there are at least three such policies on the market: American International Group's Directors' and Officers' Insurance and Private Company Reimbursement Policy with optional "Employment Plus"\textsuperscript{9}, Aetna's "The Power",\textsuperscript{10} and Chubb's "Forefront" policy.\textsuperscript{11}

\textsuperscript{4} Directors, Officers and Trustees Liability Insurance including Healthcare Organization Reimbursement Policy, Executive Risk Indemnity Inc. Form C2114 (1/96 ed.).

\textsuperscript{5} Wyatt 1995 Survey at 11, figure 9.


\textsuperscript{7} To adjust coverage to the lower securities claim exposure of privately held companies, underwriters would generally insert by endorsement a securities claims exclusion, thus reducing the required premium.

\textsuperscript{8} See Section 10.09 <infra>.

\textsuperscript{9} National Union Private Company Policy Form with Employment Plus Endorsement (8/96).


\textsuperscript{11} Federal Insurance Company, ForeFront By Chubb, form 14-02-1968 (Ed. 5-96) ("ForeFront").
a. Employment Practices Liability Coverage

The most frequent claimants against directors and officers of privately held companies are employees, and the most common allegations are for wrongful termination of employment, discrimination and sexual harassment. As a result, the focus point of the privately held D&O policy has been employee suits. Policies usually have an expressed "employment practices liability" coverage grant. A typical coverage grant is as follows:

Coverage C: Employment Practices Liability Insurance.

This policy shall pay the loss of:

(i) each and every Director, Officer or employee of the Company arising from an Employment Practices Claim first made against such Insured during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy for any actual or alleged Wrongful Act in their respective capacities as Directors, Officers or employees, except when and to the extent that the Company has indemnified such Insured; or

(ii) the Company arising from an Employment Practices Claim first made against a Director, Officer or employee of the Company during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy for any actual or alleged Wrongful Act in their respective capacities as Directors, Officers or employees, but only when and to the extent that the Company has indemnified such Insured pursuant to law, common or statutory, or contract, or the Charter or By-laws of the Company duly effective under such law which determines and defines such rights of indemnity; or

(iii) the Company arising from an Employment Practices Claim first made against the Company, during the Policy Period or the Discovery Period (if applicable) and reported to the Insurer pursuant to the terms of this policy for any actual or alleged Wrongful Act.

Policies for privately held companies typically include a broad definition of "employment practices claim," which includes all three common types of employment-related claims. A typical definition of "employment practices claim" is as follows:

"Employment Practices Wrongful Act" means any actual or alleged:

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12 Employees/Unions represent 37% of all claims against D&Os of privately held companies. 1995 Wyatt Survey, Private Company Peer Group Report.

13 Id.

14 National Union Private Company Policy Form with Employment Plus endorsement (8/96).
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(1) wrongful termination of the employment of, or demotion of or failure or refusal to hire or promote, any person;
(2) discrimination or sexual harassment adversely affecting any employee of, or applicant for employment with, the Company; or
(3) retaliatory treatment against an employee of the Company on account of such employee’s exercise or attempted exercise of his or her rights under law.15

Full Entity Coverage of employment practices claims is typically provided by D&O policies for private companies.16 Thus, a typical definition of "Insured" is as follows: Insured, either in the singular or plural, means any Insured Person or any Insured Organization.17

b. Exclusions

In addition to the normal exclusions found in a D&O policy, privately held company forms usually have one or more additional exclusions. As mentioned above, because premium levels for privately held companies do not contemplate the securities exposure associated with publicly traded companies, the private company policies typically contain some type of securities claims exclusion.18 Of course, this type of exclusion can become highly important when the time comes for the company to make an initial public offering of its securities (an "IPO"). Because a successful IPO is often an important goal of a privately held corporation, it is most important for a company fully to understand from the beginning the approach of its D&O insurer toward IPOs. Is liability under the Securities Act of 1933 an exposure the insurer will be willing to add to the policy holder’s policy when the need arises? To reduce this uncertainty, some policies contain provisions requiring the insurer to give the policy holder a quote for coverage of

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16 The National Union Private Company form permits the policy holder to choose to whether it wants to require a director, officer or employee to be a co-defendant, thus preventing the policy’s limits from being used for employment practice claims solely against the entity, a type of claim that is common, or, in some jurisdictions, required type of claim. See National Union Private Company Form at ¶ 1, Coverage C(iii). The co-defendant requirement can be removed by the Employment Plus endorsement. Also note that some policies expressly may provide the option for Entity Coverage for other types of claims for an additional premium. See, e.g., The Power ¶ I(B)(2). In general, if not restricted by exclusions, this type of policy can provide very broad insurance protection. Of course, the exact extent of an "all risk" entity coverage needs more analysis if the policy also contains a broad contract exclusion (which probably excludes most customer and supplier claims), a patent exclusion or an antitrust exclusion. Finally, coverage can be extended to the insured corporation’s parent company, a useful provision if the policy is being issued to a U.S. subsidiary of a foreign parent, the latter of whom is being asked to pay for the policy. See, e.g., National Union Private Company Form ¶ II(b).
17 ForeFront at para. 38
18 See, e.g., ForeFront at para. 9(c) and para. 13(d).
an IPO or other securities offering. Of course, such a requirement may be impracticable for companies that have come to be considered such poor risks that the pricing of the added coverage becomes too expensive.

Other exclusions in private company policy forms arise from the fact that additional coverage has been granted for employment practices claims for the entity. These exclusions are of two general types. First, there are exclusions which are intended to clarify that the kind of employee claims covered under the policy are "civil rights" types of claims and not types of employer-employee problems for which compensation or relief is provided by specific federal or state regulation. Thus, specific exclusions are present for: Fair Labor Standards Act, Worker Adjustment and Retraining Notification Act (WARN), Consolidated Omnibus Budget Reconciliation Act (COBRA) (continuation of health benefits), the Occupational Safety and Health Act (OSHA), and payments under any worker's compensation, disability, unemployment, retirement, social security or similar law. A second broad category of exclusions contains provisions designed to clarify that certain employment-related company expenses are not covered under the policy. Typical of these exclusions are costs of modifying a building pursuant to the Americans with Disabilities Act and certain future employee benefits.

Unlike standard D&O policies, however, forms for private companies frequently do not exclude actions for emotional distress, libel, slander, defamation and violation of the right of privacy, which typically are found excluded as part of a D&O policy's bodily injury/property damage exclusion.


Another significant difference between standard D&O policies utilized by public companies and forms available for privately held companies is that the latter are usually "duty to defend" policies. From the insurer's point of view, it is understandable that, with the granting of Entity Coverage for employee claims, the insurer would desire to control the defense of the

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19 See, for example, AIG Privately Held D&O form at exclusion (a), "... this exclusion shall not apply to any Offering of Securities by the Company in the event that within 30 days prior to the effective time of such Offering of Securities: (1) the Company gives written notice of such Offering of Securities to the Insurer, together with all particulars and underwriting information required thereto; and (2) the Company accepts such terms, conditions and additional premium required by the Insurer for such coverage."

20 See, e.g., The Power at exclusion A(3) and B.

21 See, e.g., National Union Private Company Policy Form; also see The Power at exclusion (A)(2) excluding "any portion of a Claim for an Employment Practices Wrongful Act seeking relief or redress in any form other than money damages ... ."

22 For example, AIG Privately Held D&O policy specifically states that the exclusion "for emotional distress, or for injury from libel or slander, or defamation or disparagement, or for injury from violation of a person's right of privacy ... shall not apply to an Employment Practices Claim;" (at exclusion (c)).
claim. As discussed in Section 10.07[1], however, companies and their management should be cautious about agreeing to the insurer's control of defense when the personal liability of the company's directors and officers is involved. Unlike standard D&O forms, which give the insurer (who has no duty to defend under such policies) rights of "effective association" in the defense, privately held policies typically give the insureds, as "non-defending parties," no such rights. As discussed in Section 10.07[4][a], policies may also contain a "hammer" clause giving the insurer the right to walk away from any claim if a settlement offer is made that is acceptable to the insurer but unacceptable to the insureds.24 Possibly modifications that might be discussed with carriers offering such policy provisions might include giving the insured: (1) the option rather than the obligation to tender the defense of the claim over to the insurer,25 (2) the expressed right to associate in the defense and settlement of the claim in the event the insurer does defend the claim26 and (3) the right to agree in advance to the list of defense counsel to be hired in the event of a claim.27

[Footnote continued from previous page]

23 See, e.g., ForeFront at para. 16.

24 See, e.g., The Power at clause IV(C).

25 See, for example, "In accordance with and subject to Clause 8 and subject otherwise to the terms and conditions of the policy, the Insured may at its option tender the defense of an Employment Practices Claim for which coverage is provided by this policy to the Insurer . . . Once the defense has been so tendered, the Insured shall have the right to effectively associate with the Insurer in the defense of such Employment Practices Claim, including, but not limited to, negotiating a settlement, subject to the provisions of this Clause 8. (emphasis added)," AIG privately held company policy, clauses 2(C)(iii) and 8.

26 Id.

27 Id at clause 1.
Post-Script

Negotiating a directors and officers insurance policy can be a tricky thing. There is no standard industry form or ISO form to rely upon. Different carriers use different phrases to mean similar things, and most aggravating, can use the same phrases but mean totally different things! In essence, each policy becomes more akin to a negotiated commercial contract than an "off the shelf" insurance product. The authors hope that his work, together with advice from counsel and professional insurance brokers, will make the negotiation process a bit easier.