American College of Coverage Counsel ("ACCC")

The American College of Coverage Counsel, established in 2012, is comprised of preeminent coverage and extracontractual counsel in the United States and Canada, representing the interests of both insurers and policyholders. The College is focused on the creative, ethical and efficient adjudication of insurance coverage and extracontractual disputes, peer-provided scholarship, professional coordination and the improvement of the relationship between and among our diverse members. Through its Board of Regents and its working committees, the College engages in a wide variety of activities designed to promote those goals, in addition to improving the civility and the quality of the practice of insurance law.

The Competition Assignment

The submission will be in the form of a double spaced memorandum of points and authorities in support of or in opposition to a motion for summary judgment totaling no more than 3,000 words. See more details below.

When and How to Submit Brief

If you plan to participate, please notify us of your intention to do so by sending an email to competition2019@americancollegecoverage.org no later than January 10, 2019.

When your brief is complete, you should submit it electronically in Word or PDF format to competition2019@americancollegecoverage.org. Your brief should contain a separate cover page which sets out the following information: your name, your mailing address, your email address, your phone number, the name of the law school you are attending, and your year (first, second, third, or other (with explanation if other)).

The deadline for submission is Friday, March 15, 2019, at 12:00 noon Eastern Time.

Upon receipt, your personal information will be anonymized by the staff of the American College of Coverage Counsel. Your brief will then be reviewed by one or more fellows in the
ACCC who are serving as judges for the competition and who, because of the anonymization, will not know your identity or any of the information provided about you.

The submissions will be evaluated based on the quality of the legal arguments, the persuasiveness of the writing, and the quality of the writing (including citation form according to the Bluebook). You must use the policy and the case law accompanying this assignment.

There will be three winners of the competition, with the following prizes:

- First Place: Cash prize of $2,000; an invitation to attend the ACCC Annual Meeting in Chicago on May 8-10, 2019, funded by a travel stipend from the ACCC, to meet and network with ACCC fellows (for information about the Annual Meeting, see www.americancollegececc.org); and a plaque acknowledging the achievement.

- Second Place: Cash prize of $1,500; an invitation to attend the ACCC Annual Meeting in Chicago on May 8-10, 2019, funded by a travel stipend from the ACCC, to meet and network with ACCC fellows; and a plaque acknowledging the achievement.

- Third Place: Cash prize of $1,000; an invitation to attend the ACCC Annual Meeting in Chicago on May 8-10, 2019, funded by a travel stipend from the ACCC, to meet and network with ACCC fellows; and a plaque acknowledging the achievement.

The winners of the competition will be notified no later than Friday, April 5, 2019.

**Honor Code Requirements**

You are free to discuss this project with anyone, and to consult any sources of information in doing your research. However, the brief is to be your own work, and should not be written, reviewed, edited or in any other way improved by anyone else. You are not to cite any case or secondary source other than the materials provided herewith.

**The Facts**

The following facts are undisputed, although the significance of the facts is subject to argument.

1. Ingrid Ingall purchased an insurance policy from Acme Baker Charles Assurance Corporation (“ABCAC”). The policy limits are $300,000.

2. Ingrid provides childcare in her home to earn extra money. On July 16, 2015, she was providing childcare to Billy Bazzell, who was five years old at the time. On that day, Billy had been pestering the other children in Ingrid’s care. When the
other children failed to relinquish their toys to Billy on demand, he would grab the child, put his face very close to the child’s, and yell at them. Ingrid had put Billy in “time-out” on two occasions that morning because of this behavior.

3. Billy approached Cory, Ingrid’s four-year-old son, who was playing with a plastic sword, and demanded the sword. Cory refused, and started swinging the sword back and forth. Billy was hit in the eye by the sword, ultimately leading to blindness in that eye.

4. Billy’s parents, Bernard and Norma Bazzell, filed a lawsuit against Ingrid and Cory in the Santa Clara County, California, Superior Court, seeking damages for the injuries sustained by Billy.

5. There have been depositions taken of witnesses concerning the details of the incident, which shows the following:

   a. Cory testified that he was swinging the sword back and forth to prevent Billy from getting in his face and screaming at him, and that Billy stepped towards him before he was hit.

   b. Billy admitted that he demanded the sword, but testified that Cory yelled "No," and then hit him in retaliation without any further provocation.

   c. Willemina Ortega, a third-party witness, who is Ingrid’s assistant, testified that she could not remember if Billy had taken a step towards Cory, but that Cory did not start swinging until about 2-3 seconds after telling Billy "No" in a loud voice.

   d. Ingrid did not see the incident because she was changing a baby’s diaper in the next room.

6. ABCAC declined to defend Ingrid and Cory on the grounds that the claim was excluded from coverage. Ingrid hired and paid counsel to defend herself and Cory against the Bazzells’ suit. Ingrid expended approximately $135,000 in legal and expert fees and costs in the defense of the Bazzells’ suit.

7. About three months after ABCAC declined to defend, the Bazzells offered to settle with, and provide a full release to, Ingrid and Cory if ABCAC would pay $300,000, the policy limits. Ingrid demanded in writing that ABCAC accept the settlement, but ABCAC declined the offer on the grounds of the lack of coverage.
8. About a year after ABCAC declined to defend, Ingrid and Cory entered into a settlement with the Bazzells pursuant to which they stipulated to liability for negligence and damages in the amount of $1,250,000. The parties to the settlement stipulated to the breakdown of damages as follows: $10,000 in medical expenses for Billy’s injury and $1,240,000 for loss of use of Billy’s eye. Ingrid also agreed to assign her rights under the ABCAC policy and under common law bad faith to the Bazzells. The Bazzells, in turn, agreed to restrict their recovery for their claim to whatever they could obtain from Ingrid’s insurer, ABCAC. The settlement was approved by the judge having jurisdiction over the Bazzells’ lawsuit.

9. Ingrid filed suit against ABCAC in the United States District Court for the Northern District of California seeking to recover her attorneys’ fees and costs in defense of the Bazzells’ suit. The Bazzells filed suit against ABCAC in the same court, seeking to collect on the amount of the settlement and alleging bad faith against ABCAC. The court has consolidated the cases.

For purposes of this submission, you are to assume:

- Children can be sued and called to testify.
- Jurisdiction is proper.
- There are no evidentiary issues.
- The amount of attorneys’ fees and costs incurred by Ingrid Ingall was reasonable and necessary.

**Details of Competition Submission**

Ingrid Ingall plans to move for summary judgment asserting that ABCAC breached its duty to defend and that she is entitled to recover her fees and costs totaling $135,000.

The Bazzells plan to move for summary judgment against ABCAC asserting that they are entitled to recover their stipulated settlement of $1,250,000.

The contestant may pick one of four scenarios:

1. Representing Ingrid Ingall moving for summary judgment that ABCAC breached its duty to defend.

2. Representing ABCAC in opposing Ingall’s motion for summary judgment, asserting that it had no duty to defend.
3. Representing the Bazzells moving for summary judgment that ABCAC owes the stipulated settlement in the amount of $1,250,000.

4. Representing ABCAC in opposing the Bazzells’ motion for summary judgment seeking recovery of the $1,250,000 stipulated settlement.

As stated above, the submission will be in the form of a double spaced memorandum of points and authorities in support of or in opposition to the motion for summary judgment totaling no more than 3,000 words. The brief should identify your position as to each issue, and the insurance policy provisions and case and/or statutory authorities upon which you rely.

*   *   *   *
POLICY
# HOMEOWNERS POLICY DECLARATIONS

**Company Name:** Acme Baker Charles Assurance Corporation

**Producer Name:** Xylophone Insurance Brokers

**Named Insured:** Ingrid Ingall

**Mailing Address:**
42979 West Broadway Place  
San Jose, California

**The Residence Premises Is Located At The Above Address Unless Otherwise Stated:**
N/A

**Policy Period Year(s):**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>Standard Time at the Residence Premises</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 1, 2015</td>
<td>February 1, 2016</td>
<td>12:01 AM</td>
</tr>
</tbody>
</table>

We will provide the insurance described in this policy in return for the premium and compliance with all applicable policy provisions.

Coverage is provided where a premium or limit of liability is shown for the coverage.

### Section I – Coverages

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Limit Of Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Dwelling</td>
<td>$450,000</td>
</tr>
<tr>
<td>B. Other Structures</td>
<td>$50,000</td>
</tr>
<tr>
<td>C. Personal Property</td>
<td>$50,000</td>
</tr>
<tr>
<td>D. Loss Of Use</td>
<td>$75,000</td>
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</tbody>
</table>

### Section II – Coverages

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Limit Of Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Personal Liability</td>
<td>$300,000 Each Occurrence</td>
</tr>
<tr>
<td>F. Medical Payments To Others</td>
<td>$10,000 Each Person</td>
</tr>
</tbody>
</table>

**Basic Policy Premium**

$1,297.28

**Additional Premium Charges Or Credits Related To Other Coverages Or Endorsements:**

$  

**Total Premium**

$1,297.28
Forms And Endorsements Made Part Of This Policy  
(Number(s) And Edition Date(s))

HO 00 03 05 11

<table>
<thead>
<tr>
<th>Deductible: Section I</th>
<th>Other:</th>
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</thead>
<tbody>
<tr>
<td>$ N/A</td>
<td>$ N/A</td>
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</tbody>
</table>

Section II – Other Insured Locations (Address):
N/A

<table>
<thead>
<tr>
<th>Mortgagee(s)/Lienholder(s)</th>
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<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>------</td>
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<tr>
<td>1.</td>
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<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

Loss Payee(s) – Personal Property  
(Name and Address of Loss Payee and Personal Property Involved)

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Personal Property</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>N/A</td>
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</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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<td>Countersignature Of Authorized Representative</td>
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<tr>
<td>-----------------------------------------------</td>
<td></td>
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</tr>
<tr>
<td><strong>Name:</strong> Phyllis B. Xylophone</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Title:</strong> President, Xylophone Insurance Brokers</td>
<td></td>
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</tr>
<tr>
<td><strong>Signature:</strong> Phyllis B. Xylophone</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date:</strong> February 1, 2015</td>
<td></td>
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</tbody>
</table>
AGREEMENT

We will provide the insurance described in this policy in return for the premium and compliance with all applicable provisions of this policy.

DEFINITIONS

A. In this policy, "you" and "your" refer to the "named insured" shown in the Declarations and the spouse if a resident of the same household. "We", "us" and "our" refer to the Company providing this insurance.

B. In addition, certain words and phrases are defined as follows:

1. "Aircraft Liability", "Hovercraft Liability", "Motor Vehicle Liability" and "Watercraft Liability", subject to the provisions in b. below, mean the following:

   a. Liability for "bodily injury" or "property damage" arising out of the:

      (1) Ownership of such vehicle or craft by an "insured";

      (2) Maintenance, occupancy, operation, use, loading or unloading of such vehicle or craft by any person;

      (3) Entrustment of such vehicle or craft by an "insured" to any person;

      (4) Failure to supervise or negligent supervision of any person involving such vehicle or craft by an "insured";

      (5) Vicarious liability, whether or not imposed by law, for the actions of a child or minor involving such vehicle or craft.

   b. For the purpose of this definition:

      (1) Aircraft means any contrivance used or designed for flight except model or hobby aircraft not used or designed to carry people or cargo;

      (2) Hovercraft means a self-propelled motorized ground effect vehicle and includes, but is not limited to, flarecraft and air cushion vehicles;

      (3) Watercraft means a craft principally designed to be propelled on or in water by wind, engine power or electric motor; and

      (4) Motor vehicle means a "motor vehicle" as defined in 7. below.

2. "Bodily injury" means bodily harm, sickness or disease, including required care, loss of services and death that results.

3. "Business" means:

   a. A trade, profession or occupation engaged in on a full-time, part-time or occasional basis; or

   b. Any other activity engaged in for money or other compensation, except the following:

      (1) One or more activities, not described in (2) through (4) below, for which no "insured" receives more than $2,000 in total compensation for the 12 months before the beginning of the policy period;

      (2) Volunteer activities for which no money is received other than payment for expenses incurred to perform the activity;

      (3) Providing home day care services for which no compensation is received, other than the mutual exchange of such services; or

      (4) The rendering of home day care services to a relative of an "insured".

4. "Employee" means an employee of an "insured", or an employee leased to an "insured" by a labor leasing firm under an agreement between an "insured" and the labor leasing firm, whose duties are other than those performed by a "residence employee".

5. "Insured" means:

   a. You and residents of your household who are:

      (1) Your relatives; or

      (2) Other persons under the age of 21 and in your care or the care of a resident of your household who is your relative;

   b. A student enrolled in school full-time, as defined by the school, who was a resident of your household before moving out to attend school, provided the student is under the age of:

      (1) 24 and your relative; or
(2) 21 and in your care or the care of a resident of your household who is your relative; or

c. Under Section II:

(1) With respect to animals or watercraft to which this policy applies, any person or organization legally responsible for these animals or watercraft which are owned by you or any person described in 5.a. or b. "Insured" does not mean a person or organization using or having custody of these animals or watercraft in the course of any "business" or without consent of the owner; or

(2) With respect to a "motor vehicle" to which this policy applies:

(a) Persons while engaged in your employ or that of any person described in 5.a. or b.; or

(b) Other persons using the vehicle on an "insured location" with your consent.

Under both Sections I and II, when the word an immediately precedes the word "insured", the words an "insured" together mean one or more "insureds".

6. "Insured location" means:

a. The "residence premises";

b. The part of other premises, other structures and grounds used by you as a residence; and

(1) Which is shown in the Declarations; or

(2) Which is acquired by you during the policy period for your use as a residence;

c. Any premises used by you in connection with a premises described in a. and b. above;

d. Any part of a premises:

(1) Not owned by an "insured"; and

(2) Where an "insured" is temporarily residing;

e. Vacant land, other than farm land, owned by or rented to an "insured";

f. Land owned by or rented to an "insured" on which a one-, two-, three- or four-family dwelling is being built as a residence for an "insured";

g. Individual or family cemetery plots or burial vaults of an "insured"; or

h. Any part of a premises occasionally rented to an "insured" for other than "business" use.

7. "Motor vehicle" means:

a. A self-propelled land or amphibious vehicle; or

b. Any trailer or semitrailer which is being carried on, towed by or hitched for towing by a vehicle described in a. above.

8. "Occurrence" means an accident, including continuous or repeated exposure to substantially the same general harmful conditions, which results, during the policy period, in:

a. "Bodily injury"; or

b. "Property damage".

9. "Property damage" means physical injury to, destruction of, or loss of use of tangible property.

10. "Residence employee" means:

a. An employee of an "insured", or an employee leased to an "insured" by a labor leasing firm, under an agreement between an "insured" and the labor leasing firm, whose duties are related to the maintenance or use of the "residence premises", including household or domestic services; or

b. One who performs similar duties elsewhere not related to the "business" of an "insured".

A "residence employee" does not include a temporary employee who is furnished to an "insured" to substitute for a permanent "residence employee" on leave or to meet seasonal or short-term workload conditions.

11. "Residence premises" means:

a. The one-family dwelling where you reside;

b. The two-, three- or four-family dwelling where you reside in at least one of the family units; or

c. That part of any other building where you reside;

and which is shown as the "residence premises" in the Declarations.

"Residence premises" also includes other structures and grounds at that location.
SECTION I – PROPERTY COVERAGE

A. Coverage A – Dwelling

1. We cover:
   a. The dwelling on the "residence premises" shown in the Declarations, including structures attached to the dwelling; and
   b. Materials and supplies located on or next to the "residence premises" used to construct, alter or repair the dwelling or other structures on the "residence premises".

2. We do not cover land, including land on which the dwelling is located.

B. Coverage B – Other Structures

1. We cover other structures on the "residence premises" set apart from the dwelling by clear space. This includes structures connected to the dwelling by only a fence, utility line, or similar connection.

2. We do not cover:
   a. Land, including land on which the other structures are located;
   b. Other structures rented or held for rental to any person not a tenant of the dwelling, unless used solely as a private garage;
   c. Other structures from which any "business" is conducted; or
   d. Other structures used to store "business" property. However, we do cover a structure that contains "business" property solely owned by an "insured" or a tenant of the dwelling, provided that "business" property does not include gaseous or liquid fuel, other than fuel in a permanently installed fuel tank of a vehicle or craft parked or stored in the structure.

3. The limit of liability for this coverage will not be more than 10% of the limit of liability that applies to Coverage A. Use of this coverage does not reduce the Coverage A limit of liability.

C. Coverage C – Personal Property

1. Covered Property

   We cover personal property owned or used by an "insured" while it is anywhere in the world. After a loss and at your request, we will cover personal property owned by:

   a. Others while the property is on the part of the "residence premises" occupied by an "insured"; or

   b. A guest or a "residence employee", while the property is in any residence occupied by an "insured".

2. Limit For Property At Other Locations

   a. Other Residences

      Our limit of liability for personal property usually located at an "insured's" residence, other than the "residence premises", is 10% of the limit of liability for Coverage C, or $1,000, whichever is greater. However, this limitation does not apply to personal property:

      (1) Moved from the "residence premises" because it is:

         (a) Being repaired, renovated or rebuilt; and
         (b) Not fit to live in or store property in; or

      (2) In a newly acquired principal residence for 30 days from the time you begin to move the property there.

   b. Self-storage Facilities

      Our limit of liability for personal property owned or used by an "insured" and located in a self-storage facility is 10% of the limit of liability for Coverage C, or $1,000, whichever is greater. However, this limitation does not apply to personal property:

      (1) Moved from the "residence premises" because it is:

         (a) Being repaired, renovated or rebuilt; and
         (b) Not fit to live in or store property in; or

      (2) Usually located in an "insured's" residence, other than the "residence premises".
3. Special Limits Of Liability

The special limit for each category shown below is the total limit for each loss for all property in that category. These special limits do not increase the Coverage C limit of liability.

a. $200 on money, bank notes, bullion, gold other than goldware, silver other than silverware, platinum other than platinumware, coins, medals, scrip, stored value cards and smart cards.

b. $1,500 on securities, accounts, deeds, evidences of debt, letters of credit, notes other than bank notes, manuscripts, personal records, passports, tickets and stamps. This dollar limit applies to these categories regardless of the medium (such as paper or computer software) on which the material exists.

This limit includes the cost to research, replace or restore the information from the lost or damaged material.

c. $1,500 on watercraft of all types, including their trailers, furnishings, equipment and outboard engines or motors.

d. $1,500 on trailers or semitrailers not used with watercraft of all types.

e. $1,500 for loss by theft of jewelry, watches, furs, precious and semiprecious stones.

f. $2,500 for loss by theft of firearms and related equipment.

g. $2,500 for loss by theft of silverware, silver-plated ware, goldware, gold-plated ware, platinumware, platinum-plated ware and pewterware. This includes flatware, hollowware, tea sets, trays and trophies made of or including silver, gold or pewter.

h. $2,500 on property, on the "residence premises", used primarily for "business" purposes.

i. $1,500 on property, away from the "residence premises", used primarily for "business" purposes. However, this limit does not apply to antennas, tapes, wires, records, disks or other media that are:

(1) Used with electronic equipment that reproduces, receives or transmits audio, visual or data signals; and

(2) In or upon a "motor vehicle".

j. $1,500 on portable electronic equipment that:

(1) Reproduces, receives or transmits audio, visual or data signals;

(2) Is designed to be operated by more than one power source, one of which is a "motor vehicle's" electrical system; and

(3) Is in or upon a "motor vehicle".

k. $250 for antennas, tapes, wires, records, disks or other media that are:

(1) Used with electronic equipment that reproduces, receives or transmits audio, visual or data signals; and

(2) In or upon a "motor vehicle".

4. Property Not Covered

We do not cover:

a. Articles separately described and specifically insured, regardless of the limit for which they are insured, in this or other insurance;

b. Animals, birds or fish;

c. "Motor vehicles".

This includes a "motor vehicle's" equipment and parts. However, this Paragraph 4.c. does not apply to:

(1) Portable electronic equipment that:

(a) Reproduces, receives or transmits audio, visual or data signals; and

(b) Is designed so that it may be operated from a power source other than a "motor vehicle's" electrical system.

(2) "Motor vehicles" not required to be registered for use on public roads or property which are:

(a) Used solely to service a residence; or

(b) Designed to assist the handicapped;

d. Aircraft, meaning any contrivance used or designed for flight, including any parts whether or not attached to the aircraft.

We do cover model or hobby aircraft not used or designed to carry people or cargo;

e. Hovercraft and parts. Hovercraft means a self-propelled motorized ground effect vehicle and includes, but is not limited to, flarecraft and air cushion vehicles;

f. Property of roomers, boarders and other tenants, except property of roomers and boarders related to an "insured";
g. Property in an apartment regularly rented or held for rental to others by an "insured", except as provided in E.10. Landlord’s Furnishings under Section I – Property Coverages;

h. Property rented or held for rental to others off the "residence premises";

i. "Business" data, including such data stored in:
   (1) Books of account, drawings or other paper records; or
   (2) Computers and related equipment.
   We do cover the cost of blank recording or storage media and of prerecorded computer programs available on the retail market;

j. Credit cards, electronic fund transfer cards or access devices used solely for deposit, withdrawal or transfer of funds except as provided in E.6. Credit Card, Electronic Fund Transfer Card Or Access Device, Forgery And Counterfeit Money under Section I – Property Coverages;

k. Water or steam.

D. Coverage D – Loss Of Use

   The limit of liability for Coverage D is the total limit for the coverages in 1. Additional Living Expense, 2. Fair Rental Value and 3. Civil Authority Prohibits Use below.

1. Additional Living Expense

   If a loss covered under Section I makes that part of the "residence premises" where you reside not fit to live in, we cover any necessary increase in living expenses incurred by you so that your household can maintain its normal standard of living.

   Payment will be for the shortest time required to repair or replace the damage or, if you permanently relocate, the shortest time required for your household to settle elsewhere.

2. Fair Rental Value

   If a loss covered under Section I makes that part of the "residence premises" rented to others or held for rental by you not fit to live in, we cover the fair rental value of such premises less any expenses that do not continue while it is not fit to live in.

   Payment will be for the shortest time required to repair or replace such premises.

3. Civil Authority Prohibits Use

   If a civil authority prohibits you from use of the "residence premises" as a result of direct damage to neighboring premises by a Peril Insured Against, we cover the loss as provided in 1. Additional Living Expense and 2. Fair Rental Value above for no more than two weeks.

4. Loss Or Expense Not Covered

   We do not cover loss or expense due to cancellation of a lease or agreement.

   The periods of time under 1. Additional Living Expense, 2. Fair Rental Value and 3. Civil Authority Prohibits Use above are not limited by expiration of this policy.

E. Additional Coverages

1. Debris Removal

   a. We will pay your reasonable expense for the removal of:
      (1) Debris of covered property if a Peril Insured Against that applies to the damaged property causes the loss; or
      (2) Ash, dust or particles from a volcanic eruption that has caused direct loss to a building or property contained in a building.

      This expense is included in the limit of liability that applies to the damaged property. If the amount to be paid for the actual damage to the property plus the debris removal expense is more than the limit of liability for the damaged property, an additional 5% of that limit is available for such expense.

   b. We will also pay your reasonable expense, up to $1,000, for the removal from the "residence premises" of:
      (1) Your trees felled by the peril of Windstorm or Hail or Weight of Ice, Snow or Sleet; or
      (2) A neighbor’s trees felled by a Peril Insured Against under Coverage C;

      provided the trees:
      (3) Damage a covered structure; or
      (4) Do not damage a covered structure, but:
          (a) Block a driveway on the "residence premises" which prevents a "motor vehicle", that is registered for use on public roads or property, from entering or leaving the "residence premises"; or
(b) Block a ramp or other fixture designed to assist a handicapped person to enter or leave the dwelling building.

The $1,000 limit is the most we will pay in any one loss, regardless of the number of fallen trees. No more than $500 of this limit will be paid for the removal of any one tree.

This coverage is additional insurance.

2. Reasonable Repairs
   a. We will pay the reasonable cost incurred by you for the necessary measures taken solely to protect covered property that is damaged by a Peril Insured Against from further damage.
   b. If the measures taken involve repair to other damaged property, we will only pay if that property is covered under this policy and the damage is caused by a Peril Insured Against. This coverage does not:
      (1) Increase the limit of liability that applies to the covered property; or
      (2) Relieve you of your duties, in case of a loss to covered property, described in C.4. under Section I – Conditions.

3. Trees, Shrubs And Other Plants
   We cover trees, shrubs, plants or lawns, on the "residence premises", for loss caused by the following Perils Insured Against:
   a. Fire or Lightning;
   b. Explosion;
   c. Riot or Civil Commotion;
   d. Aircraft;
   e. Vehicles not owned or operated by a resident of the "residence premises";
   f. Vandalism or Malicious Mischief; or
   g. Theft.
   We will pay up to 5% of the limit of liability that applies to the dwelling for all trees, shrubs, plants or lawns. No more than $500 of this limit will be paid for any one tree, shrub or plant. We do not cover property grown for "business" purposes.

   This coverage is additional insurance.

4. Fire Department Service Charge
   We will pay up to $500 for your liability assumed by contract or agreement for fire department charges incurred when the fire department is called to save or protect covered property from a Peril Insured Against. We do not cover fire department service charges if the property is located within the limits of the city, municipality or protection district furnishing the fire department response.

   This coverage is additional insurance. No deductible applies to this coverage.

5. Property Removed
   We insure covered property against direct loss from any cause while being removed from a premises endangered by a Peril Insured Against and for no more than 30 days while removed.

   This coverage does not change the limit of liability that applies to the property being removed.

6. Credit Card, Electronic Fund Transfer Card Or Access Device, Forgery And Counterfeit Money
   a. We will pay up to $500 for:
      (1) The legal obligation of an "insured" to pay because of the theft or unauthorized use of credit cards issued to or registered in an "insured's" name;
      (2) Loss resulting from theft or unauthorized use of an electronic fund transfer card or access device used for deposit, withdrawal or transfer of funds, issued to or registered in an "insured's" name;
      (3) Loss to an "insured" caused by forgery or alteration of any check or negotiable instrument; and
      (4) Loss to an "insured" through acceptance in good faith of counterfeit United States or Canadian paper currency.

   All loss resulting from a series of acts committed by any one person or in which any one person is concerned or implicated is considered to be one loss.
This coverage is additional insurance. No deductible applies to this coverage.

b. We do not cover:
   (1) Use of a credit card, electronic fund transfer card or access device:
   (a) By a resident of your household;
   (b) By a person who has been entrusted with either type of card or access device; or
   (c) If an "insured" has not complied with all terms and conditions under which the cards are issued or the devices accessed; or
   (2) Loss arising out of "business" use or dishonesty of an "insured".

c. If the coverage in a. above applies, the following defense provisions also apply:
   (1) We may investigate and settle any claim or suit that we decide is appropriate.
       Our duty to defend a claim or suit ends when the amount we pay for the loss equals our limit of liability.
   (2) If a suit is brought against an "insured" for liability under a.(1) or (2) above, we will provide a defense at our expense by counsel of our choice.
   (3) We have the option to defend at our expense an "insured" or an "insured's" bank against any suit for the enforcement of payment under a.(3) above.

7. Loss Assessment
   a. We will pay up to $1,000 for your share of loss assessment charged during the policy period against you, as owner or tenant of the "residence premises", by a corporation or association of property owners. The assessment must be made as a result of direct loss to property, owned by all members collectively, of the type that would be covered by this policy if owned by you, caused by a Peril Insured Against under Coverage A, other than:
      (1) Earthquake; or
      (2) Land shock waves or tremors before, during or after a volcanic eruption.
   The limit of $1,000 is the most we will pay with respect to any one loss, regardless of the number of assessments. We will only apply one deductible, per unit, to the total amount of any one loss to the property described above, regardless of the number of assessments.

b. We do not cover assessments charged against you or a corporation or association of property owners by any governmental body.

c. Paragraph Q. Policy Period under Section I – Conditions does not apply to this coverage.

This coverage is additional insurance.

8. Collapse
   a. The coverage provided under this Additional Coverage – Collapse applies only to an abrupt collapse.
   b. For the purpose of this Additional Coverage – Collapse, abrupt collapse means an abrupt falling down or caving in of a building or any part of a building with the result that the building or part of the building cannot be occupied for its intended purpose.
   c. This Additional Coverage – Collapse does not apply to:
      (1) A building or any part of a building that is in danger of falling down or caving in;
      (2) A part of a building that is standing, even if it has separated from another part of the building; or
      (3) A building or any part of a building that is standing, even if it shows evidence of cracking, bulging, sagging, bending, leaning, settling, shrinkage or expansion.
   d. We insure for direct physical loss to covered property involving abrupt collapse of a building or any part of a building if such collapse was caused by one or more of the following:
      (1) The Perils Insured Against named under Coverage C;
      (2) Decay, of a building or any part of a building, that is hidden from view, unless the presence of such decay is known to an "insured" prior to collapse;
      (3) Insect or vermin damage, to a building or any part of a building, that is hidden from view, unless the presence of such damage is known to an "insured" prior to collapse;
      (4) Weight of contents, equipment, animals or people;
      (5) Weight of rain which collects on a roof; or
(6) Use of defective material or methods in construction, remodeling or renovation if the collapse occurs during the course of the construction, remodeling or renovation.

e. Loss to an awning, fence, patio, deck, pavement, swimming pool, underground pipe, flue, drain, cesspool, septic tank, foundation, retaining wall, bulkhead, pier, wharf or dock is not included under d.(2) through (6) above, unless the loss is a direct result of the collapse of a building or any part of a building.

f. This coverage does not increase the limit of liability that applies to the damaged covered property.

9. Glass Or Safety Glazing Material

a. We cover:

(1) The breakage of glass or safety glazing material which is part of a covered building, storm door or storm window;

(2) The breakage of glass or safety glazing material which is part of a covered building, storm door or storm window when caused directly by earth movement; and

(3) The direct physical loss to covered property caused solely by the pieces, fragments or splinters of broken glass or safety glazing material which is part of a building, storm door or storm window.

b. This coverage does not include loss:

(1) To covered property which results because the glass or safety glazing material has been broken, except as provided in a.(3) above; or

(2) On the "residence premises" if the dwelling has been vacant for more than 60 consecutive days immediately before the loss, except when the breakage results directly from earth movement as provided in a.(2) above. A dwelling being constructed is not considered vacant.

c. This coverage does not increase the limit of liability that applies to the damaged property.

10. Landlord's Furnishings

We will pay up to $2,500 for your appliances, carpeting and other household furnishings, in each apartment on the "residence premises" regularly rented or held for rental to others by an "insured", for loss caused by a Peril Insured Against in Coverage C, other than Theft.

This limit is the most we will pay in any one loss regardless of the number of appliances, carpeting or other household furnishings involved in the loss.

This coverage does not increase the limit of liability applying to the damaged property.

11. Ordinance Or Law

a. You may use up to 10% of the limit of liability that applies to Coverage A for the increased costs you incur due to the enforcement of any ordinance or law which requires or regulates:

(1) The construction, demolition, remodeling, renovation or repair of that part of a covered building or other structure damaged by a Peril Insured Against;

(2) The demolition and reconstruction of the undamaged part of a covered building or other structure, when that building or other structure must be totally demolished because of damage by a Peril Insured Against to another part of that covered building or other structure; or

(3) The remodeling, removal or replacement of the portion of the undamaged part of a covered building or other structure necessary to complete the remodeling, repair or replacement of that part of the covered building or other structure damaged by a Peril Insured Against.

b. You may use all or part of this ordinance or law coverage to pay for the increased costs you incur to remove debris resulting from the construction, demolition, remodeling, renovation, repair or replacement of property as stated in a. above.

c. We do not cover:

(1) The loss in value to any covered building or other structure due to the requirements of any ordinance or law; or

(2) The costs to comply with any ordinance or law which requires any "insured" or others to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of, pollutants in or on any covered building or other structure.
Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalies, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

This coverage is additional insurance.

12. Grave Markers

We will pay up to $5,000 for grave markers, including mausoleums, on or away from the "residence premises" for loss caused by a Peril Insured Against under Coverage C.

This coverage does not increase the limits of liability that apply to the damaged covered property.

SECTION I – PERILS INSURED AGAINST

A. Coverage A – Dwelling And Coverage B – Other Structures

1. We insure against direct physical loss to property described in Coverages A and B.

2. We do not insure, however, for loss:

   a. Excluded under Section I – Exclusions;

   b. Involving collapse, including any of the following conditions of property or any part of the property:

      (1) An abrupt falling down or caving in;

      (2) Loss of structural integrity, including separation of parts of the property or property in danger of falling down or caving in; or

      (3) Any cracking, bulging, sagging, bending, leaning, settling, shrinkage or expansion as such condition relates to (1) or (2) above;

         except as provided in E.8. Collapse under Section I – Property Coverages; or

   c. Caused by:

      (1) Freezing of a plumbing, heating, air conditioning or automatic fire protective sprinkler system or of a household appliance, or by discharge, leakage or overflow from within the system or appliance caused by freezing. This provision does not apply if you have used reasonable care to:

         (a) Maintain heat in the building; or

         (b) Shut off the water supply and drain all systems and appliances of water.

However, if the building is protected by an automatic fire protective sprinkler system, you must use reasonable care to continue the water supply and maintain heat in the building for coverage to apply.

For purposes of this provision, a plumbing system or household appliance does not include a sump, sump pump or related equipment or a roof drain, gutter, downspout or similar fixtures or equipment;

(2) Freezing, thawing, pressure or weight of water or ice, whether driven by wind or not, to a:

   (a) Fence, pavement, patio or swimming pool;

   (b) Footing, foundation, bulkhead, wall, or any other structure or device that supports all or part of a building, or other structure;

   (c) Retaining wall or bulkhead that does not support all or part of a building or other structure; or

   (d) Pier, wharf or dock;

(3) Theft in or to a dwelling under construction, or of materials and supplies for use in the construction until the dwelling is finished and occupied;

(4) Vandalism and malicious mischief, and any ensuing loss caused by any intentional and wrongful act committed in the course of the vandalism or malicious mischief, if the dwelling has been vacant for more than 60 consecutive days immediately before the loss. A dwelling being constructed is not considered vacant;

(5) Mold, fungus or wet rot. However, we do insure for loss caused by mold, fungus or wet rot that is hidden within the walls or ceilings or beneath the floors or above the ceilings of a structure if such loss results from the accidental discharge or overflow of water or steam from within:

   (a) A plumbing, heating, air conditioning or automatic fire protective sprinkler system, or a household appliance, on the "residence premises"; or

   (b) A storm drain, or water, steam or sewer pipes, off the "residence premises".
For purposes of this provision, a plumbing system or household appliance does not include a sump, sump pump or related equipment or a roof drain, gutter, downspout or similar fixtures or equipment; or

(6) Any of the following:

(a) Wear and tear, marring, deterioration;
(b) Mechanical breakdown, latent defect, inherent vice or any quality in property that causes it to damage or destroy itself;
(c) Smog, rust or other corrosion, or dry rot;
(d) Smoke from agricultural smudging or industrial operations;
(e) Discharge, dispersal, seepage, migration, release or escape of pollutants unless the discharge, dispersal, seepage, migration, release or escape is itself caused by a Peril Insured Against named under Coverage C.

Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed;

(f) Settling, shrinking, bulging or expansion, including resultant cracking, of bulkheads, pavements, patios, footings, foundations, walls, floors, roofs or ceilings;

(g) Birds, rodents or insects;

(h) Nesting or infestation, or discharge or release of waste products or secretions, by any animals; or

(i) Animals owned or kept by an "insured".

Exception To c.(6)

Unless the loss is otherwise excluded, we cover loss to property covered under Coverage A or B resulting from an accidental discharge or overflow of water or steam from within a:

(i) Storm drain, or water, steam or sewer pipe, off the "residence premises"; or

(ii) Plumbing, heating, air conditioning or automatic fire protective sprinkler system or household appliance on the "residence premises". This includes the cost to tear out and replace any part of a building, or other structure, on the "residence premises", but only when necessary to repair the system or appliance. However, such tear out and replacement coverage only applies to other structures if the water or steam causes actual damage to a building on the "residence premises".

We do not cover loss to the system or appliance from which this water or steam escaped.

For purposes of this provision, a plumbing system or household appliance does not include a sump, sump pump or related equipment or a roof drain, gutter, downspout or similar fixtures or equipment.

Section I – Exclusion A.3. Water, Paragraphs a. and c. that apply to surface water and water below the surface of the ground do not apply to loss by water covered under c.(5) and (6) above.

Under 2.b. and c. above, any ensuing loss to property described in Coverages A and B not precluded by any other provision in this policy is covered.

B. Coverage C – Personal Property

We insure for direct physical loss to the property described in Coverage C caused by any of the following perils unless the loss is excluded in Section I – Exclusions.

1. Fire Or Lightning

2. Windstorm Or Hail

This peril includes loss to watercraft of all types and their trailers, furnishings, equipment, and outboard engines or motors, only while inside a fully enclosed building.

This peril does not include loss to the property contained in a building caused by rain, snow, sleet, sand or dust unless the direct force of wind or hail damages the building causing an opening in a roof or wall and the rain, snow, sleet, sand or dust enters through this opening.
3. Explosion
4. Riot Or Civil Commotion
5. Aircraft
   This peril includes self-propelled missiles and spacecraft.
6. Vehicles
7. Smoke
   This peril means sudden and accidental damage from smoke, including the emission or puffback of smoke, soot, fumes or vapors from a boiler, furnace or related equipment.
   This peril does not include loss caused by smoke from agricultural smudging or industrial operations.
8. Vandalism Or Malicious Mischief
9. Theft
   a. This peril includes attempted theft and loss of property from a known place when it is likely that the property has been stolen.
   b. This peril does not include loss caused by theft:
      (1) Committed by an "insured";
      (2) In or to a dwelling under construction, or of materials and supplies for use in the construction until the dwelling is finished and occupied;
      (3) From that part of a "residence premises" rented by an "insured" to someone other than another "insured";
      or
      (4) That occurs off the "residence premises" of:
         (a) Trailers, semitrailers and campers;
         (b) Watercraft of all types, and their furnishings, equipment and outboard engines or motors; or
         (c) Property while at any other residence owned by, rented to, or occupied by an "insured", except while an "insured" is temporarily living there. Property of an "insured" who is a student is covered while at the residence the student occupies to attend school as long as the student has been there at any time during the 90 days immediately before the loss.
10. Falling Objects
    This peril does not include loss to property contained in a building unless the roof or an outside wall of the building is first damaged by a falling object. Damage to the falling object itself is not included.
11. Weight Of Ice, Snow Or Sleet
    This peril means weight of ice, snow or sleet which causes damage to property contained in a building.
12. Accidental Discharge Or Overflow Of Water Or Steam
    a. This peril means accidental discharge or overflow of water or steam from within a plumbing, heating, air conditioning or automatic fire protective sprinkler system or from within a household appliance.
    b. This peril does not include loss:
       (1) To the system or appliance from which the water or steam escaped;
       (2) Caused by or resulting from freezing except as provided in Peril Insured Against 14, Freezing;
       (3) On the "residence premises" caused by accidental discharge or overflow which occurs off the "residence premises";
       (4) Caused by mold, fungus or wet rot unless hidden within the walls or ceilings or beneath the floors or above the ceilings of a structure.
    c. In this peril, a plumbing system or household appliance does not include a sump, sump pump or related equipment or a roof drain, gutter, downspout or similar fixtures or equipment.
    d. Section I – Exclusion A.3. Water, Paragraphs a. and c. that apply to surface water and water below the surface of the ground do not apply to loss by water covered under this peril.
13. Sudden And Accidental Tearing Apart, Cracking, Burning Or Bulging
    This peril means sudden and accidental tearing apart, cracking, burning or bulging of a steam or hot water heating system, an air conditioning or automatic fire protective sprinkler system, or an appliance for heating water.
    We do not cover loss caused by or resulting from freezing under this peril.
14. Freezing
   a. This peril means freezing of a plumbing, heating, air conditioning or automatic fire
      protective sprinkler system or of a household appliance, but only if you have
      used reasonable care to:
      (1) Maintain heat in the building; or
      (2) Shut off the water supply and drain all systems and appliances of water.
      However, if the building is protected by an automatic fire protective sprinkler system,
      you must use reasonable care to continue the water supply and maintain heat in the
      building for coverage to apply.
   b. In this peril, a plumbing system or household appliance does not include a
      sump, sump pump or related equipment or a roof drain, gutter, downspout or similar
      fixtures or equipment.

15. Sudden And Accidental Damage From
    Artificially Generated Electrical Current
    This peril does not include loss to tubes, transistors, electronic components or circuitry
    that is a part of appliances, fixtures, computers, home entertainment units or other
    types of electronic apparatus.

16. Volcanic Eruption
    This peril does not include loss caused by earthquake, land shock waves or tremors.

SECTION I – EXCLUSIONS

A. We do not insure for loss caused directly or indirectly by any of the following. Such loss is
   excluded regardless of any other cause or event contributing concurrently or in any sequence to
   the loss. These exclusions apply whether or not the loss event results in widespread damage or
   affects a substantial area.

1. Ordinance Or Law
   Ordinance Or Law means any ordinance or law:
   a. Requiring or regulating the construction, demolition, remodeling, renovation or repair
      of property, including removal of any resulting debris. This Exclusion A.1.a. does not
      apply to the amount of coverage that may be provided for in E.11. Ordinance Or
      Law under Section I – Property Coverages;
   b. The requirements of which result in a loss in value to property; or
   c. Requiring any "insured" or others to test for, monitor, clean up, remove, contain,
      treat, detoxify or neutralize, or in any way respond to, or assess the effects of,
      pollutants.
      Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including
      smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes
      materials to be recycled, reconditioned or reclaimed.
      This Exclusion A.1. applies whether or not the property has been physically damaged.

2. Earth Movement
   Earth Movement means:
   a. Earthquake, including land shock waves or tremors before, during or after a volcanic
      eruption;
   b. Landslide, mudslide or mudflow;
   c. Subsidence or sinkhole; or
   d. Any other earth movement including earth sinking, rising or shifting.
   This Exclusion A.2. applies regardless of whether any of the above, in A.2.a. through
   A.2.d., is caused by an act of nature or is otherwise caused.
   However, direct loss by fire, explosion or theft resulting from any of the above, in A.2.a.
   through A.2.d., is covered.

3. Water
   This means:
   a. Flood, surface water, waves, including tidal wave and tsunami, tides, tidal water,
      overflow of any body of water, or spray from any of these, all whether or not driven
      by wind, including storm surge;
   b. Water which:
      (1) Backs up through sewers or drains; or
      (2) Overflows or is otherwise discharged from a sump, sump pump or related
          equipment;
   c. Water below the surface of the ground, including water which exerts pressure on,
      or seeps, leaks or flows through a building, sidewalk, driveway, patio, foundation,
      swimming pool or other structure; or
   d. Waterborne material carried or otherwise moved by any of the water referred to in
      A.3.a. through A.3.c. of this exclusion.
This Exclusion A.3. applies regardless of whether any of the above, in A.3.a. through A.3.d., is caused by an act of nature or is otherwise caused. This Exclusion A.3. applies to, but is not limited to, escape, overflow or discharge, for any reason, of water or waterborne material from a dam, levee, seawall or any other boundary or containment system.

However, direct loss by fire, explosion or theft resulting from any of the above, in A.3.a. through A.3.d., is covered.

4. Power Failure

Power Failure means the failure of power or other utility service if the failure takes place off the "residence premises". But if the failure results in a loss, from a Peril Insured Against on the "residence premises", we will pay for the loss caused by that peril.

5. Neglect

Neglect means neglect of an "insured" to use all reasonable means to save and preserve property at and after the time of a loss.

6. War

War includes the following and any consequence of any of the following:

a. Undeclared war, civil war, insurrection, rebellion or revolution;
b. Warlike act by a military force or military personnel; or
c. Destruction, seizure or use for a military purpose.

Discharge of a nuclear weapon will be deemed a warlike act even if accidental.

7. Nuclear Hazard

This Exclusion A.7 pertains to Nuclear Hazard to the extent set forth in N. Nuclear Hazard Clause under Section I — Conditions.

8. Intentional Loss

Intentional Loss means any loss arising out of any act an "insured" commits or conspires to commit with the intent to cause a loss.

In the event of such loss, no "insured" is entitled to coverage, even "insureds" who did not commit or conspire to commit the act causing the loss.

9. Governmental Action

Governmental Action means the destruction, confiscation or seizure of property described in Coverage A, B or C by order of any governmental or public authority.

This exclusion does not apply to such acts ordered by any governmental or public authority that are taken at the time of a fire to prevent its spread, if the loss caused by fire would be covered under this policy.

B. We do not insure for loss to property described in Coverages A and B caused by any of the following. However, any ensuing loss to property described in Coverages A and B not precluded by any other provision in this policy is covered.

1. Weather conditions. However, this exclusion only applies if weather conditions contribute in any way with a cause or event excluded in A. above to produce the loss.

2. Acts or decisions, including the failure to act or decide, of any person, group, organization or governmental body.

3. Faulty, inadequate or defective:

a. Planning, zoning, development, surveying, siting;
b. Design, specifications, workmanship, repair, construction, renovation, remodeling, grading, compaction;
c. Materials used in repair, construction, renovation or remodeling; or
d. Maintenance;

of part or all of any property whether on or off the "residence premises".

SECTION I — CONDITIONS

A. Insurable Interest And Limit Of Liability

Even if more than one person has an insurable interest in the property covered, we will not be liable in any one loss:

1. To an "insured" for more than the amount of such "insured's" interest at the time of loss; or

2. For more than the applicable limit of liability.

B. Deductible

Unless otherwise noted in this policy, the following deductible provision applies:

With respect to any one loss:

1. Subject to the applicable limit of liability, we will pay only that part of the total of all loss payable that exceeds the deductible amount shown in the Declarations.

2. If two or more deductibles under this policy apply to the loss, only the highest deductible amount will apply.
C. Duties After Loss

In case of a loss to covered property, we have no duty to provide coverage under this policy if the failure to comply with the following duties is prejudicial to us. These duties must be performed either by you, an "insured" seeking coverage, or a representative of either:

1. Give prompt notice to us or our agent;
2. Notify the police in case of loss by theft;
3. Notify the credit card or electronic fund transfer card or access device company in case of loss as provided for in E.6. Credit Card, Electronic Fund Transfer Card Or Access Device, Forgery And Counterfeit Money under Section I – Property Coverages;
4. Protect the property from further damage. If repairs to the property are required, you must:
   a. Make reasonable and necessary repairs to protect the property; and
   b. Keep an accurate record of repair expenses;
5. Cooperate with us in the investigation of a claim;
6. Prepare an inventory of damaged personal property showing the quantity, description, actual cash value and amount of loss. Attach all bills, receipts and related documents that justify the figures in the inventory;
7. As often as we reasonably require:
   a. Show the damaged property;
   b. Provide us with records and documents we request and permit us to make copies; and
   c. Submit to examination under oath, while not in the presence of another "insured", and sign the same;
8. Send to us, within 60 days after our request, your signed, sworn proof of loss which sets forth, to the best of your knowledge and belief:
   a. The time and cause of loss;
   b. The interests of all "insureds" and all others in the property involved and all liens on the property;
   c. Other insurance which may cover the loss;
   d. Changes in title or occupancy of the property during the term of the policy;
   e. Specifications of damaged buildings and detailed repair estimates;
   f. The inventory of damaged personal property described in 6. above;
   g. Receipts for additional living expenses incurred and records that support the fair rental value loss; and
   h. Evidence or affidavit that supports a claim under E.6. Credit Card, Electronic Fund Transfer Card Or Access Device, Forgery And Counterfeit Money under Section I – Property Coverages, stating the amount and cause of loss.

D. Loss Settlement

In this Condition D., the terms "cost to repair or replace" and "replacement cost" do not include the increased costs incurred to comply with the enforcement of any ordinance or law, except to the extent that coverage for these increased costs is provided in E.11. Ordinance Or Law under Section I – Property Coverages. Covered property losses are settled as follows:

1. Property of the following types:
   a. Personal property;
   b. Awnings, carpeting, household appliances, outdoor antennas and outdoor equipment, whether or not attached to buildings;
   c. Structures that are not buildings; and
   d. Grave markers, including mausoleums: at actual cash value at the time of loss but not more than the amount required to repair or replace.

2. Buildings covered under Coverage A or B at replacement cost without deduction for depreciation, subject to the following:
   a. If, at the time of loss, the amount of insurance in this policy on the damaged building is 80% or more of the full replacement cost of the building immediately before the loss, we will pay the cost to repair or replace, without deduction for depreciation, but not more than the least of the following amounts:
      (1) The limit of liability under this policy that applies to the building;
      (2) The replacement cost of that part of the building damaged with material of like kind and quality and for like use, or
      (3) The necessary amount actually spent to repair or replace the damaged building.

If the building is rebuilt at a new premises, the cost described in (2) above is limited to the cost which would have been incurred if the building had been built at the original premises.
b. If, at the time of loss, the amount of insurance in this policy on the damaged building is less than 80% of the full replacement cost of the building immediately before the loss, we will pay the greater of the following amounts, but not more than the limit of liability under this policy that applies to the building:

(1) The actual cash value of that part of the building damaged; or
(2) That proportion of the cost to repair or replace, without deduction for depreciation, that part of the building damaged, which the total amount of insurance in this policy on the damaged building bears to 80% of the replacement cost of the building.

c. To determine the amount of insurance required to equal 80% of the full replacement cost of the building immediately before the loss, do not include the value of:

(1) Excavations, footings, foundations, piers, or any other structures or devices that support all or part of the building, which are below the undersurface of the lowest basement floor;
(2) Those supports described in (1) above which are below the surface of the ground inside the foundation walls, if there is no basement; and
(3) Underground flues, pipes, wiring and drains.

d. We will pay no more than the actual cash value of the damage until actual repair or replacement is complete. Once actual repair or replacement is complete, we will settle the loss as noted in 2.a. and b. above.

However, if the cost to repair or replace the damage is both:

(1) Less than 5% of the amount of insurance in this policy on the building; and
(2) Less than $2,500;
we will settle the loss as noted in 2.a. and b. above whether or not actual repair or replacement is complete.

e. You may disregard the replacement cost settlement provisions and make claim under this policy for loss to buildings on an actual cash value basis. You may then make claim for any additional liability according to the provisions of this Condition D. Loss Settlement, provided you notify us, within 180 days after the date of loss, of your intent to repair or replace the damaged building.

E. Loss To A Pair Or Set
In case of loss to a pair or set we may elect to:

1. Repair or replace any part to restore the pair or set to its value before the loss; or
2. Pay the difference between actual cash value of the property before and after the loss.

F. Appraisal
If you and we fail to agree on the amount of loss, either may demand an appraisal of the loss. In this event, each party will choose a competent and impartial appraiser within 20 days after receiving a written request from the other. The two appraisers will choose an umpire. If they cannot agree upon an umpire within 15 days, you or we may request that the choice be made by a judge of a court of record in the state where the "residence premises" is located. The appraisers will separately set the amount of loss. If the appraisers submit a written report of an agreement to us, the amount agreed upon will be the amount of loss. If they fail to agree, they will submit their differences to the umpire. A decision agreed to by any two will settle the amount of loss.

Each party will:

1. Pay its own appraiser; and
2. Bear the other expenses of the appraisal and umpire equally.

G. Other Insurance And Service Agreement
If a loss covered by this policy is also covered by:

1. Other insurance, we will pay only the proportion of the loss that the limit of liability that applies under this policy bears to the total amount of insurance covering the loss; or
2. A service agreement, this insurance is excess over any amounts payable under any such agreement. Service agreement means a service plan, property restoration plan, home warranty or other similar service warranty agreement, even if it is characterized as insurance.
H. Suit Against Us

No action can be brought against us unless there has been full compliance with all of the terms under Section I of this policy and the action is started within two years after the date of loss.

I. Our Option

If we give you written notice within 30 days after we receive your signed, sworn proof of loss, we may repair or replace any part of the damaged property with material or property of like kind and quality.

J. Loss Payment

We will adjust all losses with you. We will pay you unless some other person is named in the policy or is legally entitled to receive payment. Loss will be payable 60 days after we receive your proof of loss and:

1. Reach an agreement with you;
2. There is an entry of a final judgment; or
3. There is a filing of an appraisal award with us.

K. Abandonment Of Property

We need not accept any property abandoned by an "insured".

L. Mortgage Clause

1. If a mortgagee is named in this policy, any loss payable under Coverage A or B will be paid to the mortgagee and you, as interests appear. If more than one mortgagee is named, the order of payment will be the same as the order of precedence of the mortgagees.

2. If we deny your claim, that denial will not apply to a valid claim of the mortgagee, if the mortgagee:
   a. Notifies us of any change in ownership, occupancy or substantial change in risk of which the mortgagee is aware;
   b. Pays any premium due under this policy on demand if you have neglected to pay the premium; and
   c. Submits a signed, sworn statement of loss within 60 days after receiving notice from us of your failure to do so. Paragraphs F. Appraisal, H. Suit Against Us and J. Loss Payment under Section I - Conditions also apply to the mortgagee.

3. If we decide to cancel or not to renew this policy, the mortgagee will be notified at least 10 days before the date cancellation or nonrenewal takes effect.

4. If we pay the mortgagee for any loss and deny payment to you:
   a. We are subrogated to all the rights of the mortgagee granted under the mortgage on the property; or
   b. At our option, we may pay to the mortgagee the whole principal on the mortgage plus any accrued interest. In this event, we will receive a full assignment and transfer of the mortgage and all securities held as collateral to the mortgage debt.

5. Subrogation will not impair the right of the mortgagee to recover the full amount of the mortgagee's claim.

M. No Benefit To Bailee

We will not recognize any assignment or grant any coverage that benefits a person or organization holding, storing or moving property for a fee regardless of any other provision of this policy.

N. Nuclear Hazard Clause

1. "Nuclear Hazard" means any nuclear reaction, radiation, or radioactive contamination, all whether controlled or uncontrolled or however caused, or any consequence of any of these.

2. Loss caused by the nuclear hazard will not be considered loss caused by fire, explosion, or smoke, whether these perils are specifically named in or otherwise included within the Perils Insured Against.

3. This policy does not apply under Section I to loss caused directly or indirectly by nuclear hazard, except that direct loss by fire resulting from the nuclear hazard is covered.

O. Recovered Property

If you or we recover any property for which we have made payment under this policy, you or we will notify the other of the recovery. At your option, the property will be returned to or retained by you or it will become our property. If the recovered property is returned to or retained by you, the loss payment will be adjusted based on the amount you received for the recovered property.

P. Volcanic Eruption Period

One or more volcanic eruptions that occur within a 72-hour period will be considered as one volcanic eruption.

Q. Policy Period

This policy applies only to loss which occurs during the policy period.
R. Concealment Or Fraud
We provide coverage to no "insureds" under this policy if, whether before or after a loss, an "insured" has:
1. Intentionally concealed or misrepresented any material fact or circumstance;
2. Engaged in fraudulent conduct; or
3. Made false statements; relating to this insurance.

S. Loss Payable Clause
If the Declarations shows a loss payee for certain listed insured personal property, the definition of "insured" is changed to include that loss payee with respect to that property.

If we decide to cancel or not renew this policy, that loss payee will be notified in writing.

SECTION II – LIABILITY COVERAGES

A. Coverage E – Personal Liability
If a claim is made or a suit is brought against an "insured" for damages because of "bodily injury" or "property damage" caused by an "occurrence" to which this coverage applies, we will:

1. Pay up to our limit of liability for the damages for which an "insured" is legally liable. Damages include prejudgment interest awarded against an "insured"; and
2. Provide a defense at our expense by counsel of our choice, even if the suit is groundless, false or fraudulent. We may investigate and settle any claim or suit that we decide is appropriate. Our duty to settle or defend ends when our limit of liability for the "occurrence" has been exhausted by payment of a judgment or settlement.

B. Coverage F – Medical Payments To Others
We will pay the necessary medical expenses that are incurred or medically ascertainment within three years from the date of an accident causing "bodily injury". Medical expenses means reasonable charges for medical, surgical, x-ray, dental, ambulance, hospital, professional nursing, prosthetic devices and funeral services. This coverage does not apply to you or regular residents of your household except "residence employees". As to others, this coverage applies only:

1. To a person on the "insured location" with the permission of an "insured"; or
2. To a person off the "insured location", if the "bodily injury":
   a. Arises out of a condition on the "insured location" or the ways immediately adjoining;
   b. Is caused by the activities of an "insured";
   c. Is caused by a "residence employee" in the course of the "residence employee's" employment by an "insured"; or
   d. Is caused by an animal owned by or in the care of an "insured".

SECTION II – EXCLUSIONS

A. "Motor Vehicle Liability"

1. Coverages E and F do not apply to any "motor vehicle liability" if, at the time and place of an "occurrence", the involved "motor vehicle":
   a. Is registered for use on public roads or property;
   b. Is not registered for use on public roads or property, but such registration is required by law, regulation issued by a government agency, for it to be used at the place of the "occurrence"; or
   c. Is being:
      (1) Operated in, or practicing for, any prearranged or organized race, speed contest or other competition;
      (2) Rented to others;
      (3) Used to carry persons or cargo for a charge; or
      (4) Used for any "business" purpose except for a motorized golf cart while on a golfing facility.

2. If Exclusion A.1. does not apply, there is still no coverage for "motor vehicle liability", unless the "motor vehicle" is:
   a. In dead storage on an "insured location";
   b. Used solely to service a residence;
   c. Designed to assist the handicapped and, at the time of an "occurrence", it is:
      (1) Being used to assist a handicapped person; or
      (2) Parked on an "insured location";
   d. Designed for recreational use off public roads and:
      (1) Not owned by an "insured"; or
(2) Owned by an “insured” provided the “occurrence” takes place:
(a) On an “insured location” as defined in Definition B.6.a., b., d., e. or h.; or
(b) Off an “insured location” and the “motor vehicle” is:
(i) Designed as a toy vehicle for use by children under seven years of age;
(ii) Powered by one or more batteries; and
(iii) Not built or modified after manufacture to exceed a speed of five miles per hour on level ground;
e. A motorized golf cart that is owned by an “insured”, designed to carry up to four persons, not built or modified after manufacture to exceed a speed of 25 miles per hour on level ground and, at the time of an “occurrence”, is within the legal boundaries of:
(1) A golfing facility and is parked or stored there, or being used by an “insured” to:
(a) Play the game of golf or for other recreational or leisure activity allowed by the facility;
(b) Travel to or from an area where “motor vehicles” or golf carts are parked or stored; or
(c) Cross public roads at designated points to access other parts of the golfing facility; or
(2) A private residential community, including its public roads upon which a motorized golf cart can legally travel, which is subject to the authority of a property owners association and contains an “insured’s” residence.

B. "Watercraft Liability"

1. Coverages E and F do not apply to any “watercraft liability” if, at the time of an “occurrence”, the involved watercraft is being:
a. Operated in, or practicing for, any prearranged or organized race, speed contest or other competition. This exclusion does not apply to a sailing vessel or a predicted log cruise;
b. Rented to others;
c. Used to carry persons or cargo for a charge; or
d. Used for any “business” purpose.

2. If Exclusion B.1. does not apply, there is still no coverage for “watercraft liability” unless, at the time of the “occurrence”, the watercraft:
a. Is stored;
b. Is a sailing vessel, with or without auxiliary power, that is:
   (1) Less than 26 feet in overall length; or
   (2) 26 feet or more in overall length and not owned by or rented to an “insured”; or
c. Is not a sailing vessel and is powered by:
   (1) An inboard or inboard-outdrive engine or motor, including those that power a water jet pump, of:
      (a) 50 horsepower or less and not owned by an “insured”; or
      (b) More than 50 horsepower and not owned by or rented to an “insured”; or
   (2) One or more outboard engines or motors with:
      (a) 25 total horsepower or less;
      (b) More than 25 horsepower if the outboard engine or motor is not owned by an “insured”;
      (c) More than 25 horsepower if the outboard engine or motor is owned by an “insured” who acquired it during the policy period; or
      (d) More than 25 horsepower if the outboard engine or motor is owned by an “insured” who acquired it before the policy period, but only if:
         (i) You declare them at policy inception; or
         (ii) Your intent to insure them is reported to us in writing within 45 days after you acquire them.

The coverages in (c) and (d) above apply for the policy period.

Horsepower means the maximum power rating assigned to the engine or motor by the manufacturer.

C. "Aircraft Liability"

This policy does not cover “aircraft liability”.

D. "Hovercraft Liability"

This policy does not cover “hovercraft liability".
E. Coverage E – Personal Liability And Coverage F – Medical Payments To Others

Coverages E and F do not apply to the following:

1. Expected Or Intended Injury

"Bodily injury" or "property damage" which is expected or intended by an "insured", even if the resulting "bodily injury" or "property damage":

a. Is of a different kind, quality or degree than initially expected or intended; or
b. Is sustained by a different person, entity or property than initially expected or intended.

However, this Exclusion E.1. does not apply to "bodily injury" or "property damage" resulting from the use of reasonable force by an "insured" to protect persons or property.

2. "Business"

a. "Bodily injury" or "property damage" arising out of or in connection with a "business" conducted from an "insured location" or engaged in by an "insured", whether or not the "business" is owned or operated by an "insured" or employs an "insured".

This Exclusion E.2. applies but is not limited to an act or omission, regardless of its nature or circumstance, involving a service or duty rendered, promised, owed, or implied to be provided because of the nature of the "business".

b. This Exclusion E.2. does not apply to:

(1) The rental or holding for rental of an "insured location";
   (a) On an occasional basis if used only as a residence;
   (b) In part for use only as a residence, unless a single-family unit is intended for use by the occupying family to lodge more than two roomers or boarders; or
   (c) In part, as an office, school, studio or private garage; and

(2) An "insured" under the age of 21 years involved in a part-time or occasional, self-employed "business" with no employees;

3. Professional Services

"Bodily injury" or "property damage" arising out of the rendering of or failure to render professional services;

4. "Insured's" Premises Not An "Insured Location"

"Bodily injury" or "property damage" arising out of a premises:

a. Owned by an "insured";

b. Rented to an "insured"; or

c. Rented to others by an "insured"; that is not an "insured location";

5. War

"Bodily injury" or "property damage" caused directly or indirectly by war, including the following and any consequence of any of the following:

a. Undeclared war, civil war, insurrection, rebellion or revolution;

b. Warlike act by a military force or military personnel;

c. Destruction, seizure or use for a military purpose.

Discharge of a nuclear weapon will be deemed a warlike act even if accidental;

6. Communicable Disease

"Bodily injury" or "property damage" which arises out of the transmission of a communicable disease by an "insured";

7. Sexual Molestation, Corporal Punishment Or Physical Or Mental Abuse

"Bodily injury" or "property damage" arising out of sexual molestation, corporal punishment or physical or mental abuse;

8. Controlled Substance

"Bodily injury" or "property damage" arising out of the use, sale, manufacture, delivery or possession by any person of a Controlled Substance as defined by the Federal Food and Drug Law at 21 U.S.C.A. Sections 811 and 812. Controlled Substances include but are not limited to cocaine, LSD, marijuana and all narcotic drugs. However, this exclusion does not apply to the legitimate use of prescription drugs by a person following the lawful orders of a licensed health care professional.

Exclusions A. "Motor Vehicle Liability", B. "Watercraft Liability", C. "Aircraft Liability", D. "Hovercraft Liability" and E.4. "Insured's" Premises Not An "Insured Location" do not apply to "bodily injury" to a "residence employee" arising out of and in the course of the "residence employee's" employment by an "insured".
F. Coverage E – Personal Liability
Coverage E does not apply to:

1. Liability:
   a. For any loss assessment charged against you as a member of an association, corporation or community of property owners, except as provided in D. Loss Assessment under Section II – Additional Coverages;
   b. Under any contract or agreement entered into by an "insured". However, this exclusion does not apply to written contracts:
      (1) That directly relate to the ownership, maintenance or use of an "insured location"; or
      (2) Where the liability of others is assumed by you prior to an "occurrence";
      unless excluded in a. above or elsewhere in this policy;
   2. "Property damage" to property owned by an "insured". This includes costs or expenses incurred by an "insured" or others to repair, replace, enhance, restore or maintain such property to prevent injury to a person or damage to property of others, whether on or away from an "insured location";
   3. "Property damage" to property rented to, occupied or used by or in the care of an "insured". This exclusion does not apply to "property damage" caused by fire, smoke or explosion;
   4. "Bodily injury" to any person eligible to receive any benefits voluntarily provided or required to be provided by an "insured" under any:
      a. Workers' compensation law;
      b. Non-occupational disability law; or
      c. Occupational disease law;
   5. "Bodily injury" or "property damage" for which an "insured" under this policy:
      a. Is also an insured under a nuclear energy liability policy issued by the:
         (1) Nuclear Energy Liability Insurance Association;
         (2) Mutual Atomic Energy Liability Underwriters;
         (3) Nuclear Insurance Association of Canada;
         or any of their successors; or
      b. Would be an insured under such a policy but for the exhaustion of its limit of liability; or
   6. "Bodily injury" to you or an "insured" as defined under Definition 5.a. or b.
This exclusion also applies to any claim made or suit brought against you or an "insured" to:
   a. Repay; or
   b. Share damages with;
   another person who may be obligated to pay damages because of "bodily injury" to an "insured".

G. Coverage F – Medical Payments To Others
Coverage F does not apply to "bodily injury":

1. To a "residence employee" if the "bodily injury":
   a. Occurs off the "insured location"; and
   b. Does not arise out of or in the course of the "residence employee's" employment by an "insured";
2. To any person eligible to receive benefits voluntarily provided or required to be provided under any:
   a. Workers' compensation law;
   b. Non-occupational disability law; or
   c. Occupational disease law;
3. From any:
   a. Nuclear reaction;
   b. Nuclear radiation; or
   c. Radioactive contamination;
   all whether controlled or uncontrolled or however caused; or
   d. Any consequence of any of these; or
4. To any person, other than a "residence employee" of an "insured", regularly residing on any part of the "insured location".

SECTION II – ADDITIONAL COVERAGES
We cover the following in addition to the limits of liability:

A. Claim Expenses
We pay:
1. Expenses we incur and costs taxed against an "insured" in any suit we defend;
2. Premiums on bonds required in a suit we defend, but not for bond amounts more than the Coverage E limit of liability. We need not apply for or furnish any bond;
3. Reasonable expenses incurred by an "insured" at our request, including actual loss of earnings (but not loss of other income) up to $250 per day, for assisting us in the investigation or defense of a claim or suit; and

4. Interest on the entire judgment which accrues after entry of the judgment and before we pay or tender, or deposit in court that part of the judgment which does not exceed the limit of liability that applies.

B. First Aid Expenses
We will pay expenses for first aid to others incurred by an "insured" for "bodily injury" covered under this policy. We will not pay for first aid to an "insured".

C. Damage To Property Of Others
1. We will pay, at replacement cost, up to $1,000 per "occurrence" for "property damage" to property of others caused by an "insured".

2. We will not pay for "property damage":
   a. To the extent of any amount recoverable under Section I;
   b. Caused intentionally by an "insured" who is 13 years of age or older;
   c. To property owned by an "insured";
   d. To property owned by or rented to a tenant of an "insured" or a resident in your household; or
   e. Arising out of:
      (1) A "business" engaged in by an "insured";
      (2) Any act or omission in connection with a premises owned, rented or controlled by an "insured", other than the "insured location"; or
      (3) The ownership, maintenance, occupancy, operation, use, loading or unloading of aircraft, hovercraft, watercraft or "motor vehicles".

   This Exclusion e.(3) does not apply to a "motor vehicle" that:
   (a) Is designed for recreational use off public roads;
   (b) Is not owned by an "insured"; and
   (c) At the time of the "occurrence", is not required by law, or regulation issued by a government agency, to have been registered for it to be used on public roads or property.

D. Loss Assessment
1. We will pay up to $1,000 for your share of loss assessment charged against you, as owner or tenant of the "residence premises", during the policy period by a corporation or association of property owners, when the assessment is made as a result of:
   a. "Bodily injury" or "property damage" not excluded from coverage under Section II – Exclusions; or
   b. Liability for an act of a director, officer or trustee in the capacity as a director, officer or trustee, provided such person:
      (1) Is elected by the members of a corporation or association of property owners; and
      (2) Serves without deriving any income from the exercise of duties which are solely on behalf of a corporation or association of property owners.

2. Paragraph I. Policy Period under Section II – Conditions does not apply to this Loss Assessment Coverage.

3. Regardless of the number of assessments, the limit of $1,000 is the most we will pay for loss arising out of:
   a. One accident, including continuous or repeated exposure to substantially the same general harmful condition; or
   b. A covered act of a director, officer or trustee. An act involving more than one director, officer or trustee is considered to be a single act.

4. We do not cover assessments charged against you or a corporation or association of property owners by any governmental body.

SECTION II – CONDITIONS

A. Limit Of Liability
Our total liability under Coverage E for all damages resulting from any one "occurrence" will not be more than the Coverage E Limit Of Liability shown in the Declarations. This limit is the same regardless of the number of "insureds", claims made or persons injured. All "bodily injury" and "property damage" resulting from any one accident or from continuous or repeated exposure to substantially the same general harmful conditions shall be considered to be the result of one "occurrence".
Our total liability under Coverage F for all medical expense payable for "bodily injury" to one person as the result of one accident will not be more than the Coverage F Limit Of Liability shown in the Declarations.

B. Severability Of Insurance
This insurance applies separately to each "insured". This condition will not increase our limit of liability for any one "occurrence".

C. Duties After "Occurrence"
In case of an "occurrence", you or another "insured" will perform the following duties that apply. We have no duty to provide coverage under this policy if your failure to comply with the following duties is prejudicial to us. You will help us by seeing that these duties are performed:

1. Give written notice to us or our agent as soon as is practical, which sets forth:
   a. The identity of the policy and the "named insured" shown in the Declarations;
   b. Reasonably available information on the time, place and circumstances of the "occurrence"; and
   c. Names and addresses of any claimants and witnesses;
2. Cooperate with us in the investigation, settlement or defense of any claim or suit;
3. Promptly forward to us every notice, demand, summons or other process relating to the "occurrence";
4. At our request, help us:
   a. To make settlement;
   b. To enforce any right of contribution or indemnity against any person or organization who may be liable to an "insured";
   c. With the conduct of suits and attend hearings and trials; and
   d. To secure and give evidence and obtain the attendance of witnesses;
5. With respect to C. Damage To Property Of Others under Section II – Additional Coverages, submit to us within 60 days after the loss a sworn statement of loss and show the damaged property, if in an "insured's" control;
6. No "insured" shall, except at such "insured's" own cost, voluntarily make payment, assume obligation or incur expense other than for first aid to others at the time of the "bodily injury".

D. Duties Of An Injured Person – Coverage F – Medical Payments To Others
1. The injured person or someone acting for the injured person will:
   a. Give us written proof of claim, under oath if required, as soon as is practical; and
   b. Authorize us to obtain copies of medical reports and records.
2. The injured person will submit to a physical exam by a doctor of our choice when and as often as we reasonably require.

E. Payment Of Claim – Coverage F – Medical Payments To Others
Payment under this coverage is not an admission of liability by an "insured" or us.

F. Suit Against Us
1. No action can be brought against us unless there has been full compliance with all of the terms under this Section II.
2. No one will have the right to join us as a party to any action against an "insured".
3. Also, no action with respect to Coverage E can be brought against us until the obligation of such "insured" has been determined by final judgment or agreement signed by us.

G. Bankruptcy Of An "Insured"
Bankruptcy or insolvency of an "insured" will not relieve us of our obligations under this policy.

H. Other Insurance
This insurance is excess over other valid and collectible insurance except insurance written specifically to cover as excess over the limits of liability that apply in this policy.

I. Policy Period
This policy applies only to "bodily injury" or "property damage" which occurs during the policy period.

J. Concealment Or Fraud
We do not provide coverage to an "insured" who, whether before or after a loss, has:
1. Intentionally concealed or misrepresented any material fact or circumstance;
2. Engaged in fraudulent conduct; or
3. Made false statements;
   relating to this insurance.
SECTIONS I AND II – CONDITIONS

A. Liberalization Clause

If we make a change which broadens coverage under this edition of our policy without additional premium charge, that change will automatically apply to your insurance as of the date we implement the change in your state, provided that this implementation date falls within 60 days prior to or during the policy period stated in the Declarations.

This Liberalization Clause does not apply to changes implemented with a general program revision that includes both broadenings and restrictions in coverage, whether that general program revision is implemented through introduction of:

1. A subsequent edition of this policy; or
2. An amendatory endorsement.

B. Waiver Or Change Of Policy Provisions

A waiver or change of a provision of this policy must be in writing by us to be valid. Our request for an appraisal or examination will not waive any of our rights.

C. Cancellation

1. You may cancel this policy at any time by returning it to us or by letting us know in writing of the date cancellation is to take effect.

2. We may cancel this policy only for the reasons stated below by letting you know in writing of the date cancellation takes effect. This cancellation notice may be delivered to you, or mailed to you at your mailing address shown in the Declarations. Proof of mailing will be sufficient proof of notice.

   a. When you have not paid the premium, we may cancel at any time by letting you know at least 10 days before the date cancellation takes effect.

   b. When this policy has been in effect for less than 60 days and is not a renewal with us, we may cancel for any reason by letting you know at least 10 days before the date cancellation takes effect.

   c. When this policy has been in effect for 60 days or more, or at any time if it is a renewal with us, we may cancel:

      (1) If there has been a material misrepresentation of fact which if known to us would have caused us not to issue the policy; or

      (2) If the risk has changed substantially since the policy was issued.

This can be done by letting you know at least 30 days before the date cancellation takes effect.

   d. When this policy is written for a period of more than one year, we may cancel for any reason at anniversary by letting you know at least 30 days before the date cancellation takes effect.

3. When this policy is canceled, the premium for the period from the date of cancellation to the expiration date will be refunded pro rata.

4. If the return premium is not refunded with the notice of cancellation or when this policy is returned to us, we will refund it within a reasonable time after the date cancellation takes effect.

D. Nonrenewal

We may elect not to renew this policy. We may do so by delivering to you, or mailing to you at your mailing address shown in the Declarations, written notice at least 30 days before the expiration date of this policy. Proof of mailing will be sufficient proof of notice.

E. Assignment

Assignment of this policy will not be valid unless we give our written consent.

F. Subrogation

An "insured" may waive in writing before a loss all rights of recovery against any person. If not waived, we may require an assignment of rights of recovery for a loss to the extent that payment is made by us.

If an assignment is sought, an "insured" must sign and deliver all related papers and cooperate with us.

Subrogation does not apply to Coverage F or Paragraph C, Damage To Property Of Others under Section II – Additional Coverages.

G. Death

If any person named in the Declarations or the spouse, if a resident of the same household, dies, the following apply:

1. We insure the legal representative of the deceased but only with respect to the premises and property of the deceased covered under the policy at the time of death; and
2. "Insured" includes:
   a. An "insured" who is a member of your household at the time of your death, but only while a resident of the "residence premises"; and

   b. With respect to your property, the person having proper temporary custody of the property until appointment and qualification of a legal representative.
CASE LAW
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97 Cal.Rptr.3d 298  
211 P.3d 1083

JONATHAN DELGADO, Plaintiff and Appellant,  

V.  

INTERINSURANCE EXCHANGE OF THE AUTOMOBILE CLUB OF SOUTHERN CALIFORNIA,  
Defendant and Respondent.  

No. S155129.  

Supreme Court of California.  


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Steven W. Murray as Amicus Curiae on behalf of Plaintiff and Appellant.  


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Summers & Shives, Robert V. Clossen and Ian G. Williamson for Employers Mutual Casualty Company as Amicus Curiae on behalf of Defendant and Respondent.  

OPINION  

KENNARD, J.  

This case involves an insurance policy that covers injury resulting from “an accident.” After an assault and battery by the insured, the injured party sued the insured, alleging that the insured had acted under the unreasonable belief of having to defend himself, an act that according to the injured party fell within the policy’s coverage of “an accident.” Does the insurance company have a duty to defend that action? The answer is “no.” We therefore reverse the judgment of the Court of Appeal, which had reversed the trial court.  

Interinsurance Exchange of the Automobile Club of Southern California (ACSC) issued to Craig Reid a homeowners insurance policy providing liability coverage for up to $100,000. On November 7, 2003, while the policy was in effect, insured Reid hit and kicked 17-year-old Jonathan Delgado.  

In March 2004, Delgado sued Reid. The complaint alleged two causes of action. The first alleged an intentional tort in that Reid “in an unprovoked fashion and without any justification physically struck, battered and kicked” Delgado.
The second cause of action alleged that Reid "negligently and unreasonably believed" he was engaging in self-defense "and unreasonably acted in self defense when [Reid] negligently and unreasonably physically and violently struck and kicked minor Jonathan Delgado repeatedly causing serious and permanent injuries."

Reid tendered to ACSC the defense of Delgado's lawsuit. ACSC denied coverage and refused to provide Reid a defense. ACSC asserted that the assault was not covered because it was not an "occurrence," which was defined in the policy as an "accident," and that the complaint's allegations arose out of Reid's intentional acts, which came within the policy's intentional acts exclusion.

In January 2005, the trial court, at Delgado's request, dismissed the intentional tort claim. Delgado and Reid then settled the action by stipulating that Reid's use of force occurred because he negligently believed he was acting in self-defense, and by stipulating to entry of a $150,000 judgment against Reid. Later, Reid agreed to pay Delgado $25,000 and he assigned to Delgado Reid's claims against his insurer, ACSC; Delgado in turn agreed to give Reid a partial satisfaction of judgment and a covenant not to execute on the remainder of the judgment.

Delgado then brought this action against ACSC. The trial court sustained ACSC's demurrer on the ground that no facts were pled to establish coverage under the policy, but the court allowed Delgado leave to amend the complaint. Delgado then filed a first amended complaint alleging, on information and belief, that at the time of the incident the insured, Reid, acted "without intent to injure" Delgado "but with intent to defend himself and his family... from what [Reid] perceived was an imminent threat of harm...." It further alleged that Reid's "reaction to what he perceived was an imminent "307 threat of harm was an overreaction, [was] not willful or malicious, and was an accident... within the meaning of Reid's insurance policy."

The first amended complaint alleged two causes of action seeking declarations from the trial court that ACSC had a duty to defend and indemnify its insured, Reid, in the underlying lawsuit brought by Delgado; one cause of action brought under Insurance Code section 11580, subdivision (b)(2), in which Delgado sought to recover from ACSC as a judgment creditor of ACSC's insured, Reid; and three causes of action alleging bad faith—one for failure to defend, one for refusal to indemnify, and one for failure to pay medical benefits.

ACSC demurred to the first amended complaint. At the hearing on the demurrer, the trial court asked Delgado's counsel what facts were alleged regarding the events that led insured Reid to think he was acting in self-defense. Counsel responded: "We can't allege facts leading up to what happened when my client was ultimately struck. We can't allege those facts."

The trial court sustained ACSC's demurrer without leave to amend, finding that the settlement and stipulated judgment between Reid and Delgado were "contrived" to expose ACSC to liability, that it was "disingenuous at best" to characterize insured Reid's assault and battery as an "accident," and that there were no facts alleged to support Delgado's claim that Reid believed he was acting in self-defense.

The Court of Appeal reversed. After stating that allegations of harmful acts done with an unreasonable belief in self-defense describe conduct that is "properly characterized as nonintentional tortious conduct," the Court of Appeal concluded that Delgado's first amended complaint alleged acts by insured Reid that potentially were an "accident" covered by the policy.

We granted ACSC's petition for review.

II

As mentioned earlier, in this case the trial court sustained ACSC's demurrer to Delgado's complaint without leave to amend. In reviewing the ensuing judgment of dismissal, "we treat the demurrer as admitting all material facts properly pleaded, but do not assume the truth of contentions, deductions or "308 conclusions of law." (City of Dinuba v. County of Tulare (2007) 41 Cal.4th 859, 865 [82 Cal.Rptr.3d 614, 161 P.3d 1168].)"
(1) At issue here is whether the insurer had a duty to defend its insured in an action brought by a third party. To prevail in an action seeking declaratory relief on the question of the duty to defend, "the insured must prove the existence of a potential for coverage, while the insurer must establish the absence of any such potential." In other words, the insured need only show that the underlying claim may fail within policy coverage; the insurer must prove it cannot." (Montrose Chemical Corp. v. Superior Court, supra, 6 Cal.4th at p. 300.) The duty to defend exists if the insurer "becomes aware of, or if the third party lawsuit pleads, facts giving rise to the potential for coverage under the insuring agreement." (Wallace v. Truck Ins. Exchange, Inc. (1995) 11 Cal.4th 1, 19 [44 Cal.Rptr.2d 370, 900 P.2d 619].) We look first to the terms of the policy. (Ibid.)

(2) ACSC's policy provides liability coverage for bodily injury caused by an "occurrence," which the policy defines as "an accident ... which, during the policy period, results in bodily injury ...." In the context of liability insurance, an accident is "an unexpected, unforeseen, or undesigned happening or consequence from either a known or an unknown cause." (Geddes & Smith, Inc. v. St. Paul Mercury Indemnity Co. (1959) 51 Cal.2d 558, 563-564 [334 P.2d 881] (Geddes); accord, Hogan v. Midland National Ins. Co. (1970) 3 Cal.3d 553, 559 [91 Cal.Rptr. 153, 476 P.2d 823].) "This common law construction of the term 'accident' becomes part of the policy and precludes any assertion that the term is ambiguous." (Collins v. American Empire Ins. Co. (1994) 21 Cal.App.4th 787, 810 [26 Cal.Rptr.2d 391]; see Bartolome v. State Farm Fire & Casualty Co. (1989) 208 Cal.App.3d 1235, 1239 [256 Cal.Rptr. 719].)

Here, injured party Delgado contends that because insured Reid's assault and battery was motivated by an unreasonable belief in the need for self-defense, the act fell within the policy's definition of "an accident," because from the perspective of the injured party the assault was "unexpected, unforeseen, and undesigned." We disagree that whether there was an "accident" within the policy language must be determined from the injured party's perspective.

(3) In support of his contention, Delgado points to certain language by this court in Geddes, supra, 51 Cal.2d at page 553. This court there stated: "No all-inclusive definition of the word 'accident' can be given. It has been defined as 'a casualty—something out of the usual course of events and which happens suddenly and unexpectedly without design of the person injured.'" Geddes went on to state that the term "accident" "includes any event which takes place without the foresight or expectation of the person acted upon or affected by the event." (Ibid.) It is this italicized sentence on which Delgado relies. But that language should be read in context, not in isolation, as Delgado does. Geddes quoted several sources that had defined "accident." The italicized sentence on which Delgado relies is only one of those definitions. Immediately after the sentence in question, Geddes quoted this definition of "accident": "Accident, as a source and cause of damage to property, within the terms of an accident policy, is an unexpected, unforeseen, or undesigned happening or consequence from either a known or an unknown cause." (Id. at pp. 563-564.) Notably, this quoted definition lacks any mention of the need to consider the perspective of the injured party. And it was this definition of "accident" that this court in Geddes applied to the case before it. As Geddes pointed out, it is the "unexpected, undesigned, and unforeseen" nature of the injury-causing event that determines whether there is an "accident" within the policy's coverage. (Id. at p. 564.)

Similarly misplaced is Delgado's reliance on this court's later decision in Hogan v. Midland National Ins. Co., supra, 3 Cal.3d 553. Hogan held that to the extent the property damage that the injured party incurred was the result of the injured party's deliberate acts, "no accident occurred within the Geddes ... definition." (Id. at p. 560.) Hogan did not hold that whether an event is an "accident" is, as Delgado would have us conclude, to be determined from the perspective of the injured party independent of the insured's intention. Indeed, Hogan concluded that a deliberate act causing an injury is not an accident. (Ibid.)

Delgado's contention does find support in some language from Maxon v. Security Ins. Co. (1963) 214 Cal.App.2d 603 [29 Cal.Rptr. 588] (Maxon). The Court of Appeal there held that an insurance company was not obligated to defend its insured against a claim of malicious prosecution by a third party. (Id. at p. 617.) Although unnecessary to its decision, Maxon nevertheless discussed whether malicious prosecution was an "accident" within the...
coverage of the insurance policy there in issue. In the course of that discussion, Maxon quoted the same language from this court's decision in Geddes, supra, 51 Cal.2d at page 563, on which Delgado relies: ""[A]ccident] includes any event which takes place without the foresight or expectation of the person acted upon or affected by the event."" Based on that language from Geddes, Maxon stated that the third party's claim against the insured for malicious prosecution was based on an accident, reasoning that the arrest and prosecution of a person who is innocent and has no reason to expect an arrest "is, as to such person, an accident." (Maxon, supra, at p. 612.) Maxon's reliance on the Geddes language was wrong. As we explained earlier, that language played no role in the holding that Geddes ultimately reached: that the injury there was caused by an accident because it was "unexpected, undesigned, and unforeseen" (Geddes, supra, 51 Cal.2d at p. 564), and not because the injury was unexpected by the injured party.

Were we to accept Delgado's argument that any interpretation of the policy term "accident" should be based solely on whether the injury-causing event was expected, foreseen, or designed by the injured party, then intentional acts that by no stretch could be considered accidental nevertheless would fall within the policy's coverage of an "accident." Under Delgado's reasoning, even child molestation could be considered an "accident" within the policy's coverage, because presumably the child neither expected nor intended the molestation to occur. (See J. C. Penney Casualty Ins. Co. v. M. K. (1991) 52 Cal.3d 1009, 1028, fn. 17 [278 Cal.Rptr. 64, 804 P.2d 689] ["[T]he very notion of 'accidental' child molestation is implausible."]). Other examples that come to mind are arson, robbery, and premeditated murder, which are acts that do not fit the common understanding of the word "accident" because they involve acts intentionally done with the intent to cause harm.

Delgado contends that ACSC could have included in the policy's coverage of an "accident" the phrase "from the standpoint of the insured," if the insurer's intent was to have the word "accident" defined from the perspective of the insured as opposed to that of the injured party. In support, he points out that earlier standard comprehensive general liability policies defined the word "occurrence" as "an accident ... which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured." (2 Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2008) ¶ 7:42.1, p. 7A-13 (rev. # 1, 2008).)

We are not persuaded that because the coverage clause of ACSC's policy does not use the words "neither expected nor intended from the standpoint of '311 the insured," the word "accident" as used in the policy means that whether an event is an accident must be determined from the injured party's viewpoint. The phrase "neither expected nor intended from the standpoint of the insured" in earlier comprehensive general liability policies has been construed as modifying the policy term "injury and damages," not "accident." (See City of South El Monte v. Southern Cal. Joint Powers Ins. Authority (1995) 38 Cal.App.4th 1629, 1646 [45 Cal.Rptr. 2d 729]; United Pacific Ins. Co. v. McGuire Co. (1991) 229 Cal.App.3d 1560, 1566 [281 Cal.Rptr. 375]; Commercial Union Ins. Co. v. Superior Court (1987) 196 Cal.App.3d 1205, 1209 [242 Cal.Rptr. 454].) We note that in 1985 that phrase was deleted from the standard comprehensive general liability policy coverage clauses because of conflicting judicial interpretations of the phrase. Some courts had conflated the concept of "an accident" with the phrase "neither expected nor intended from the standpoint of the insured." This led those courts to "conclude[s] that an 'accident' refers to an unexpected or unintended injury." (3 New Appleman Insurance Law Practice Guide (2008) ¶ 30.07[4], p. 30-48.) Other courts, however, "concluding that the terms are different and have their own meanings, held that the 'occurrence' definition is limited to events that are accidental in nature, and the rest of the definition merely confirms that expected or intended injuries are not 'accidental.'" (Ibid.)

(4) Under California law, the word "accident" in the coverage clause of a liability policy refers to the conduct of the insured for which liability is sought to be imposed on the insured. (Quan v. Truck Ins. Exchange (1998) 67 Cal.App.4th 583, 596 [79 Cal.Rptr.2d 134]; Collin v. American Empire Ins. Co., supra, 21 Cal.App.4th at p. 804.) This view is consistent with the purpose of liability insurance. (5) Generally, liability insurance is a contract between the insured and the insurance company to provide the insured, in return for the payment of premiums, protection against liability for risks that are within the scope of the policy's coverage. (6) Insurance policies are read in light of the parties' reasonable expectations and, when ambiguous, are interpreted to protect the reasonable expectations of the insured. (State of California v. Allstate Ins. Co. (2009) 45 Cal.4th 1008, 1018, 1026 [90 Cal.Rptr.3d 1, 201

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Therefore, the appropriate inquiry here is not, as Delgado would have it, confined to viewing the pertinent event from the perspective of the injured party.

Delgado insists that an insured's unreasonable, subjective belief in the need for self-defense converts into "an accident" an act that is purposeful and intended to inflict injury. We disagree.

(7) We begin by noting that an injury-producing event is not an "accident" within the policy's coverage language when all of the acts, the manner "312 in which they were done, and the objective accomplished occurred as intended by the actor. (Hogan v. Midland National Ins. Co., supra, 3 Cal.3d at p. 560; Stellar v. State Farm General Ins. Co. (2007) 157 Cal.App.4th 1468, 1505 [69 Cal.Rptr.3d 360]; Merced Mutual Ins. Co. v. Mendez (1989) 213 Cal.App.3d 41, 50 [281 Cal.Rptr. 273].) Here, insured Reid's assault and battery on Delgado were acts done with the intent to cause injury; there is no allegation in the complaint that the acts themselves were merely shielding or the result of a reflex action. Therefore, the injuries were not as a matter of law accidental, and consequently there is no potential for coverage under the policy. (Scottsdale Ins. Co. v. MV Transportation (2005) 36 Cal.4th 643, 655 [31 Cal.Rptr.3d 147, 115 P.3d 460].)

We also note that in a number of contexts other than those involving claims pertaining to assault and battery, which is the conduct at issue here, courts have in insurance cases rejected the notion that an insured's mistake of fact or law transforms a knowing and purposefully inflicted harm into an accidental injury. (E.g., Merced Mutual Ins. Co. v. Mendez, supra, 213 Cal.App.3d 41 [oral copulation and attempted oral copulation not accidents notwithstanding insured's mistaken belief that victim consented]; Collin v. American Empire Ins. Co., supra, 21 Cal.App.4th 787 [misunderstanding of legal rights did not turn conversion of property into an accident]; Quan v. Truck Ins. Exchange, supra, 67 Cal.App.4th 583 [rape not transformed into an accident notwithstanding insured's mistaken belief that victim consented]; Swain v. California Casualty Ins. Co. (2002) 99 Cal.App.4th 1 [120 Cal.Rptr.2d 808] [mistaken belief that acts were lawful did not render wrongful eviction of tenant an accident]; Lyons v. Fire Ins. Exchange (2008) 161 Cal.App.4th 880 [74 Cal.Rptr.3d 649] [insured's subjective miscalculation of victim's state of mind did not make sexual attack an accident]; see J. C. Penney Casualty Ins. Co. v. M. K., supra, 52 Cal.3d 1009 [homeowners policy as a matter of law did not provide coverage for child molestation regardless of lack of intent to harm].)

Here, injured party Delgado advances two different arguments to support his claim that, unlike the above cited decisions pertaining to oral copulation, conversion, rape, wrongful eviction, and child molestation, an actor's unreasonable belief in the need for self-defense converts an assault and battery into an unintentional act and therefore is "an accident" within the policy's coverage. We reject these contentions.

Delgado's first argument relies on a statement by this court in Gray v. Zurich Insurance Co. (1966) 65 Cal.2d 263 [54 Cal.Rptr. 104, 419 P.2d 1681] (Gray). The issue there was whether an insurance company had a duty to "313 defend an action alleging that the insured had "willfully, maliciously, brutally and intentionally assaulted" the plaintiff. (Id. at p. 267.) Unlike the case now before us, the policy's coverage clause in Gray did not define coverage in terms of injuries resulting from "an accident." It stated that the insurer would defend its insured against "any suit" alleging "bodily injury or property damage ... even if any of the allegations are groundless, false or fraudulent." (Ibid.) In discussing the scope of the policy's exclusion for intentional injury and the rules allowing liberal amendments to pleadings, Gray remarked that the insured "might have been able to show that in physically defending himself, even if he exceeded the reasonable bounds of self-defense, he did not commit wilful and intended injury, but engaged only in nonintentional tortious conduct." (Gray, supra, 65 Cal.2d at p. 277, italics added.) Delgado relies on that statement from Gray and on several cases that have cited Gray for the proposition that acts done in self-defense are unintentional and therefore accidental.

That reliance is misplaced. Gray and the cases that have cited it pertained to the question of unreasonable use of force or unreasonable self-defense in the context of an insurance policy's exclusionary clauses, not as here in the context of a policy's coverage clause. (Gray, supra, 65 Cal.2d at p. 266; Quan v. Truck Ins. Exchange, supra, 67 Cal.App.4th at pp. 595-596; David Kleis, Inc. v. Superior Court (1995) 37 Cal.App.4th 1035, 1048 [44 Cal.Rptr.2d 683].)
Gray, supra, 65 Cal.2d at page 277, stated that an unreasonable belief in the need for self-defense could remove the resulting act from the reach of the policy's exclusion clause for intentional acts (that is, makes the act "nonintentional"). Gray did not say, however, that such a belief would convert an intentional act into an unintentional act, as Delgado here asserts. Acceptance of Delgado's argument would render Gray's statement nonsensical, because a purposeful and intentional act remains purposeful and intentional regardless of the reason or motivation for the act. (Hogan v. Midland National Ins. Co., supra, 3 Cal.3d at p. 560 [whatever the motivation, a deliberate and calculated act is not an accident]; Lyons v. Fire Ins. Exchange, supra, 161 Cal.App.4th at p. 889 [mental miscalculation of victim's state of mind does not transform intentional conduct done with knowledge of objective facts into an accident]; Swain v. California Casualty Ins. Co., supra, 99 Cal.App.4th at p. 10 ["We know of no case from this or any other jurisdiction where a harm knowingly and purposefully inflicted was held 'accidental' merely because the person inflicting it erroneously believed himself entitled to do so."]) [2]

Delgado's second argument—that an insured's mistaken and unreasonable belief in the need for self-defense converts the assault into an accidental act—is based on the notion that a provocative act by the injured party turns the insured's physical response into an accidental act. Under this view, the injured party's provocative acts are unforeseen and unexpected from the perspective of the insured, making the insured's responsive acts unplanned and therefore accidental, triggering the policy's coverage for "an accident."

"315 The source of that argument is a statement by the Court of Appeal in Merced Mutual Ins. Co. v. Mendez, supra, 213 Cal.App.3d 41. There the court, in rejecting the argument that an "accident" may have occurred because the insured mistakenly believed the victim consented to a sexual battery and assault, stated that "an 'accident' exists when any aspect in the causal series of events leading to the injury or damage was unintended by the insured and a matter of fortuity." (Id. at p. 50, italics added.) The premise of Delgado's argument is that whenever a provocative act by the injured person is part of the causal chain of events that ultimately led to the insured's injury-causing conduct—here an assault and battery—the insured's conduct should be considered accidental.

9 Delgado overlooks the context in which the Court of Appeal in Merced Mutual Ins. Co. v. Mendez, supra, 213 Cal.App.3d at page 50, made the statement in question. In the same paragraph, the court also observed: "An accident, however, is never present when the insured performs a deliberate act unless some additional, unexpected, independent, and unforeseen happening occurs that produces the damage. [Citation.] Clearly, where the insured acted deliberately with the intent to cause injury, the conduct would not be deemed an accident." (Ibid.) Thus, the statement upon which Delgado relies—that an accident exists whenever any part of the causal events leading to the injury was unintended—referred to events in the causal chain after the acts of the insured, not to events preceding the acts of the insured.
(10) Here, Delgado's complaint alleges acts of wrongdoing by the insured against him. Those are the acts that must be considered the starting point of the causal series of events, not the injured party's acts that purportedly provoked the insured into committing assault and battery on Delgado. The term "accident" in the policy's coverage clause refers to the injury-producing acts of the insured, not those of the injured party. (Quan v. Truck Ins. Exchange, supra, 67 Cal.App.4th at p. 596; Collins v. American Empire Ins. Co., supra, 21 Cal.App.4th at p. 804.) In determining whether the injury is a result of an accident, taking into consideration acts or events before the insured's acts would be illogical and contrary to California case law.

(11) "Any given event, including an injury, is always the result of many causes." (1 Dobbs, The Law of Torts (2001) § 171, p. 414.) For that reason, the law looks for purposes of causation analysis "to those causes which are so closely connected with the result and of such significance that the law is justified in imposing liability." (Prosser & Keeton on Torts (5th ed. 1984) § 41, p. 264.) In a case of assault and battery, it is the use of force on another that is closely connected to the resulting injury. To look to acts within the causal chain that are antecedent to and more remote from the assaultive conduct would render legal responsibilities too uncertain. "When a driver intentionally speeds and, as a result, negligently hits another car, the speeding would be an intentional act. However, the act directly responsible for the injury—hitting the other car—was not intended by the driver and was fortuitous. Accordingly, the occurrence resulting in injury would be deemed an accident." (Merced Mutual Ins. Co. v. Mendez, supra, 213 Cal.App.3d at p. 50; see Quan v. Truck Ins. Exchange, supra, 67 Cal.App.4th at p. 600, fn. 16; see generally Maples v. Aetna Cas. & Surety Co. (1978) 83 Cal.App.3d 641, 647-648 [148 Cal.Rptr. 80] ["the term 'accident' unambiguously refers to the event causing damage, not the earlier event creating the potential for future injury"]).

Delgado's argument that the insured's assault was an accidental act because a provocative act by the injured party was unforeseen and unexpected would also be inconsistent with California case law. In Quan v. Truck Ins. Exchange, supra, 67 Cal.App.4th 583, the insured was sued for assault and battery based upon the insured's act of forcibly raping the victim. (Id. at pp. 587, 588, fn. 5.) In his action against his insurance company for breach of the duty to defend, the insured argued that there was a potential for coverage under a policy insuring against bodily injury caused by an accident (id. at p. 592) because he could simply be found negligent or "found to have mistakenly believed the claimant had "consented" (id. at p. 596). Quan rejected the argument that the victim's antecedent act that induced the insured's mistaken belief in consent converted the forcible rape into an "accident." Quan first observed that to determine whether an injury resulted from an accident, and thus fell within the policy's coverage, one needs to consider the nature of the insured's act. Quan then concluded that the insured's conduct could not have been accidental because it was intentional, and that an unreasonable belief in the victim's consent could not alter the nature of the act of forcible rape itself. (Id. at pp. 596-598.) Other courts have come to similar conclusions. (E.g., Lyons v. Fire Ins. Exchange, supra, 161 Cal.App.4th 880 [false imprisonment relating to alleged sexual attack not an accident even when insured may have acted under mistaken belief victim would not rebuff advances]; Modern Development Co. v. Navigators Ins. Co. (2003) 111 Cal.App.4th 932, 942 [4 Cal.Rptr.3d 528] ["A mistake of fact in an employment termination does not transform the intentional act of terminating an employee into an accident"]; Swain v. California Casualty Ins. Co., supra, 99 Cal.App.4th 1 [insured's belief that he was entitled to inflict harm does not transform wrongful eviction into an accident]; Merced Mutual Ins. Co. v. Mendez, supra, 213 Cal.App.3d 41 [unreasonable belief in victim's consent did not make oral copulation and attempted oral copulation accidents].)

(12) We conclude here that an insured's unreasonable belief in the need for self-defense does not turn the resulting purposeful and intentional act of assault and battery into "an accident" within the policy's coverage clause. Therefore, the insurance company had no duty to defend its insured in the lawsuit brought against him by the injured party.

The judgment of the Court of Appeal is reversed.


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Appellant's petition for a rehearing was denied September 30, 2009.

[1] Because the duty to defend is broader than the duty to indemnify (Montrose Chemical Corp. v. Superior Court (1993) 6 Cal.4th 297, 299 [24 Cal.Rptr.2d 467, 861 P.2d 1153]), a conclusion that here ACSC did not have a duty to defend will be dispositive of plaintiff Delgado's claim that ACSC had a duty to indemnify. That conclusion is also dispositive of Delgado's claim that he is a judgment creditor under Insurance Code section 11580, subdivision (b)(2). Under that statute, an action by a judgment creditor of an insured against an insurance company is "on the policy and subject to its terms and limitations...."

[2] Delgado's amicus curiae Steven W. Murray cites this court's decision in Lowell v. Maryland Casualty Co. (1966) 65 Cal.2d 298 [54 Cal. Rptr. 116, 419 P.2d 180] as supporting Delgado's claim that acts done in self-defense are accidents. Lowell, however, is readily distinguishable from this case. There the policy provided coverage for injuries caused by an accident. The third party sued the insured, alleging assault and battery; the insured tendered the defense of that action to the insurance company, asserting that the assault and battery never happened. (Id. at p. 300.) This court held that the insurance company had a duty to defend because the policy promised to defend the insured even against groundless claims, because language in the policy's exclusion clause stated that assault and battery "shall be deemed an accident unless committed by or at the direction of the insured," and because the exclusionary language was not conspicuous, plain and clear. This court, without further reference to the language in the policy's exclusion clause regarding assaultive conduct committed by the insured, stated that the policy there "categorically states that assault and battery is to be deemed an accident, covered by the policy." (Id. at p. 301.) Lowell reasoned that there the insured could reasonably expect a defense, as the policy stated that the insurer would defend against groundless claims and that "[a]ssault and battery shall be deemed an accident...." (Ibid.) There is nothing in the policy now before us that would support a conclusion that the insured reasonably expected a defense. Here, unlike the situation in Lowell, nothing in the policy defines an assault and battery as accidental conduct.

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SONIA GRACIANO, Plaintiff and Respondent,

v.

MERCURY GENERAL CORPORATION et al., Defendants and Appellants.

No. D061956.

Court of Appeals of California, Fourth District, Division One.

October 17, 2014.

`417 Hager Dowling Lim & Slack, John V. Hager and Alison M. Bernal for Defendants and Appellants.

Dabney Finch and Carla DeDominicis for Plaintiff and Respondent.

`418 OPINION

McDONALD, J. —

Plaintiff Sonia Graciano suffered severe injuries when she was struck by a car driven by Saul Ayala (Saul). Saul was insured by a policy issued by defendant California Automobile Insurance Company (CAIC), which had policy limits of $50,000. Less than three weeks after Graciano's attorney first contacted CAIC alleging Graciano was injured by one of CAIC's insureds, during which time Graciano misidentified both the name of the driver and the applicable insurance policy, CAIC completed its investigation of the accident, identified the correct insurance policy and driver, and tried to settle Graciano's claim against Saul by delivering to Graciano's attorney a "full policy limits offer."

Graciano did not accept CAIC's full policy limits offer and, in the present action, asserts CAIC and its parent and affiliated companies (together Defendants) acted in bad faith, based on an alleged "wrongful failure to settle." Graciano argues CAIC could have and should have earlier discovered the facts, and should have made the full policy limits offer more quickly. The jury found in favor of Graciano and this appeal followed.

CAIC asserts that, as a matter of law, there was no evidence to support the verdict that CAIC acted in bad faith by unreasonably failing to settle Graciano's claim against Saul. We agree, and reverse the judgment.[1]

I

FACTUAL BACKGROUND

A. The Accident

In the early morning hours of October 20, 2007, Graciano was severely injured when she was struck by a 2004 Cadillac driven by Saul, who had been drinking before the accident.

B. The Two CAIC Policies
Saul was a named insured on CAIC policy No. 040115180005897, in effect on the date of the accident (Saul's policy) with a policy limit of $50,000. The Cadillac was a listed vehicle on Saul's policy.

419  CAIC had also insured Jose Saul Ayala (Jose) under a separate policy (policy No. AP00401514; Jose's policy), and the Cadillac was also a listed vehicle on Jose's policy. Jose's policy, which had policy limits of $15,000, had been canceled approximately six months before the accident.

C. The Two Reports of the Accident

Saul's Report (CAIC Claim No. 20070032006723-81)

Late on the afternoon of October 23, 2007, CAIC first learned of the accident when Saul contacted an adjuster working for CAIC to report he had been in an accident in the early morning hours of October 21, 2007. Saul reported he fell asleep while driving and had struck a woman and injured her. Saul's claim was handled by the adjusters of the Vista claims unit, and CAIC immediately began investigating this claim. CAIC contacted the California Highway Patrol (CHP) that same day to order a copy of the police report and, at that time, learned the actual date of the accident was October 20, 2007. CAIC also contacted the tow yard the following day and learned the CHP had an "evidence hold" on the Cadillac, which would require permission from the CHP to allow CAIC to inspect it.

Based on the preliminary information, CAIC believed the driver was 100 percent at fault. By October 30, 2007, CAIC's adjuster believed it would likely be an "excess bodily injury claim," meaning the amount for which Saul was liable would exceed the amount of coverage provided by CAIC's policy. However, CAIC apparently did not know at that point the identity of the person injured by Saul.

Graciano's Report (CAIC Claim No. 20070065006697-01)

Three days after Saul's report, Ms. DeDominicis contacted a CAIC call center in Texas to report her client (Graciano) had been injured by a driver insured by CAIC. DeDominicis reported Graciano was injured on October 21, 2007, gave the call center "AP00297623" as the driver's policy number with CAIC, and told CAIC the driver's name was "Saul Ayala." 420

CAIC assigned this report to a different claim identification number (claim No. 20070065006697-01), which identified Jose as the insured and identified his last effective policy number as AP00401514. 420 Graciano's claim was assigned to the La Mesa claims unit. The La Mesa claims unit transferred Graciano's claim to the factfinder unit (Factfinder unit) in Sacramento, which did coverage investigations, because the listed policy (policy No. AP00401514) appeared to have been canceled before the date of the accident and the Factfinder unit needed to determine whether policy No. AP00401514 had validly been canceled. Ms. Talley of the Factfinder unit attempted to contact Jose without success, requested the underwriting file, and also confirmed it appeared Jose's policy had been canceled in April 2007. Talley also corresponded with DeDominicis on November 1, 2007, to inform DeDominicis it was investigating a "coverage problem" for Jose under policy No. AP00401514 and had been unable to confirm coverage. Talley also spoke with DeDominicis on November 6, 2007, confirming the coverage investigation was still ongoing but had not been completed.

D. Graciano's Demand Letter

On November 5, 2007, DeDominicis mailed a demand letter to Talley. The letter identified Jose as the "named insured," the policy as "Policy # AP00401514," the "Date of Loss [as] October 21, 2007," and described Graciano's extensive injuries. DeDominicis stated she had been retained to pursue Graciano's remedies "arising out of an
event in which your above-referenced insured and/or their vehicle struck [Graciano]." (Italics added.) DeDominicis stated that, considering Graciano’s extensive injuries, “demand is made that Mercury immediately provide a copy of the declaration page and payment of the maximum bodily injury policy limits to Mrs. Graciano. [] The offer to settle for verified policy limits shall expire within ten days of today’s date, and shall not be renewed. [] Thereafter, Mrs. Graciano shall take the position that Mercury is responsible for any extra-policy judgment that is certain to be rendered. . . . [] If there is anything else you need to consider and respond in a timely fashion to this policy limit demand, please do not hesitate to call immediately. . . .” That letter was not received by Talley until November 8.

The previous day, Talley first received the police report of the incident. The police report correctly reflected Saul was the driver but still listed Jose's old policy (i.e., policy No. AP00297623) as the applicable insurance policy.41

421 E. CAIC’s Response to the Demand for Jose’s Policy Limits

In the late afternoon of Thursday, November 8, 2007, although its initial investigation indicated Jose's policy had been canceled for underwriting reasons, CAIC nevertheless requested DeDominicis to grant an extension on Graciano’s demand for a policy limits settlement to give it time to complete its coverage investigation before responding to her demand. DeDominicis refused CAIC's request.

By Monday, November 12, CAIC’s investigation of Graciano’s report and claim had determined Saul, whom the newly obtained police report listed as the driver who struck Graciano, was a “non-listed driver” on Jose’s policy and, according to the police report, did not reside at Jose's address. However, CAIC was still concerned Saul could have been the son of the named insured, even though Saul’s address did not match that of Jose. That day, CAIC again tried, without success, to speak with DeDominicis about Graciano’s claim.

On November 14, 2007, CAIC responded to DeDominicis’s “policy limit demand” on Jose’s policy and informed her that its preliminary investigation over the preceding seven days, although not yet complete, made it appear that Jose’s policy was not in force at the time of the accident, and therefore CAIC could not accept DeDominicis’s policy limit demand before the November 15, 2007, deadline. CAIC cautioned that its determination was not final, but did advise Graciano to pursue her uninsured motorist coverage with her own insurer.

F. CAIC Connects Saul’s Report with Graciano’s Report and Offers Policy Limits

On the late afternoon of November 14, Talley of the Factfinder unit again called Jose to inform him the claimant was seriously injured and might pursue Jose. Talley also left messages with the driver named in the police report, Saul, to ask whether Saul had any insurance. However, Talley did not at that time know whether Saul had any insurance, much less that he had insurance with CAIC.

Shortly after noon the following day, Talley spoke on the phone with Saul, who told Talley he did have insurance and that his insurance was with CAIC. This was the first time Talley discovered that a claim under Saul’s name and policy had already been opened in the Vista claims unit. Talley immediately gave Graciano’s claim and demands to the persons in the Vista claims unit handling Saul’s claim. Around 1:45 p.m., an adjuster in the Vista claims unit contacted DeDominicis to explain they were the unit handling Saul’s claim and had just found out that Graciano was the person whom Saul had reported he had injured, and asked DeDominicis for a 24-hour extension to respond to her settlement demand. DeDominicis refused and stated that if CAIC could not “get its act together on what policy handles what, it’s not her problem.” The adjuster immediately forwarded his recommendation to the Vista claims supervisor, who recommended CAIC make a full policy limits offer on Saul’s policy to settle Graciano’s claims against him, and the supervisor immediately approved this offer.
CAIC immediately prepared a letter offering $50,000, which it identified as the full policy limits on Saul's policy, in full and final settlement of Graciano's injury claim. The letter specified the settlement would include any lien claims (noting the hospital at which Graciano was treated would have a statutory lien) and any loss of consortium claims, and asked DeDominicis to advise whether Graciano was married. Graciano stipulated DeDominicis received CAIC's settlement offer letter before the November 15, 2007, deadline of her demand on Jose's policy expired.\[3\]

Graciano did not accept CAIC’s offer to settle her claims against Saul. Instead, she pursued her action against Saul.\[4\] Graciano obtained a judgment against Saul for over $2 million and obtained an alleged assignment of Saul's rights against CAIC.

G. The Other Admitted and Excluded Evidence

Graciano introduced evidence that CAIC could have more promptly obtained the police report, or at a minimum could have more promptly obtained the "face pages" from the police report of the accident, but negligently did not do so. Had CAIC earlier obtained these pages, it would have earlier learned the driver's identity. Once the driver's identity was known, CAIC could have searched its computers to determine whether CAIC insured the driver.

423 Although the Factfinder unit did receive the police report on November 7, and therefore knew Saul was the driver, no one in the Factfinder unit searched its computerized database under "Saul Ayala" to determine if he was insured by CAIC. Had anyone conducted that search, they could have earlier learned he was insured by CAIC, and this could have led the Factfinder unit to learn of the claim Saul had opened two weeks earlier being processed by the Vista claims unit.\[5\] Additionally, the Factfinder unit had (by Nov. 12) made a preliminary determination that Jose's policy had expired and therefore there was no coverage, and at that time the supervisor noted (among other tasks to be performed) someone should contact Jose to determine if he had any "excess" coverage that might be applicable, and also "verify if [Saul] has his own insurance." These calls to Jose and Saul were made two days later, and when Saul returned this call the next day, Talley first learned of his insurance with CAIC.

When CAIC tendered their policy limits on November 15, it was unaccompanied by either a check or by the declarations page for Saul's policy. This offer was also subject to the conditions that the policy limits offer of settlement would include (1) any loss of consortium claim and (2) all lien claims "known and unknown."\[6\]

424 The court excluded evidence proffered by the defense to support its argument that DeDominicis’s offer to settle for the policy limits was not a genuine offer and that, once CAIC informed her that it appeared there was no coverage under Jose's policy, its subsequent efforts to settle on behalf of Saul were hampered by DeDominicis's machinations. For example, although DeDominicis knew (not later than Nov. 7, 2007) that the driver's name was Saul Ayala, Jr., her November 5 demand letter, as well as her November 7 letter enclosing Graciano's medical bills and her November 8 letter reiterating the November 15 deadline for CAIC to respond, continued to refer solely to Jose and Jose's policy number without any mention of Saul. Additionally, the court excluded evidence that CAIC tried to reach DeDominicis telephonically on the afternoon of November 15 to convey the offer to settle, but that those calls went unanswered, and excluded evidence that CAIC’s efforts to fax the offer of policy limits during this same timeframe were prevented because DeDominicis had (in a departure from ordinary procedures) turned her fax machine off. (See fn. 5, ante.)

II

PROCEDURAL HISTORY
Graciano disregarded CAIC's full policy limits offer and instead pursued her previously filed action against Saul. She obtained a judgment of over $2 million and obtained a partial assignment of Saul's rights against CAIC to pursue the present action.

The present action alleged a claim for insurance bad faith based on CAIC's alleged unreasonable refusal to settle Graciano's claim against Saul. The jury returned a verdict in Graciano's favor, and CAIC timely appealed.

III

APPLICABLE LEGAL STANDARDS

A. Substantive Standards

Because this action was limited to a claim that CAIC breached its duties to Saul by not taking reasonable steps to settle Graciano's claim against him, we outline the principles applicable to the claim.

"425 (1) "In each policy of liability insurance, California law implies a covenant of good faith and fair dealing. This implied covenant obligates the insurance company, among other things, to make reasonable efforts to settle a third party's lawsuit against the insured. If the insurer breaches the implied covenant by unreasonably refusing to settle the third party suit, the insured may sue the insurer in tort to recover damages proximately caused by the insurer’s breach." (PPG Industries, Inc. v. Transamerica Ins. Co. (1999) 20 Cal.4th 310, 312 [84 Cal.Rptr.2d 455, 975 P.2d 652]) The standard of good faith and fairness examines the reasonableness of the insurer's conduct, and mere errors by an insurer in discharging its obligations to its insured "does not necessarily make the insurer liable in tort for violating the covenant of good faith and fair dealing; to be liable in tort, the insurer's conduct must also have been unreasonable. [Citations]." (Brandt v. Superior Court (1985) 37 Cal.3d 813, 819 [210 Cal.Rptr. 211, 693 P.2d 796]; accord, Wallbrook Ins. Co. v. Liberty Mutual Ins. Co. (1992) 5 Cal.App.4th 1445, 1460 [7 Cal.Rptr.2d 513] ["so long as insurers are not subject to a strict liability standard, there is still room for an honest, innocent mistake"]; Tomaselli v. Transamerica Ins. Co. (1994) 25 Cal.App.4th 1269, 1280-1281 [31 Cal.Rptr.2d 433] ["The law clearly states that erroneous denial of a claim does not alone support tort liability; instead, tort liability requires that the insurer be found to have withheld benefits unreasonably."])"

(2) An insured's claim for bad faith based on an alleged wrongful refusal to settle first requires proof the third party made a reasonable offer to settle the claims against the insured for an amount within the policy limits. (Merritt, supra, 34 Cal.App.3d at p. 877.) The offer satisfies this first element if (1) its terms are clear enough to have created an enforceable contract resolving all claims had it been accepted by the insurer (Coe v. State Farm Mut. Auto. Ins. Co. (1977) 66 Cal.App.3d 981, 992-993 [138 Cal.Rptr. 331 (Coe)], (2) all of the third party claimants have joined in the demand (ibid.), (3) it provides for a complete release of all insureds (Strauss v. Farmers Ins. Exchange (1994) 26 Cal.App.4th 1017, 1021 [31 Cal.Rptr.2d 811]), and (4) the time provided for acceptance did not deprive the insurer of an adequate opportunity to investigate and evaluate its insured's exposure. (Critz v. Farmers Ins. Group (1964) 230 Cal.App.2d 788, 798 [41 Cal.Rptr. 401] [Critz] [One-week time limit "426 attached to settlement offer does not preclude a finding of bad faith rejection where insurer's investigation and evaluation of claim had been completed; claimant "had a right to attach a time limit to her offer, but the insurer was not bound by it. [Citation.] Had the company needed more time for investigation, for a good faith assessment of the claim's value or for consultation with its policyholder, it might have chosen neither to accept nor reject her offer, but rather to suggest additional time."]) disapproved on other grounds in Crisci v. Security Ins. Co. (1967) 66 Cal.2d 425, 433 [58 Cal.Rptr. 13, 426 P.2d 173]."

A claim for bad faith based on an alleged wrongful refusal to settle also requires proof the insurer unreasonably failed to accept an otherwise reasonable offer within the time specified by the third party for acceptance. (Critz, supra, 230 Cal.App.2d at p. 798.) However, when a liability insurer timely tenders its "full policy limits" in an attempt
to effectuate a reasonable settlement of its insured’s liability, the insurer has acted in good faith as a matter of law (Crane, supra, 217 Cal.App.3d at p. 1136; accord, Poicourt v. Amex Assurance Co. (2000) 78 Cal.App.4th 1390, 1400 [3 Cal.Rptr.2d 783]) because "by offering the policy limits in exchange for a release, the insurer has done all within its power to effect a settlement." (Lehto v. Allstate Ins. Co. (1994) 31 Cal.App.4th 60, 73 [36 Cal.Rptr.2d 814].)

B. Standard of Review

When a verdict is challenged for lack of substantial evidence, we must determine whether there is evidence that is ""reasonable in nature, credible, and of solid value: [constituting] 'substantial' proof of the essentials which the law requires in a particular case." [Citations.]" (DiMartino v. City of Orinda (2000) 80 Cal.App.4th 329, 336 [95 Cal.Rptr.2d 16].) "In evaluating the legal sufficiency of the evidence, the following basic approach is required: 'First, one must resolve all explicit conflicts in the evidence in favor of the respondent and presume in favor of the judgment all reasonable inferences. [Citation.] Second, one must determine whether the evidence thus marshaled is substantial. While it is commonly stated that our "power" begins and ends with a determination that there is substantial evidence [citation], this does not mean we must blindly seize any evidence in support of the respondent in order to affirm the judgment. The Court of Appeal "was not created ... merely to echo the determinations of the trial court. A decision supported by a mere scintilla of evidence need not be affirmed on review." [Citation.]"" If the word 'substantial' [is to mean] anything at all, it clearly implies that such evidence must be of ponderable legal significance. Obviously the word cannot be deemed synonymous with 'any' evidence. It must be reasonable,..., credible, and of solid value..." [Citation.]" (Valenzuela v. State Personnel Bd. (2007) 153 Cal.App.4th 1179, 1184-1185 [63 Cal.Rptr.3d 427, 529], quoting Kuhn v. Department of General Services (1994) 22 Cal.App.4th 1627, 1632-1633 [29 Cal.Rptr.2d 191].) "The ultimate determination is whether a reasonable trier of fact could have found for the respondent based on the whole record. [Citation.] While substantial evidence may consist of inferences, such inferences must be 'a product of logic and reason' and 'must rest on the evidence' [citation]; inferences that are the result of mere speculation or conjecture cannot support a finding [citations]." (Kuhn, at p. 1633.)

When a claim is based on the insurer's bad faith, alleging either the insurer unreasonably refused to pay policy benefits or did not conduct an adequate investigation, the ultimate test is whether the insurer's conduct was unreasonable under all of the circumstances. (Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co. (2001) 90 Cal.App.4th 335, 346 [108 Cal.Rptr.2d 776].) Although "the reasonableness of an insurer's claims-handling conduct is ordinarily a question of fact, it becomes a question of law where the evidence is undisputed and only one reasonable inference can be drawn from the evidence." (Ibid.)

IV

ANALYSIS

A. There Is No Substantial Evidence CAIC Unreasonably Rejected an Offer to Settle Saul's Liability

(3) An insured's claim for "wrongful refusal to settle" cannot be based on his or her insurer's failure to initiate settlement overtures with the injured third party (Reid v. Mercury Ins. Co. (2013) 220 Cal.App.4th 262, 277 [162 Cal.Rptr.3d 894] ["nothing in California law supports the proposition that bad faith liability for failure to settle may attach if an insurer fails to initiate settlement discussions, or offer its policy limits, as soon as an insured's liability in excess of policy limits has become clear"]), but instead requires proof the third party made a reasonable offer to settle the claims against the insured for an amount within the policy limits. (Merritt, supra, 34 Cal.App.3d at p. 877.)
We conclude there is no substantial evidence Graciano ever offered to settle her claims against Saul for an amount within Saul's policy limits.

The only settlement "offer" CAIC could have accepted was DeDominicis's November 5, 2007, letter. It identified Jose as the named insured, the relevant policy as Jose's policy (e.g., "Policy # AP00401514"), and (after describing Graciano's extensive injuries) stated DeDominicis had been retained to pursue Graciano's remedies "arising out of an event in which your above-referenced insured and/or their vehicle struck [Graciano]" (italics added), and "428 demanded that CAIC "immediately provide a copy of the declaration page and payment of the maximum bodily injury policy limits...." (Italics added.) Even assuming (as Graciano contends on appeal) the letter implicitly contained an agreement to release "the above referenced insured" in exchange for the "policy limits" of the referenced policy, the plain import of this letter is that Graciano offered only to settle her claims against Jose. Because Graciano never demanded payment of Saul's policy limits in exchange for a release of Saul's liability, Saul would not have been protected even had CAIC accepted the terms of Graciano's demand.

Graciano cites no authority that an offer to release one potentially liable party (here, Jose) in exchange for that party's policy limits, if rejected by the insurer, can serve as the basis for a "wrongful refusal to settle" claim by a different potentially liable party (here, Saul), and analogous authorities suggest a contrary rule. In McLaughlin v. National Union Fire Ins. Co. (1994) 23 Cal.App.4th 1132 [29 Cal.Rptr.2d 559], the injured party made a settlement demand that was apparently within policy limits, but the offer contained no suggestion the injured party would release the insured, and the McLaughlin court rejected the argument that such offer could support the verdict against the insurer for wrongful refusal to settle. (id. at p. 1145, fn. 5.) Similarly, in Strauss v. Farmers Ins. Exchange, supra, 26 Cal.App.4th 1017, the plaintiff's demand for policy limits did not include an offer to release all of the insureds, and the court concluded rejection of such an offer could not support an action for wrongful refusal to settle. (id. at pp. 1020-1022.) Finally, in Coe, supra, 66 Cal.App.3d 981, the court concluded the insurer's failure to accept the plaintiff's settlement demand could not provide a basis for a wrongful refusal to settle the claim because it would not have released the insured from all potential claims. (id. at pp. 992-993.)

"429 Graciano argues these cases do not support reversal because claimants are not required "to begin settlement overtures with letter-perfect offers to which insurers need only respond 'Yes' or 'No.' An insurer's duty of good faith would be trifling if it did not require the insured to explore the details of a settlement offer that could prove extremely beneficial to its insured." (Allen v. Allstate Ins. Co. (9th Cir. 1981) 656 F.2d 487, 490, fn. omitted; see Betts v. Allstate Ins. Co. (1984) 154 Cal.App.3d 688, 708, fn. 7 [201 Cal.Rptr. 528] [noting in dicta that where insurer deems settlement offers ambiguous or incomplete it should attempt to seek clarification rather than rejecting offer].) Indeed, Graciano's argument on appeal is that McLaughlin and Strauss are distinguishable because her November 7 letter never refused to release Saul; by the same token, however, neither did her November 7 letter ever offer to release Saul in exchange for Saul's policy limits. Graciano also suggests that, even if there was some ambiguity as to whether Saul would have been encompassed in her settlement demand, "if [CAIC] had contacted Ms. DeDominicis before the settlement expiration date to verify her client would sign releases, as did the insurer in Coe, that issue could have been resolved." This argument, however, ignores the undisputed evidence CAIC did contact Ms. DeDominicis before the settlement expiration date to inquire whether her client would agree to release Saul in exchange for his policy limits, and those inquiries were rebuffed.

Graciano alternatively argues that, even assuming the November 7 demand letter incorrectly identified the insured and the applicable policy number, those defects were attributable to CAIC because it was CAIC that, in response to Graciano's report of the injury, changed the driver's name from "Saulay Ala" (as reported by DeDominicis) to Jose. Graciano argues it is CAIC—not a third party—who is obligated to investigate claims against its insured, and therefore any defect in her demand letter must be attributed to CAIC's default of their obligations. However, the undisputed evidence is that CAIC did comply with its obligations to investigate potential coverage on this reported claim, because once CAIC received this report from Graciano (which tied her claim to an apparently canceled policy) it tried to contact Jose, immediately began investigating whether the policy had been validly canceled, and kept Graciano apprised of its progress. The defect in her demand letter thus had its genesis in the defect in
DeDominicis's first report of Graciano's claim, and was not impacted by the investigation undertaken by the Factfinder unit in response to her initial claim.

Graciano attempts to bring the circumstances of this case under the aegis of *Safeco Ins. Co. of America v. Parks* (2009) 170 Cal.App.4th 992 [88 Cal.Rptr.3d 730] (*Safeco*), arguing that an insurer is charged with constructive knowledge of its own insurance agreements and, if it fails to search for, "discover and disclose potential coverage under a policy other than the one under which the claim is made, it can be held liable for wrongful failure to defend and to settle. However, even under the analysis of the *Safeco* court, we are unpersuaded that case supports the judgment here.

Our reason for rejecting Graciano's reliance on *Safeco* requires a nuanced understanding of the facts presented to, and the resulting analysis by, the *Safeco* court. There, the victim (Parks) sued three tortfeasors, including Miller, for injuries he sustained in 1999 when he was struck by a third person after Miller and the others left Parks at the side of a road. (*Safeco, supra, 170 Cal.App.4th at p. 998.) Miller, a minor, lived with her father and grandmother in a condominium rented by the grandmother. Miller's mother was living with Mr. Barnett, who had a homeowners insurance policy issued by *Safeco*, and Miller occasionally stayed with her mother at Barnett's house. (*Ibid.*) Miller tendered her defense to *Safeco* under the homeowners policy issued to Barnett (the Barnett policy), but *Safeco* declined the defense (*ibid.*), apparently contending an automobile exclusion precluded coverage for this accident (*id. at p. 1004*). In a subsequent action, Parks recovered a judgment against Miller, who settled with Parks by assigning to him any claims she might have against *Safeco* and, in 2002, Parks sued *Safeco* to recover the judgment he obtained against Miller (the bad faith action). He alleged that *Safeco* breached the Barnett policy by refusing, in bad faith, to defend Miller under the Barnett policy and to settle within the limits of that policy. (*Id. at p. 998.*) Sometime later, apparently in 2003 and well after Parks's bad faith action was filed, Miller's father asked her grandmother (Evelyn) whether she had any insurance on her condominium and discovered *Safeco* insured Evelyn under a renter's insurance policy (the Evelyn policy). Miller's father then gave the Evelyn policy to Miller or to her lawyer. (*Id. at p. 999.*)

In a bifurcated proceeding in the original bad faith action, the trial court entered a declaratory judgment in favor of Parks, finding *Safeco* had a duty to defend and to indemnify Miller because she was an insured under the Barnett policy. However, *Safeco* appealed and, in 2004, the appellate court reversed and held *Safeco* had no duty to defend Miller under the Barnett *431* policy because she was not an insured under that policy. (*Safeco, supra, 170 Cal.App.4th at p. 999.*) Thereafter, Parks's counsel demanded *Safeco* pay the policy limits under the Evelyn policy, and the adjuster for *Safeco* (within a week of receiving the demand letter) concluded Miller was an insured under the Evelyn policy and that its automobile exclusion did *not* preclude coverage. Parks then amended his bad faith action to allege for the first time that *Safeco* had a duty under the Evelyn policy to pay the judgment and that it breached the implied covenant of good faith by refusing to defend or indemnify Miller under that policy. (*Id. at pp. 999-1000.*) The trial court ultimately concluded *Safeco* had breached the implied covenant of good faith by refusing to defend or indemnify Miller based on a policy (the Evelyn policy) under which Miller had never sought a defense. (*Id. at p. 1000.*)

(4) The lynchpin of the *Safeco* court's analysis, upon which the balance of its remaining holdings depended, was its discussion of the insurer's claim that its duty of good faith and fair dealing under the Evelyn policy "never arose because ... Miller tendered her defense only under the Barnett policy and there was no evidence *Safeco* had actual knowledge of the [Evelyn] policy when it declined the defense." (*Safeco, supra, 170 Cal.App.4th at p. 1003, fn. omitted.*) The *Safeco* court, after noting the duty of good faith and fair dealing includes a duty on the part of the insurer to investigate claims submitted by its insured, specifically noted that the "duties, however, arise after the insured complies with the claims procedure described in the insurance policy. [Citations.]" (*Id.*) Without actual presentation of a claim by the insured in compliance with claims procedures contained in the policy, there is no duty imposed on the insurer to investigate the claim. (*Citing California Shoppers, Inc. v. Royal Globe Ins. Co. (1985) 175 Cal.App.3d 1, 57 [221 Cal.Rptr. 171].*) (*Safeco, at p. 1003.*) However, the *Safeco* court noted the insured's failure to comply with the notice or claims provisions will not excuse the insurer's obligations under the policy.

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"unless the insurer proves it was substantially prejudiced by the late notice. [Citations.] 'Prejudice is not presumed from delayed notice alone. [Citations.] The insurer must show actual prejudice, not the mere possibility of prejudice.' [(Quoting Shell Oil Co. v. Winterthur Swiss Ins. Co. (1953) 12 Cal.App.4th 715, 761 [15 Cal.Rptr.2d 815].)] Where, as here, the insurer denies coverage, it may establish substantial prejudice only by demonstrating that, 'in the event that a timely tender of the defense [in the underlying action] had been made, it would have undertaken the defense.' [(Quoting Clemmer v. Hartford Insurance Co. (1978) 22 Cal.3d 865, 863 [151 Cal.Rptr. 285, 587 P.2d 1098].)] 'If the insurer asserts that the underlying claim is not a covered occurrence or is excluded from basic coverage, then earlier notice would only result in earlier denial of coverage. To establish actual prejudice, the insurer must show a "432 substantial likelihood that, with timely notice, and notwithstanding a denial of coverage or reservation of rights, it would have settled the claim...." [(Quoting Shell Oil Co. v. Winterthur Swiss Ins. Co., supra, 12 Cal.App.4th at p. 763.)]" (Safeco, supra, 170 Cal.App.4th at p. 1004, italics added.)

The Safeco court then concluded the "notice defense" was correctly rejected by the trial court (on a motion for summary adjudication) and later by the jury because the insurer did not establish it had been prejudiced by the delayed notice, reasoning Safeco had attempted to justify its rejection of coverage under the Barnette policy by asserting its automobile exclusion precluded coverage for this accident, and "Safeco now relies on the same automobile exclusion to contend there was no potential for coverage under the substantially identical [Evelyn] policy. As a result, both the trial court and the jury could reasonably infer that Safeco was not prejudiced by the late notice because it would have relied on the automobile exclusion to decline the defense under the [Evelyn] policy." (Safeco, supra, 170 Cal.App.4th at p. 1004.)

Here, in contrast, there is no evidence Graciano's misidentification of the applicable policy in her settlement demand did not cause prejudice to CAIC, because there is no evidence CAIC would have relied on the same basis for declining to pay the policy limits on Saul's policy (had Graciano correctly submitted her claim under Saul's policy) as it cited when it declined her request for the policy limits under Jose's policy. To the contrary, the only evidence in the record is that Graciano's misidentification of the applicable policy did cause "actual prejudice [because] the insurer ... show[ed] a substantial likelihood that, with timely notice, ... it would have [attempted to] settle[] the claim...." (Safeco, supra, 170 Cal.App.4th at p. 1004.) The undisputed evidence showed CAIC rejected Graciano's request for the policy limits under the misidentified policy because it had expired, but, once it learned of the applicable policy, it did not decline coverage for the same reason (or for any reason) but instead proffered the full policy limits in an attempt to protect its insured. We are convinced Safeco does not support the verdict here.

Moreover, Safeco provides no support for Graciano's argument for a second reason: the same conduct the Safeco court opined should have been undertaken by the insurer (and whose absence supported the wrongful failure to settle verdict there) was undertaken by CAIC here. Once the Safeco court concluded Miller's misidentification of the applicable policy caused no prejudice to the insurer, and hence the insurer's duty to investigate was not "excused, it concluded Safeco was obligated to investigate whether any other policy potentially covered her liability to the claimant, and its failure to investigate and discover the Evelyn policy led to the insurer's rejection of the policy limit demand. (Safeco, supra, 170 Cal.App.4th at p. 1005.) The Safeco court specifically noted the insurer determined Miller did not reside with her mother and therefore was not an insured under the Barnette policy, and declined coverage, and thereafter there was "no evidence [the insurer] ever searched its own records for potentially applicable Safeco policies issued to the adults with whom [Miller] resided[...]] nor did Safeco interview [Miller's] father or grandmother to determine whether they had Safeco policies that might cover her claim." (Id. at p. 1008.) Because this search or interview would have produced the applicable Evelyn policy, the Safeco court concluded the absence of this search breached the insurer's duty to investigate and to attempt to settle Miller's liability. (Id. at p. 1009.) Here, in contrast, after CAIC determined the identified Jose policy did not cover Graciano's claim, it did not stop there; it did try to interview Jose and Saul to determine whether they had policies that might cover Graciano's claim, this search did discover another applicable policy, and CAIC did attempt to settle Saul's liability.

(5) Because the undisputed evidence shows CAIC was actually prejudiced by the misidentification of the applicable policy, and also shows (notwithstanding the misidentification) CAIC undertook the type of continued investigation
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the Safeco court concluded was required, we reject Graciano's argument that there was substantial evidence under Safeco to support the verdict.

(6) Graciano's argument under Safeco is not, at bottom, that CAIC did not conduct any effort to locate and provide coverage for Saul, but is instead an argument that there was substantial evidence CAIC "bungled its investigation" and, for its errors, could have sooner discovered there was a policy providing coverage for her claim. Although this claim is true, it is also irrelevant. A bad faith claim requires "something beyond breach of the contractual duty itself" (California Shoppers, Inc. v. Royal Globe Ins. Co., supra, 175 Cal.App.3d at p. 54 (California Shoppers)), and something more is "refusing, without proper cause, to compensate its insured for a loss covered by the policy..." [Citation.] Of course, the converse of 'without proper cause' is that declining to perform a contractual duty under the policy with proper cause is not a breach of the implied covenant. ([Ibid., italics added by California Shoppers.]) The California Shoppers court then noted that ["to refine further the nature and extent of the duty here under analysis, in terms of a particular application of 'with proper cause,' it is our view that a mistaken withholding of policy benefits, at least where, as here, such mistake (as to the insured's identity and not as to the matter of coverage) has been contributed to by the very party claiming those policy benefits, is consistent "434 with observance of the implied covenant of good faith and fair dealing because the mistake supplies the 'proper cause.'" (Id. at p. 55.) Applying California Shoppers here, although there was some delay by CAIC in locating and connecting Graciano's claim with Saul's policy, resulting in a mistaken "withholding" of policy benefits for 24-hour period, such mistake was "contributed to by the very party claiming those policy benefits" and "supplies the 'proper cause'" (ibid.), fatal to Graciano's bad faith claim.

B. There Is No Substantial Evidence CAIC Unreasonably Failed to Timely Tender Saul's Policy Limits to Attempt to Settle Saul's Liability

(7) A claim for "wrongful refusal to settle" requires proof the insurer unreasonably failed to accept an otherwise reasonable offer within the time specified by the third party for acceptance. ([Critz, supra, 230 Cal.App.2d at p. 798.) The third party is entitled to set a reasonable time limit within which the insurer must accept the settlement proposal (Martin v. Hartford Acc. & Indem. Co. (1964) 228 Cal.App.2d 178, 185 [39 Cal.Rptr. 342]), and even a one-week limitation attached to a settlement offer does not preclude a finding of bad faith rejection under some circumstances. ([Critz, at pp. 797-798 [insurer given one week to respond where claimant had not yet incurred costs of a retained attorney, company's investigation and evaluation was complete, and company never suggested it needed more time for investigation.] Although the insurer "need not be governed by whatever time limit counsel for plaintiff in a personal injury action may impose" (Martin, at p. 185), whether the insurer has satisfied its duty to seek to settle in protection of its insured "must be measured in the light of the time limitation which plaintiff had placed on her offer." (Ibid.) When a liability insurer does timely tender its "full policy limits" in an attempt to effectuate a reasonable settlement of its insured's liability, the insurer has acted in good faith as a matter of law (Crane, supra, 217 Cal.App.3d at p. 1136) because "by offering the policy limits in exchange for a release, the insurer has done all within its power to effect a settlement." ([Lehto v. Allstate Ins. Co., supra, 31 Cal.App.4th at p. 73.]

(8) Here, in the three weeks after it first learned Graciano was alleging someone insured by CAIC had injured her, CAIC was able to (1) determine that the policy identified by Graciano (Jose's policy) could not provide a source of compensation for her, (2) identify that a person (Saul) different from the one identified by Graciano ("Saulay Ala") was responsible for Graciano's injuries, (3) determine Saul did have a policy available as a source of compensation, and (4) tender CAIC's "full policy limits" in an attempt to effectuate a settlement of Saul's liability. Although there was substantial evidence from which a jury could have concluded CAIC was able to resolve the confusion engendered by Graciano's misidentification of the applicable insured and insurance policy earlier than it did, and to offer to settle earlier than it did, perfection is not required (see, e.g., Adelman v. Associated Internat. Ins. Co. (2001) 90 Cal.App.4th 352, 369 [108 Cal.Rptr.2d 788] ["to recover in tort for an insurer's mishandling of a claim, it must allege more than mere negligence"], and Graciano's evidence showed, at most, that CAIC could have resolved the confusion more promptly. [12]

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(9) More importantly, the undisputed evidence showed CAIC did timely tender Saul's full policy limits in an attempt to settle Graciano's claim, and therefore acted in good faith as a matter of law "by offering the policy limits in exchange for a release [thereby doing] all within its power to effect a settlement." (Lehto v. Allstate Ins. Co., supra, 31 Cal.App.4th at p. 73.) Although Graciano argues the evidence could have permitted a trier of fact to conclude the tender of Saul's policy limits was not timely, Graciano herself selected November 15 as the deadline for offering full policy limits in settlement. Although an injured third party's unilateral selection of a deadline does not conclusively govern whether a later tender of policy limits would have been untimely (Martin v. Hartford Acc. & Indem. Co., supra, 228 Cal.App.2d at p. 185), we conclude at a minimum that the insurer has satisfied its duty to seek to settle in protection of its insured when, "in the light of the time limitation which plaintiff had placed on her offer" (ibid.), the insurer tenders its full policy limits within the time limits imposed by an injured party's demand letter.

*436 DISPOSITION

The judgment is reversed. The trial court is directed to enter judgment on the complaint in favor of defendants. Defendants shall recover their costs on appeal.

Huffman, Acting P. J., and O'Rourke, J., concurred.

A petition for a rehearing was denied November 12, 2014, and the opinion was modified to read as printed above. Respondent's petition for review by the Supreme Court was denied January 21, 2015, S223002.

[1] CAIC alternatively asserts on appeal that, even assuming the evidence could have supported the verdict, the trial court prejudicially erred by excluding evidence elaborating on CAIC's attempt to convey its offer to settle Graciano's claim against Saul. CAIC also argues the court erred by summarily adjudicating that entities other than CAIC were jointly and severally liable for the judgment under alter ego principles. Because of our conclusion that no substantial evidence supports the finding CAIC wrongfully did not settle Graciano's claim against Saul, we do not address CAIC's alternative claims.

[2] Graciano's sister-in-law provided the name "Saulay Ala, Jr.," along with "AP00297623" as the driver's policy number, to DeDominicis when she began acting as Graciano's attorney. Graciano's sister apparently obtained that name and policy number from the CHP.

[3] Jose had previously been insured under the policy identified by DeDominicis (i.e., policy No. AP00297623) but, in March 2007, that policy had been canceled and a new policy immediately replaced it that insured Jose and bore the new policy number of AP00401514.

[4] Although Graciano's brief on appeal states the police report received by CAIC listed "Saul Ayala as the driver ... with his [CAIC] policy number" (italics added), the police report contains no reference to Saul's policy No. 040115180005897 and instead listed only Jose's old policy number as the applicable insurance policy.

[5] However, CAIC was also prepared to prove that CAIC tried twice to reach DeDominicis by phone before the deadline expired to orally convey the offer, but she did not answer. Before preparing and sending the letter offer, CAIC's adjuster apparently called DeDominicis to convey the offer, but was only able to reach her voicemail. She left a message conveying CAIC's policy limits offer and asked that DeDominicis return her call. She also tried to reach DeDominicis by phone around 4:30 p.m. and again was unsuccessful. CAIC also sought to show it tried to fax the letter to DeDominicis at 3:21 p.m., at 3:28 p.m., and again at 4:08 p.m., but the fax failed on each occasion because DeDominicis had turned off her fax machine. Because Graciano stipulated DeDominicis timely received the letter, the court excluded this evidence pursuant to Graciano's motion in limine.

[6] DeDominicis had filed an action, naming Saul, Saul's wife, and Saul's corporation, approximately one week before the expiration date set forth in Graciano's demand letter on Jose's policy. However, because of the court's in limine rulings, that evidence was excluded from the jury's consideration.

[7] The Vista claims unit supervisor apparently received an "ISO ClaimSearch Automatic Update" on November 14 that indicated there were at least two claims arising out of the accident. The claim number assigned to Graciano's claim on Jose's policy did appear in that update, but the "claimant" was listed as Saul, and Graciano's name did not appear on this ISO ClaimSearch Automatic Update. By the following day, this confusion was resolved and the two claims had been consolidated by CAIC.

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CAIC's offer observed that "Palomar Medical Center [the hospital at which Graciano was treated] will have a statutory lien." Although Graciano's evidence showed CAIC had not yet placed a "lien stamp" on either of the claim files indicating a notice of the statutory hospital lien had been received, CAIC could not have at that time known whether the statutory lien nevertheless had become effective, because a lien apparently would have been effective (and Saul would have potential liability to Palomar Hospital under Civ. Code, § 3045.4) had the lien notice been "mailed by registered mail ... prior to the payment of any monies to the injured person" by Saul or his insurer. (Civ. Code, § 3045.3, italics added.) Thus, at the time of the offer, CAIC could not "rule out the potential of a hospital lien from Palomar hospital." Also, considering the compressed timeframe, in which the only contact between the Vista claims unit and DeDominics was a short phone conversation in which DeDominics declined CAIC's request for an extension, the Vista claims unit could not have excluded potential loss of consortium claims against its insured because DeDominics's letters described her client as Mrs. Graciano. Regardless, Graciano cites no law suggesting an insurer can be held liable for bad faith failure to settle if it makes a "full policy limits" offer and conditions the offer on a full resolution of all potential claims against its insured, and the law appears to be to the contrary. (Cf. Merritt v. Reserve Ins. Co. (1973) 34 Cal.App.3d 658, 671 [110 Cal.Rptr. 511] [Merritt] ["Patently, the carrier cannot settle its share of the assured's liability and turn the assured adrift, exposed to a suit for excess liability financed by the carrier's settlement."]; accord, State Farm Mut. Auto. Ins. Co. v. Crane (1990) 217 Cal.App.3d 1127, 1136 [266 Cal.Rptr. 422] [Crane] ["The insurer is authorized to settle lawsuits, not to pay unilaterally the policy limits to a plaintiff. Moreover, it is generally recognized that such an unconditional payment, which has the effect of bankrolling a plaintiff's cause against the insured, is not made in good faith."])

We recognize that Brandt and Tomaselli, as well as many other cases on which we rely, involved insurers who allegedly breached the implied covenant of good faith and fair dealing in the context of "first party" coverage claims, whereas the present case involves an alleged breach of the implied covenant of good faith and fair dealing in the context of "third party" coverage. However, the controlling principles have equal applicability in both contexts. (See, e.g., Brehm v. 21st Century Ins. Co. (2008) 166 Cal.App.4th 1226, 1241, fn. 6 [83 Cal.Rptr.3d 410] ["Although the question whether an insurer failed to accept a reasonable settlement offer within policy limits of a third party claim against its insured is analytically distinct from the question whether an insurer unreasonably withheld benefits due under the policy in a first party coverage context [citation], both turn on the reasonableness of the insurer's position."])

Graciano appears to argue the November 7 letter did demand Saul's policy limits because it "demand[ed] the policy limits of Mercury's 'insureds'[and] nowhere refers to the policy limits of Jose" and therefore was "obviously referring to Saul." We reject Graciano's argument to the extent it suggests that a third party claimant, after specifically identifying a named insured and his or her policy number, may demand the policy limits of a company's "insureds" and by such plural reference thereby widen the net to make a demand encompass the universe of unidentified persons and entities who have coverage with the insurer and who may have potential liability for the accident. For example, had Saul been under 21 years of age and been furnished alcohol by a social host (against whom Graciano apparently would have a claim) (Civ. Code, § 1714, subd. (d)) and the host happened to be insured by CAIC, Graciano's theory would expose CAIC to a wrongful refusal to settle claim by that social host for failing to discover the policy and proffer to the social host's policy limits in response to Graciano's demand on Jose's policy. We decline to adopt a rule that a settlement demand seeking the policy limits of a specifically identified insured may, simply by employing the plural term "insureds," constitute a demand seeking the policy limits of the universe of persons and entities with whom an insurer may have issued policies.

The Safeco court itself cautioned that, "[i]n this unusual context, we conclude [the insurer's] failure to conduct a reasonable search for other Safeco policies breached duties arising under the [other] policy to reasonably investigate and settle [the claim] and concluded the insurer could not breach its duty to conduct a reasonable investigation and then use the resulting ignorance "to shield itself from liability for breach of the related duty to accept a reasonable settlement demand." (Safeco, supra, 170 Cal.App.4th at p. 1009, italics added.) Even assuming we were to agree with all aspects of the analysis of the Safeco court, we would limit that case to the peculiar facts and the self-described "unusual context" presented in Safeco.

Graciano asserts the evidence showed CAIC was negligent and cites Noticia v. State Comp. Ins. Fund (1999) 70 Cal.App.4th 911 [83 Cal.Rptr.2d 89] for the proposition that such evidence can be circumstantial evidence of bad faith. However, Noticia recognized that mere negligence does not constitute bad faith and instead held that evidence of negligent mishandling of claims such as those of the plaintiff, "if shown as a pattern, clearly would be strong circumstantial evidence that SCIF indeed engaged in the complained of conduct." (Id. at p. 931, italics added.) On appeal, Graciano cites the evidence showing CAIC could have earlier obtained the police report showing Saul was the driver and, when it did receive that report, could have phoned Saul earlier (but did not) or searched its computer database to determine whether Saul was an insured. However, Graciano has not directed this court's attention to evidence in the record demonstrating such deceptions were part of a pattern by CAIC's claims handling department when dealing with claims like Graciano's claim. (Cf. Estate of Allen (1971) 17 Cal.App.3d 401, 405, fn. 2 [194 Cal.Rptr. 648] [when respondent claims judgment is supported by substantial evidence, "it is the duty of a respondent ... to point out to the appellate court the evidence he deems sufficient to support such judgment"]). Instead, the evidence cited on appeal by Graciano
shows negligence in the handling of this specific claim, but that is not enough to support a verdict for bad faith. (Adelman v. Associated Internat. Ins. Co., supra, 90 Cal.App.4th at p. 369 [“more than mere negligence” required for tort claim (italics omitted)].)

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65 Cal.2d 263 (1966)
419 P.2d 168
54 Cal. Rptr. 104

VERNON DARTMOUTH GRAY, Plaintiff and Appellant,

V.

ZURICH INSURANCE COMPANY, Defendant and Respondent.

Docket No. L.A. 28897.

Supreme Court of California. In Bank.

October 25, 1966.

266 *266 Robert L. Brock, Edwin S. Saul and Brock & Fleishman for Plaintiff and Appellant.

William J. Currer, Jr., as Amicus Curiae on behalf of Plaintiff and Appellant.

Moss, Lyon & Dunn, Gerold C. Dunn and Henry F. Walker for Defendant and Respondent.

TOBRINER, J.

This is an action by an insured against his insurer for failure to defend an action filed against him which stemmed from a complaint alleging that he had committed an assault. [1, 2] The main issue turns on the argument of the insurer that an exclusionary clause of the policy excuses its defense of an action in which a plaintiff alleges that

267 *267 the insured intentionally caused the bodily injury. Yet the language of the policy does not clearly define the application of the exclusionary clause to the duty to defend. Since in that event we test the meaning of the policy according to the insured's reasonable expectation of coverage and since the language of the policy would lead the insured here to expect defense of the third party suit, we cannot exonerate the carrier from the rendition of such protection.

Plaintiff, Dr. Vernon D. Gray, is the named insured under an insurance policy issued by defendant. A "Comprehensive Personal Liability Endorsement" in the policy states, under a paragraph designated "Coverage L," that the insurer agrees "[T]o pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage, and the company shall defend any suit against the insured alleging such bodily injury or property damage and seeking damages which are payable under the terms of this endorsement, even if any of the allegations are groundless, false or fraudulent; but the company may make such investigation and settlement of any claim or suit as it seems expedient." The policy contains a provision that [T]his endorsement does not apply to a series of specified exclusions set forth under separate headings, including a paragraph (c) which reads, "under coverages L and M, to bodily injury or property damages caused intentionally by or at the direction of the insured."

The suit which Dr. Gray contends Zurich should have defended arose out of an altercation between him and a Mr. John R. Jones. [1] Jones filed a complaint in Missouri alleging that Dr. Gray "wilfully, maliciously, brutally and intentionally assaulted" him; he prayed for actual damages of $50,000 and punitive damages of $50,000. Dr. Gray notified defendant of the suit, stating that he had acted in self defense, and requested that the company defend. Defendant refused on the ground that the complaint alleged an intentional tort which fell outside the coverage of the policy. Dr. Gray thereafter unsuccessfully defended on the theory of self defense; he suffered a judgment of $6,000 actual damages although the jury refused to award punitive damages.

268 *268 Dr. Gray then filed the instant action charging defendant with breach of its duty to defend. Defendant answered, admitting the execution of the policy but denying any such obligation. The record on appeal has been
augmented to include an offer of proof, presented by plaintiff and rejected by the trial court, which detailed the circumstances surrounding the altercation. The augmented record also includes exhibits introduced at the trial, consisting of copies of the pleadings and verdict in the Missouri suit and a copy of the subject insurance policy. The parties waived written findings of fact and conclusions of law; the court rendered judgment in favor of defendant. We must decide whether or not defendant bore the obligation to defend plaintiff in the Missouri action.

[3a] Defendant argues that it need not defend an action in which the complaint reveals on its face that the claimed bodily injury does not fall within the indemnification coverage;[26] that here the Jones complaint alleged that the insured committed an assault, which fell outside such coverage. Defendant urges, as a second answer to plaintiff's contention, that the contract, if construed to require defense of the insured, would violate the public policy of the state and that, indeed, the judgment in the third party suit upholding the claim of an intentional bodily injury operates to estop the insured from recovery. Defendant thirdly contends that any requirement that it defend the Jones suit would embroil it in a hopeless conflict of interest. Finally it submits that, even if it should have defended the third party suit, the damages against it should encompass only the insured's expenses of defense and not the judgment against him.

We shall explain our reasons for concluding that defendant was obligated to defend the Jones suit, and our grounds for rejecting defendant's remaining propositions. Since the policy sets forth the duty to defend as a primary one and since the insurer attempts to avoid it only by an unclear exclusionary clause, the insured would reasonably expect, and is legally entitled to, such protection. As an alternative but secondary ground for our ruling we accept, for purposes of argument, defendant's contention that the duty to defend arises only if the third party suit involves a liability for which the insurer would be required to indemnify the insured, and, even upon this basis, we find a duty to defend.

269 [4] In interpreting an insurance policy we apply the general principle that doubts as to meaning must be resolved against the insurer and that any exception to the performance of the basic underlying obligation must be so stated as clearly to apprise the insured of its effect.[3]

These principles of interpretation of insurance contracts have found new and vivid restatement in the doctrine of the adhesion contract. [5] As this court has held, a contract entered into between two parties of unequal bargaining strength, expressed in the language of a standardized contract, written by the more powerful bargainer to meet its own needs, and offered to the weaker party on a "take it or leave it" basis carries some consequences that extend beyond orthodox implications. Obligations arising from such a contract inure not alone from the consensual transaction but from the relationship of the parties.[4]

Although courts have long followed the basic precept that they would look to the words of the contract to find the meaning which the parties expected from them,[5] they have also applied the doctrine of the adhesion contract to insurance "270 policies, holding that in view of the disparate bargaining status of the parties[6] we must ascertain that meaning of the contract which the insured would reasonably expect.[7] [6] Thus as Kessler stated in his classic article on adhesion contracts: "In dealing with standardized contracts courts have to determine what the weaker contracting party could legitimately expect by way of services according to the enterpriser's 'calling', and to what extent the stronger party disappointed reasonable expectations based on the typical life situation." (Kessler, Contracts of Adhesion (1943) 43 Colum.L.Rev. 629, 637.)

270 [4] Professor Patterson, in describing one characteristic consequence of "the conception of adhesion, whether that term is used or not," writes: "The court interprets the form contract to mean what a reasonable buyer would expect it to mean, and thus protects the weaker party's expectation at the expense of the stronger's. This process of interpretation was used many years ago in interpreting (or construing) insurance contracts..." (Fn. omitted; Patterson, The Interpretation and Construction of Contracts (1964) 64 Colum.L.Rev. 833, 858.)

Thus we held in *Stein v. Fidelity & Casualty Co., supra*, 58 Cal.2d 862, that we would not enforce an exclusionary clause in an insurance contract which was unclear, saying: "If [the insurer] deals with the public upon a mass basis,
the notice of noncoverage of the policy, in a situation in which the public may reasonably expect coverage, must be conspicuous, plain and clear." (P. 878.)

[3b] When we test the instant policy by these principles we find that its provisions as to the obligation to defend are uncertain and undefined; in the light of the reasonable expectation of the insured, they require the performance of that duty. At the threshold we note that the nature of the obligation to defend is itself necessarily uncertain. Although insurers have often insisted that the duty arises only if the insurer is bound to indemnify the insured, this very contention creates a dilemma. No one can determine whether the third party suit does or does not fall within the indemnification coverage of the policy until that suit is resolved; in the instant case, the determination of whether the insured engaged in intentional, negligent or even wrongful conduct depended upon the judgment in the Jones suit, and, indeed, even after that judgment, no one could be positive whether it rested upon a finding of plaintiff's negligent or his intentional conduct. The carrier's obligation to indemnify inevitably will not be defined until the adjudication of the very action which it should have defended. Hence the policy contains its own seeds of uncertainty; the insurer has held out a promise that by its very nature is ambiguous.

Although this uncertainty in the performance of the duty to defend could have been clarified by the language of the policy we find no such specificity here. An examination of the policy discloses that the broadly stated promise to defend is not conspicuously or clearly conditioned solely on a nonintentional bodily injury; instead, the insured could reasonably expect such protection.

[7] The policy is a "comprehensive personal liability" contract; the designation in itself connotes general protection for alleged bodily injury caused by the insured. The insurer makes two wide promises: [1] To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage, and [2] the company shall defend any suit against the insured alleging such bodily injury or property damage and seeking damages which are payable under the terms of this endorsement, even if any of the allegations of the suit are groundless, false, or fraudulent: clearly these promises, without further clarification, would lead the insured reasonably to expect the insurer to defend him against suits seeking damages for bodily injury, whatever the alleged cause of the injury, whether intentional or inadvertent.

But the insurer argues that the third party suit must seek "damages which are payable under the terms of this endorsement"; it contends that this limitation modifies the general duty to defend by confining the duty only to actions seeking damages within the primary coverage of the policy. Under "Exclusions" the policy provides that it "does not apply ... under coverage L and M to bodily injury ... caused intentionally by ... the insured."

The very first paragraph as to coverage, however, provides that "the company shall defend any such suit against the insured alleging such bodily injury" although the allegations of the suit are groundless, false or fraudulent. This language, in its broad sweep, would lead the insured reasonably to expect defense of any suit regardless of merit or cause. The relation of the exclusionary clause to this basic promise is anything but clear. The basic promise would support the insured's reasonable expectation that he had bought the rendition of legal services to defend against a suit for bodily injury which alleged he had caused it, negligently, nonintentionally, intentionally or in any other manner. [8] The doctrines and cases we have set forth tell us that the exclusionary clause must be "conspicuous, plain and clear." (Steven v. Fidelity & Casualty Co., supra, 58 Cal.2d 862, 878.) This clause is not "conspicuous" since it appears only after a long and complicated page of fine print, and is itself in fine print; its relation to the remaining clauses of the policy and its effect are surely not "plain and clear."

[9] A further uncertainty lurks in the exclusionary clause itself. It alludes to damage caused "intentionally by or at the direction of the insured." Yet an act of the insured may carry out his "intention" and also cause unintended harm. When set next to the words "at the direction of the insured" the word "intentionally" might mean to the layman collusive, wilful or planned action beyond the classical notion of intentional tort. This built-in ambiguity has caused debate and refined definition in many courts; in any event, the word surely cannot be "plain and clear" to the layman.

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The insured is unhappyly surrounded by concentric circles of uncertainty: the first, the unascertainable nature of the insurer's duty to defend; the second, the unknown effect of the provision that the insurer must defend even a groundless, false or fraudulent claim; the third, the uncertain extent of the indemnification coverage. Since we must resolve uncertainties in favor of the insured and interpret the policy provisions according to the layman's reasonable expectations, and since the effect of the exclusionary clause is neither conspicuous, plain, nor clear, we hold that in the present case the policy provides for an obligation to defend and that such obligation is independent of the indemnification coverage.

The insurer counters with the contention that this position would compel an insurer "issuing a policy covering liability of the insured for maintenance, use or operation of an automobile ... to defend the insured in an action for damages for negligently maintaining a stairway and thereby allegedly causing injury to another — because the insured claims that the suit for damages was false or groundless." The "groundless, false, or fraudulent" clause, however, does not extend the obligation to defend without limits; it includes only defense to those actions of the nature and kind covered by the policy. Here the policy insures against "damages because of bodily injury." As we have pointed out, in view of the language of the policy, the insured would reasonably expect protection in an action involving alleged bodily injury. On the other hand the insured could not reasonably expect protection under an automobile insurance policy for injury which occurs from defect in a stairway. Similarly an insured would not expect a defense for an injury involving an automobile under a general comprehensive policy which excluded automobile coverage. We look to the nature and kind of risk covered by the policy as a limitation upon the duty to defend; we cannot absolve the carrier from the duty to defend an insured for loss of the nature and kind against which it insured.

Our holding that the insurer bore the obligation to defend because the policy led plaintiff reasonably to expect such defense, and because the insurer's exclusionary clause did not exonerate it, cuts across defendant's answering contention that the duty arises only if the pleadings disclose a cause of action for which the insurer must indemnify the insured. Defendant would equate the duty to defend with the complaint that pleaded a liability for which the insurer was bound to indemnify the insured. Yet even if we accept defendant's premises, and define the duty to defend by measuring the allegations in the Jones case against the carrier's liability to indemnify, defendant's position still fails. We proceed to discuss this alternative ground of liability of the insurer, accepting for such purpose the insurer's argument that we must test the third party suit against the indemnification coverage of the policy. We point out that the carrier must defend a suit which potentially seeks damages within the coverage of the policy; the Jones action was such a suit.

"Defendant cannot construct a formal fortress of the third party's pleadings and retreat behind its walls. The pleadings are malleable, changeable and amendable. Although an earlier decision reads: "In determining whether or not the appellant was bound to defend ... the language of its contract must first be looked to, and next, the allegations of the complaints ..." (Lamb v. Bell Casualty Co., supra, 3 Cal. App. 2d 624, 630), courts do not examine only the pleaded word but the potential liability created by the suit. Since the instant action presented the potentiality of a judgment based upon nonintentional conduct, and since liability for such conduct would fall within the indemnification coverage, the duty to defend became manifest at the outset.

To restrict the defense obligation of the insurer to the precise language of the pleading would not only ignore the thrust of the cases but would create an anomaly for the insured. Obviously, as Ritchie v. Anchor Casualty Co., supra, 135 Cal. App. 2d 245, points out, the complainant in the third party action drafts his complaint in the broadest terms; he may very well stretch the action which lies in only nonintentional conduct to the dramatic complaint that alleges intentional misconduct. In light of the likely overstatement of the complaint and of the plasticity of modern pleading, we should hardly designate the third party as the arbiter of the policy's coverage.

Since modern procedural rules focus on the facts of a case rather than the theory of recovery in the complaint, the duty to defend should be fixed by the facts which the insurer learns from the complaint, the insured, or other sources. An insurer, therefore, bears a duty to defend its insured whenever it ascertains facts which give rise to the potential of liability under the policy. In the instant case the complaint itself, as well as the facts known to the
insurer, sufficiently apprised the insurer of these possibilities; hence we need not set out when and upon what other occasions the duty of the insurer to ascertain such possibilities otherwise arises.

Jones' complaint clearly presented the possibility that he might obtain damages that were covered by the indemnity provisions of the policy. Even conduct that is traditionally classified as "intentional" or "wilful" has been held to fall within indemnification coverage.\[10\] Moreover, despite Jones' pleading of intentional and wilful conduct, he could have amended his complaint to allege merely negligent conduct. Further, plaintiff might have been able to show that in physically defending himself, even if he exceeded the reasonable bounds of self-defense, he did not commit wilful and intended injury, but engaged only in nonintentional tortious conduct. Thus, even accepting the insurer's premise that it had no obligation to defend actions seeking damages not within the indemnification coverage, we find, upon proper measurement of the third party action against the insurer's liability to indemnify, it should have defended because the loss could have fallen within that liability.

[14] We turn to the insurer's second major contention that the contract cannot be read to require the insurer to defend an action seeking damages for an intentional wrong because such an obligation would violate public policy. In support of this argument it relies upon Insurance Code section 533, and Civil Code section 1668.\[11\]

The contention fails on two grounds. In the first place, the statutes forbid only contracts which indemnify for "loss" or "responsibility" resulting from wilful wrongdoing. Here we deal with a contract which provides for legal defense against an action charging such conduct: the contract does not call for *"278 indemnification of the insured if the third party plaintiff prevails. In the second place, as we pointed out in *Tomelini v. Canadian Indemnity Co. (1964) 61 Cal.2d 638, 648 [39 Cal. Rptr. 731, 394 P.2d 571], the statutes "establish a public policy to prevent insurance coverage from encouragement of wilful tort." Thus *Tomelini held that if an insurer's obligation to pay a judgment based on wilful conduct results from an estoppel after the conduct, the obligation could not have previously encouraged the conduct. Similarly, the present contract does not offend the statute; a contract to defend an assured upon mere accusation of a wilful tort does not encourage such wilful conduct.

[15] Nor can we accept defendant's argument that the duty to defend dissolves simply because the insured is unsuccessful in his defense and because the injured party recovers on the basis of a finding of the assured's wilful conduct. Citing *Abbott v. Western Nat'l Indem. Co. (1958) 165 Cal. App.2d 302 [331 P.2d 997], the insurer urges that if the judgment in a third party suit goes against the insured it operates as "res judicata or collateral estoppel in the insured's action or proceeding against the insurer."

We have explained that the insured would reasonably expect a defense by the insurer in all personal injury actions against him. If he is to be required to finance his own defense and then, only if successful, hold the insurer to its promise by means of a second suit for reimbursement, we defeat the basic reason for the purchase of the insurance. In purchasing his insurance the insured would reasonably expect that he would stand a better chance of vindication if supported by the resources and expertise of his insurer than if compelled to handle and finance the presentation of his case. He would, moreover, expect to be able to avoid the time, uncertainty and capital outlay in finding and retaining an attorney of his own. ""The courts will not sanction a construction of the insurer's language that will defeat the very purpose or object of the insurance."" *(Ritchie v. Anchor Casualty Co., supra, 135 Cal. App.2d 245, 257.)*

[16] Similarly, we find no merit in the insurer's third contention that our holding will embroil it in a conflict of interests. According to the insurer our ruling will require defense of an action in which the interests of insurer and insured are so opposed as to nullify the insurer's fulfillment of its duty of defense and of the protection of its own interests. For example, the argument goes, if defendant had defended against the Jones suit it would have sought to establish

*279* either that the insured was free from any liability or that such liability rested on intentional conduct. The insured, of course, would also seek a verdict holding him not liable but, if found liable, would attempt to obtain a ruling that such liability emanated from the nonintentional conduct within his insurance coverage. Thus, defendant contends, an insurer, if obligated to defend in this situation, faces an insoluble ethical problem.
Since, however, the court in the third party suit does not adjudicate the issue of coverage, the insurer's argument collapses. The only question there litigated is the insured's liability. The alleged victim does not concern himself with the theory of liability; he desires only the largest possible judgment. Similarly, the insured and insurer seek only to avoid, or at least to minimize, the judgment. As we have noted, modern procedural rules focus on whether, on a given set of facts, the plaintiff, regardless of the theory, may recover. Thus the question of whether or not the insured engaged in intentional conduct does not normally formulate an issue which is resolved in that litigation.\[18\]

[17] In any event, if the insurer adequately reserves its right to assert the noncoverage defense later, it will not be bound by the judgment. If the injured party prevails, that party or the insured will assert his claim against the insurer. At this time the insurer can raise the noncoverage defense previously reserved. In this manner the interests of insured and insurer in defending against the injured party's primary suit will be identical; the insurer will not face the suggested dilemma.

Finally, defendant urges that our holding should require only the reimbursement of the insured's expenses in defending the third party action but not the payment of the judgment. Defendant acknowledges the general rule that an insurer that wrongfully refuses to defend is liable on the judgment against the insured. (Anerson v. National Automobile & Cas. Ins. Co. (1955) 45 Cal.2d 81, 84 [286 P.2d 816]; Civ. Code, § 2778.) Defendant argues, however, that the instant situation should be distinguished from that case because here the judgment has not necessarily been rendered on a theory within the policy coverage. Thus defendant would limit the insured's recovery to the expenses of the third party suit.

We rejected a similar proposal in Tomlin v. Canadian Indemnity Co., supra, 61 Cal.2d 638, 649-650. In that case, as we have noted, the insured's obligation to defend arose out of estoppel. The insurer contended that we should apply a "tort" theory of damages to its wrongful refusal to defend. Such a theory, we explained, would impose upon the insured "the impossible burden" of proving the extent of the loss caused by the insurer's breach. [18] As this court said in an analogous situation in Anerson v. National Auto. & Cas. Ins. Co. (1957) 48 Cal.2d 528, 539 [310 P.2d 961]: "Having defaulted such agreement the company is manifestly bound to reimburse its insured for the full amount of any obligation reasonably insured by him. It will not be allowed to defeat or whittle down its obligation on the theory that plaintiff himself was of such limited financial ability that he could not afford to employ able counsel, or to present every reasonable defense, or to carry his cause to the highest court having jurisdiction, ... Sustaining such a theory ... would tend ... to discourage insurance companies to similar disavowals of responsibility with everything to gain and nothing to lose."

In summary, the individual consumer in the highly organized and integrated society of today must necessarily rely upon institutions devoted to the public service to perform the basic functions which they undertake. At the same time the consumer does not occupy a sufficiently strong economic position to bargain with such institutions as to specific clauses of their contracts of performance, and, in any event, piecemeal negotiation would sacrifice the advantage of uniformity. [19] Hence the courts in the field of insurance contracts have tended to require that the insurer render the basic insurance protection which it has held out to the insured. This obligation becomes especially manifest in the case in which the insurer has attempted to limit the principal coverage by an unclear exclusionary clause. We test the alleged limitation in the light of the insured's reasonable expectation of coverage; that test compels the indicated outcome of the present litigation.

The judgment is reversed and the trial court instructed to take evidence solely on the issue of damages alleged in plaintiff's complaint including the amount of the judgment in the Jones suit, and the costs, expenses and attorney's fees incurred in defending such suit.


McCOMB, J.

I dissent. I would affirm the judgment for the reasons expressed by Mr. Justice Fox in the opinion prepared by him for the District Court of Appeal in Gray v. Zurich Ins. Co. (Cal. App.) 49 Cal. Rptr. 271.

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[1] Immediately preceding the altercation Dr. Gray had been driving an automobile on a residential street when another automobile narrowly missed colliding with his car. Jones, the driver of the other car, left his vehicle, approached Dr. Gray's car in a menacing manner and jerked open the door. At that point Dr. Gray, fearing physical harm to himself and his passengers, rose from his seat and struck Jones.


[3] Typical of the legion of cases so holding is Continental Cas. Co. v. Phoenix Constr. Co. (1956) 46 Cal.2d 423, 437-438 [296 P.2d 801, 57 A.L.R.2d 914], which states: "It is elementary in insurance law that any ambiguity or uncertainty in an insurance policy is to be resolved against the insurer. [Citations.] If semantically permissible, the contract will be given such construction as will fairly achieve its object of securing indemnity to the insured for the losses to which the insurance relates. [Citation.] If the insurer uses language which is uncertain any reasonable doubt will be resolved against it; if the doubt relates to extent or fact of coverage, whether as to peril insured against [citations], the amount of liability [citations] or the person or persons protected [citations], the language will be understood in its most inclusive sense, for the benefit of the insured." See the numerous cases to the same effect collected in 13 Appleman, Insurance Law and Practice, § 7401 et seq.; 1 Couch, Insurance, § 15:73 et seq.; 1 Wilkin, Summary of Cal. Law (7th ed. 1960) Contracts, § 224, pp. 252-253, supplemented in 1965 Supp. pp. 68-70.


[5] The traditional rules of construction for contracts require the courts to take cognizance of the expectations of the parties. "If the court is convinced that it knows the purposes of the parties, the intended legal result, however vaguely expressed and poorly analyzed, it should be loath to adopt any interpretation of their language that would produce a different result." (3 Corbin on Contracts, p. 164.)

[6] Isaacs, The Standardizing of Contracts (1917) 27 Yale L.J. 34, in an early analysis, suggests the basis for the adhesion contract, pointing out that standardized contracts create "status" relationships as opposed to individualized relationships. The article states: "The movement toward status law clashes, of course, with the ideal of individual freedom in the negative sense of 'absence of restraint' or laissez faire. Yet, freedom in the positive sense of presence of opportunity is being served by social interference with contract. There is still much to be gained by the further standardizing of the relations in which society has an interest, in order to remove them from the control of the accident of power in individual bargaining. The new school of jurisprudence has a great work before it in educating the courts. It must, indeed, dispel the fear of status as an archaic legal institution which we have outgrown." (At p. 47.) Pound, The Spirit of Common Law (1921) states: "Taking no account of legislative [i.e., non-common law] limitations upon freedom of contract, in the purely judicial development of our law we have taken the law of insurance practically out of the category of contract, and we have established that the duties of public service companies are not contractual, as the nineteenth century sought to make them, but are instead relational; they do not flow from agreements which the public servant may make as he chooses, they flow from the calling in which he has engaged and his consequent relation to the public." (At p. 29.)

[7] Courts have long applied the doctrine of reasonable expectation to the interpretation of insurance contracts. Thus in Coast Mutual B.-I., Ass'n v. Security T.T. & G. Co. (1936) 14 Cal. App.2d 225, 229 [57 P.2d 1392], the court said: "In the decision of this question we are to be guided by well-established rules relating to the construction of insurance policies. Not only the provisions of the policy as a whole, but also the exceptions to the liability of the insurer, must be construed so as to give the insured the protection which he reasonably had a right to expect, and to that end doubts, ambiguities, and uncertainties arising out of the language used in the policy must be resolved in his favor." (Italics added.) Atlantic Nat. Ins. Co. v. Armstrong (1966) ante, p. 100 [52 Cal. Rptr. 569, 415 P.2d 801], is a recent example of the application of the doctrine. We there recognized that the insurer would not have reasonably expected a policy provision requiring him to indemnify his insurer for a risk not covered by the policy but which was required by law to be contained in all such policies. In holding the provision therefore unenforceable we said: "In interpreting an insurance contract we must consider the intent and reasonable expectations of the parties in entering into the agreement. Hence, we must evaluate not only [the insurer]s contract form, but also [the insurer]s knowledge and understanding as a layman and his normal expectation of the extent of coverage of the policy." (Italics added.) (Id. at p. 112.)

[8] In Steven we relied upon the early California case of Pauket v. Northwestern etc., Ins. Co. (1913) 157 Cal. 213 [107 P. 292], which aptly said: "It is a matter almost of common knowledge that a very small percentage of policyholders are actually cognizant of the provisions of their policies and many of them are ignorant of the names of the companies issuing the said policies. The
policies are prepared by the experts of the companies, they are highly technical in their phraseology, they are complicated and voluminous — the one before us covering thirteen pages of the transcript — and in their numerous conditions and stipulations furnishing what sometimes may be veritable traps for the unwary." (At p. 230.)


[10] Thus the subject policy affords no clear answer to the following queries: Does the carrier exercise the sole right to determine whether the "suit against the insured alleging such bodily injury" was "caused intentionally by the insured?" When, and under what circumstances, is such determination binding upon the insured? Does the carrier exercise the exclusive power to decide whether "the allegations of the suit are groundless, false, or fraudulent?" When and under what circumstances is such a determination binding upon the insured? Are these matters to be resolved by the pleadings in the third party suit, by the insured's presentation to the insurer of his version of the facts, or by the judgment rendered in the third party suit?

[11] Thus Prosser points out: "The defendant who acts in the belief or consciousness that he is causing an appreciable risk of harm to another may be negligent and if the risk is great his conduct may be characterized as reckless or wanton, but it is not classed as an intentional wrong. In such cases the distinction between intent and negligence obviously is a matter of degree." (Prosser, Law of Torts (3d ed. 1965) p. 32.)


[13] Courts have recognized the application of the reasonable expectation doctrine to a policy of insurance which sought to distinguish between intentional and accidental conduct. In Meyer v. Pacific Employers Ins. Co., supra, 233 Cal. App.2d 321, a policy covered "injury to or destruction of property ... unless caused by accident." (P. 324.) In a third party suit the plaintiff claimed that the insured's well drilling operations resulted in property damage; the trial court found that the insured "intentionally caused an indirect trespass...." (P. 323.) Reasoning that the consequent damages were not "intentional" and were "not expected," the appellate court held the damages "accidental in character" (p. 327) and covered by the policy. The court said, "A policy of insurance should not be so interpreted as to remove from the coverage of the policy a risk against which the circumstances under which and the purposes for which the policy was written indicate the insured intended to protect himself, unless such an interpretation is compelled by the express and unambiguous language of the policy." (Pp. 327-328; italics added.)

[14] "As to the insured's expectations, it is safe to assume that if the ordinary insurance consumer had thought about them, his expectations would be that the insurer would defend him whenever there was a threat of liability to him and the threat was based on facts within the policy. The insured probably would be surprised at the suggestion that defense coverage might turn on the pleading rules of the court that a third party chose or on how the third party's attorney decided to write the complaint. In some cases the insured might think in terms of his own conduct. The bar owner, for example, might well think that he is insulated from any legal expense arising from injuries to patrons so long as he personally does not intentionally injure someone or tell an employee to do so. To him the possibility of an ambitious claimant who would begin a lawsuit with a charge of an intentional injury for the sake of a favorable bargaining position and later be willing to abandon that charge for one of simple negligence might not occur; or if the possibility did occur the insured might not pause to consider whether it would be fatal to part of his insurance coverage. In short, the limits of the phrase 'suits alleging such injury,' prepared by lawyers, defended by lawyers and authoritatively interpreted by lawyers, are probably not appreciated by the lay insured. And even the more sophisticated insured has no choice in the matter, since the provision is standard." (Comment, supra, 114 U.Pa.L. Rev. 734, 748 [fn. omitted].)

[15] "Modern procedure has made for so much greater flexibility or plasticity in pleading that this rule must be applied with extreme care to include all the potenialities of the pleading and the policy coverage, ...." (Italics added.) (Columbia Southern Chemical Corp. v. Manufacturers & Wholesalers Indemn. Exch. (1961) 190 Cal. App.2d 194, 200 [11 Cal. Rptr. 762].) "And the ultimate question is whether the facts alleged do fairly apprise the insurer that plaintiff is suing the insured upon an occurrence which, if his allegations are true, gives rise to liability of insurer to insured under the terms of the policy." (Italics added.) (Ritchie v.

[16] See cases collected in fn. 12, supra. As the court said in Russ-Field Corp. v. Underwriters at Lloyd's (1958) 164 Cal. App. 2d 83, 96 [330 P.2d 432], "A 'wilful act' as used in this statute connotes something more blameworthy than the sort of misconduct involved in ordinary negligence, and something more than the mere intentional doing of an act constituting such negligence."

[17] Insurance Code section 533 provides: "An insurer is not liable for a loss caused by the wilful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others."

Civil Code section 1668 provides in relevant part: "All contracts which have for their object, directly or indirectly, to exempt anyone from responsibility for his own ... wilful injury to the person or property of another ... are against the policy of the law."

[18] In rare cases the issue of punitive damages or a special verdict might present a potential conflict of interests, but such a possibility does not outweigh the advantages of the general rule. Even in such cases, however, the insurer will still be bound, ethically and legally, to litigate in the interests of the insured.

[19] Insurance Code section 11580, subdivision (b) (2) provides that "whenever judgment is secured against the insured ... in an action based upon bodily injury, death, or property damage, then an action may be brought against the insurer on the policy and subject to its terms and limitations, by such judgment creditor to recover on the judgment."

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HARTFORD CASUALTY INSURANCE COMPANY, Plaintiff and Respondent,

v.

SWIFT DISTRIBUTION, INC., et al., Defendants and Appellants.

No. S207172.

Supreme Court of California.

June 12, 2014.

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OPINION

LIU, J.

Hartford Casualty Insurance Company (Hartford) issued a commercial general liability policy to Swift Distribution, Inc., doing business as Ultimate Support Systems (Ultimate), that covered "personal and advertising injury." This term included claims arising from "[o]ral, written, or electronic publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." Ultimate, which sells the "Ulti-Cart," was sued in federal district court by Gary-Michael Dahl (Dahl), the manufacturer of the "Multi-Cart." The

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suit included allegations of patent and trademark infringement, false designation of origin, and damage to business, reputation, and goodwill.

When Ultimate tendered defense of the suit to Hartford, Hartford denied coverage on the ground that the suit did not allege that Ultimate had disparaged Dahl or the Multi-Cart. The Court of Appeal agreed with Hartford that it had no duty to defend and expressly disagreed with the reasoning in *Travelers Property Casualty Co. of America v. Charlotte Russe Holding, Inc.* (2012) 207 Cal.App.4th 969 [144 Cal.Rptr.3d 12] (Charlotte Russe). We granted review to clarify the principles governing the scope of a commercial general liability insurer's duty to defend an insured against a claim alleging disparagement.

We hold that a claim of disparagement requires a plaintiff to show a false or misleading statement that (1) specifically refers to the plaintiff's product or business and (2) clearly derogates that product or business. Each requirement must be satisfied by express mention or by clear implication. Because Dahl's suit contains no allegation that Ultimate clearly derogated the Multi-Cart, we find no claim of disparagement triggering Hartford's duty to defend, and we affirm the judgment of the Court of Appeal.

I.

Ultimate sells a product called the Ulti-Cart, a multiuse cart marketed to help musicians load and transport their equipment. On January 26, 2010, Dahl filed an action in federal district court against Ultimate (the *Dahl* action). The complaint alleged that Dahl held multiple patents on a similar convertible transport cart called the Multi-Cart, which he had sold commercially since 1997. The Multi-Cart was described as a collapsible cart capable "of being manipulated into multiple configurations and typically used to transport music, sound, and video equipment.

According to the complaint, Ultimate impermissibly manufactured, marketed, and sold the Ulti-Cart, and thereby infringed on Dahl's patents and trademarks and diluted the Multi-Cart trademark. Dahl asserted that Ultimate's false and misleading advertisements and use of a "nearly identical mark" were likely to cause consumer confusion or mistake, or to deceive the public "as to the affiliation, connection, or association" of the two parties. He also alleged unfair competition, misleading advertising, breach of contract, and claims based on the violation of two nondisclosure agreements. The complaint attached Ultimate's advertisements, which did not name the Multi-Cart or any other product.

Ultimate delivered the suit to Hartford for defense under the commercial liability policy issued by Hartford for the period of January 29, 2009, to January 29, 2010 (the Hartford policy). The Hartford policy's insuring agreement provided: "We will pay those sums that the insured becomes legally obligated to pay as damages because of ... personal and advertising injury" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for ... personal and advertising injury" to which this insurance does not apply." It defined "personal and advertising injury," in pertinent part, as "injury ... arising out of ... [o]ral, written or electronic publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." The insuring agreement did not provide a definition for the term "disparages."

Ultimate argued that the *Dahl* action involved a claim of disparagement covered by the Hartford policy's definition of "personal and advertising injury." But Hartford found no potential claim of disparagement and denied any duty to defend or indemnify Ultimate in the underlying litigation. Citing *Total Call Internet, Inc. v. Peerless Ins. Co.* (2010) 181 Cal.App.4th 161 [104 Cal.Rptr.3d 319] (Total Call), Hartford's counsel explained in a letter to Ultimate that there could be no disparagement in the absence of a specific statement about a competitor's goods. It further found that any possibility of coverage would have been precluded by the policy's exclusion provisions, one of which denied coverage for personal or advertising injuries arising out of violations of intellectual property rights.

On July 27, 2010, Hartford filed a complaint seeking a declaratory judgment that it had no duty to defend or indemnify Ultimate in the *Dahl* action. The complaint argued that the allegations in the underlying action did...
not satisfy the elements of a disparagement offense. While the action was pending, the court in the Dahl action granted Ultimate's motion for summary adjudication on the claims of patent infringement, and the Dahl action settled. Hartford and Ultimate each filed motions for summary judgment or, in the alternative, summary adjudication. The superior court granted Hartford's motion for summary judgment.

Ultimate appealed, and the Court of Appeal affirmed. The Court of Appeal observed that the Dahl action did "not allege that Ultimate's advertisements specifically referred to Dahl by express mention" and that "Dahl did not allege that Ultimate's publication disparaged Dahl's organization, products, goods, or services" by reasonable implication. Because "Dahl was precluded from recovery on a disparagement theory," the court reasoned, "Dahl alleged no claim for injurious false statement or disparagement that was potentially within the scope of the Hartford policy coverage for advertising injury," and Hartford had no duty to defend Ultimate in the underlying action. Further, the Court of Appeal "disagreed[d] with the theory of disparagement apparently recognized" in *Charlotte Russe, supra*, 207 Cal.App.4th 969, although it acknowledged that *Charlotte Russe* was distinguishable on its facts.

We granted review.

II.

A trial court properly grants a motion for summary judgment where "all the papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." (Code Civ. Proc., § 437c, subd. (c).) "Because this case comes before us after the trial court granted a motion for summary judgment, we take the facts from the record that was before the trial court when it ruled on that motion. [Citation.] "We review the trial court's decision de novo, considering all the evidence set forth in the moving and opposing papers except that to which objections were made and sustained." [Citation.] We liberally construe the evidence in support of the party opposing summary judgment and resolve doubts concerning the evidence in favor of that party." (Yanowitz v. L'Oreal USA, Inc. (2005) 36 Cal.4th 1028, 1037 [32 Cal.Rptr.3d 436, 116 P.3d 1123].)

As discussed below, we conclude that the Court of Appeal correctly decided the issue before us.

A.

(1) An insurer's duty to indemnify and its duty to defend an insured "lie at the core of the standard policy." (Certain Underwriters at Lloyd's of London v. Superior Court (2001) 24 Cal.4th 945, 958 [103 Cal.Rptr.2d 672, 16 P.3d 94].) The duty to defend is broader than the duty to indemnify. (Horace Mann Ins. Co. v. Barbara B. (1993) 4 Cal.4th 1076, 1081 [17 Cal.Rptr.2d 210, 846 P.2d 792] (Horace Mann).) "Unlike the obligation to indemnify, which is only determined when the insured's underlying liability is established, the duty to defend must be assessed at the very outset of a case. An insurer may have a duty to defend even when it ultimately has no obligation to indemnify, either because no damages are awarded in the underlying action against the insured, or because the actual judgment is for damages not covered under the policy." (Ringler Associates Inc. v. Maryland Casualty Co. (2000) 80 Cal.App.4th 1165, 1185 [96 Cal.Rptr.2d 136] (Ringler).)

(2) The duty to defend is guided by several well-established principles. An insurer owes a broad duty to defend against claims that create a potential for indemnity under the insurance policy. (Gray v. Zurich Ins. Co. (1966) 65 Cal.2d 263, 277-278 [54 Cal.Rptr. 104, 419 P.2d 168].) An insurer must defend against a suit even "where the evidence suggests, but does not conclusively establish, that the loss is not covered." (Montrose Chemical Corp. v. Superior Court (1993) 6 Cal.4th 287, 299 [24 Cal.Rptr.2d 467, 861 P.2d 1153] (Montrose).)

"Determination of the duty to defend depends, in the first instance, on a comparison between the allegations of the complaint and the terms of the policy. [Citation.] But the duty also exists where extrinsic facts known to the insurer suggest that the claim may be covered." (Scottsdale Ins. Co. v. MV Transportation (2005) 36 Cal.4th 643, 654 [31 Cal.Rptr.3d 147, 115 P.3d 480].) This includes all facts, both disputed and undisputed, that the insurer knows or
"becomes aware of" from any source (Deltado v. Intersurance Exchange of Automobile Club of Southern California (2009) 47 Cal.4th 302, 308 [97 Cal.Rptr.3d 298, 211 P.3d 1083]), "if not "at the inception of the third party lawsuit," then "at the time of tender" (Swain v. California Casualty Ins. Co. (2002) 99 Cal.App.4th 1, 8 [120 Cal.Rptr.2d 808]). Moreover, that the precise causes of action pled by the third party complaint may fall outside policy coverage does not excuse the duty to defend where, under the facts alleged, reasonably inferable, or otherwise known, the complaint could fairly be amended to state a covered liability." (Scottsdale, supra, 36 Cal.4th at p. 654.) Thus, "[i]f any facts stated or fairly inferable in the complaint, or otherwise known or discovered by the insurer, suggest a claim potentially covered by the policy, the insurer's duty to defend arises and is not extinguished until the insurer negates all facts suggesting potential coverage." (Ibid. at p. 655.) In general, doubt as to whether an insurer owes a duty to defend "must be resolved in favor of the insured." (Ringler, supra, 80 Cal.App.4th at p. 1188.)

288 “288 (3) While the duty to defend is broad, it is "not unlimited; it is measured by the nature and kinds of risks covered by the policy." (Waller v. Truck Ins. Exchange, Inc. (1995) 11 Cal.4th 1, 19 [44 Cal.Rptr.2d 370, 900 P.2d 619] (Waller.) In an action seeking declaratory relief concerning a duty to defend, "the insured must prove the existence of a potential for coverage, while the insurer must establish the absence of any such potential. In other words, the insured need only show that the underlying claim may fall within policy coverage; the insurer must prove it cannot." (Montrose, supra, 6 Cal.4th at p. 300.) Thus, an insurer may be excused from a duty to defend only when "the third party complaint can by no conceivable theory raise a single issue which could bring it within the policy coverage." (Ibid., italics omitted.) In a "mixed" action, where some claims are potentially covered while others are not, "the insurer has a duty to defend as to the claims that are at least potentially covered...." (Buss v. Superior Court (1997) 16 Cal.4th 35, 48 [65 Cal.Rptr.2d 366, 939 P.2d 766].)

B.

(4) In determining whether a claim creates the potential for coverage under an insurance policy, "we are guided by the principle that interpretation of an insurance policy is a question of law." (Waller, supra, 11 Cal.4th at p. 18.)

(5) "Under statutory rules of contract interpretation, the mutual intention of the parties at the time the contract is formed governs interpretation. (Civ. Code, § 1636.)" (All Ins. Co. v. Superior Court (1990) 51 Cal.3d 807, 821-822 [274 Cal.Rptr. 820, 799 P.2d 1253].) In determining this intent, "[t]he rules governing policy interpretation require us to look first to the language of the contract in order to ascertain its plain meaning or the meaning a layperson would ordinarily attach to it." (Waller, at p. 18.) We consider the "clear and explicit" meaning of these provisions, interpreted in their "ordinary and popular sense," unless "used by the parties in a technical sense or a special meaning is given to them by usage." (All, at p. 822.) We must also "interpret the language in context, with regard to its intended function in the policy." (Bank of the West v. Superior Court (1992) 2 Cal.4th 1254, 1265 [10 Cal.Rptr.2d 538, 833 P.2d 545].)

(6) The issue in this case is whether the Dahl action against Ultimate included a claim of disparagement covered by the Hartford policy. According to section 629 of the Restatement Second of Torts (1977), "[a] statement is disparaging if it is understood to cast doubt upon the quality of another's land, chattels or intangible things, or upon the existence or extent of his property in them, and if (a) the publisher intends the statement to cast the doubt, or if (b) the recipient's understanding of it as casting the doubt was reasonable." The term "disparagement" in the context of an insurance policy, in light of its proximity to the terms "libel" and "slander," suggests it may be understood as a common law tort: Whereas defamation, which includes libel and slander, concerns damage to the reputation of a person or business, disparagement concerns damage to the reputation of products, goods, or services. (See Total Calli, supra, 181 Cal.App.4th at p. 169.) Yet the torts of disparagement and defamation ""protect different interests and have entirely different origins in history."" (Polgram Records, Inc. v. Superior Court (1985) 170 Cal.App.3d 543, 548-549 [216 Cal.Rptr. 252].

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Disparagement emerged from the common law tort doctrine of slander of title. In Burkett v. Griffith (1891) 90 Cal. 532 [27 P. 527], the court described slander of title as an action "against one who falsely and maliciously disparages the title of another to property, whether real or personal, and thereby causes him some special pecuniary loss or damage. In order to maintain the action, it is necessary to establish that the words spoken were false, and were maliciously spoken by the defendant, and also that the plaintiff has sustained some special pecuniary damage as the direct and natural result of their having been so spoken." (Id. at p. 537; see Hill v. Allan (1968) 259 Cal.App.2d 470, 489 [68 Cal.Rptr. 676] ["Disparagement or slander of title is a publication made without a privilege or justification of matter that is untrue and is disparaging to another's property in land, chattels or intangible things under such circumstances as would lead a reasonable man to foresee that the conduct ... results in pecuniary loss from the impairment of vendability thus caused...."]) Comment, The Law of Commercial Disparagement: Business Defamation's Impotent Ally (1953-1954) 63 Yale L.J. 65, 75.) The doctrine expanded to include statements disparaging the quality of property rather than simply its ownership, a form of disparagement commonly referred to as trade libel. (See Erlich v. Einer (1964) 224 Cal.App.2d 69 [36 Cal.Rptr. 258] (Erlich).) Eventually, disparagement came to encompass a broader theory of economic or commercial injury caused by a false, derogatory statement. (See Prosser & Keeton, Torts (6th ed. 1984 & 1988 supp.) § 128, pp. 962-963; Trade Libel: Theory and Practice Under the Common Law, the Lanham Act, and the First Amendment (1999) 89 Trademark Rep. 826, 827.)

(7) "Confusion surrounds the tort of 'commercial disparagement' because not only is its content blurred and uncertain, so also is its very name. The tort has received various labels, such as 'commercial disparagement,' 'injurious falsehood,' 'product disparagement,' 'trade libel,' 'disparagement of property,' and 'slander of goods.' These shifting names have led counsel and the courts into confusion, thinking that they were dealing with different bodies of law. In fact, all these labels denominate the same basic legal claim." (5 McCarthy on Trademarks and Unfair Competition (4th ed. 2014) § 27:100, p. 27-271 (rel. # 65, 3/2013) fn. omitted.) Disparagement is often included now as "a specific example of the more general principle of injurious falsehood." (Note, The Tort of Disparagement and the Developing First Amendment (1987) 1987 Duke L.J. 727, 729; see id. at fn. 21 [comparing the Rest. Torts (1938), which titled Div. Six as "Disparagement," with the Rest.2d Torts (1977), which titled Div. Six as "Injurious Falsehood (Including Slander of Title and Trade Libel)"].) Under the definition of an injurious falsehood, "[o]ne who publishes a false statement harmful to the interests of another is subject to liability for pecuniary loss resulting to the other if [¶] (a) he intends for publication of the statement to result in harm to interests of the other having a pecuniary value, or either recognizes or should recognize that it is likely to do so, and [¶] (b) he knows that the statement is false or acts in reckless disregard of its truth or falsity." (Rest.2d Torts § 623A.)

(8) California courts have defined disparagement in the commercial liability context by reference to the common law. In Nichols v. Great American Ins. Companies (1985) 169 Cal.App.3d 766 [215 Cal.Rptr. 416] (Nichols), the policyholders were sued by California Satellite Systems (Calsat), an official distributor of the Home Box Office (HBO) entertainment service, for selling and distributing devices to illegally intercept the HBO signal. Calsat sought injunctive relief, claiming irreparable injury from loss of business opportunities, reputation, and goodwill to its exclusive HBO license. (Id. at p. 770.) In considering the scope of disparagement under a "personal injury" provision, the court quoted Erlich, supra, 224 Cal.App.2d 69, which defined the tort of trade libel as "an intentional disparagement of the quality of property, which results in pecuniary damage to plaintiff.... 'Injurious falsehood, or disparagement, then, may consist of the publication of matter derogatory to the plaintiff's title to his property, or its quality, or to his business in general...."" (Id. at p. 73.) The court in Nichols noted that trade libel "requires (at a minimum): (1) a publication; (2) which induces others not to deal with plaintiff; and (3) special damages." (Nichols, at p. 773.) The court then held that "[t]he necessary element of a defamatory publication or utterance is missing from the complaint and cannot be supplied by reference to reports in which the defamatory innuendo appears only inferentially." (Id. at p. 775.)

In Atlantic Mutual Ins. Co. v. J. Lamb, Inc. (2002) 100 Cal.App.4th 1017 [123 Cal.Rptr.2d 256], the court interpreted a "personal injury" provision with a disparagement clause like the one at issue here as providing coverage for
"product disparagement and trade libel as well as defamation." (Ibid. at p. 1035.) The underlying complaint alleged that Lamb, the policyholder, contacted the competitor's costumers and falsely accused the competitor's products of infringing on his patent. The court noted that "the term 'disparagement' has been held to include statements about a competitor's goods that are untrue or misleading and are made to influence potential purchasers not to buy. [Citation.]" (Ibid.) It continued: "Whether characterized as a trade libel or product disparagement, an injurious falsehood directed at the organization or products, goods, or services of another falls within the coverage of the [insurance] policy." (Ibid.) Quoting the definition of trade libel stated in "921 Nicholls, the court concluded that allegations in the underlying complaint "clearly constituted a "publication of matter derogatory to the plaintiff's title to his property, or its quality, or to his business in general." (Ibid., quoting Nicholls, supra, 169 Cal.App.3d at p. 773.)

These cases and others have understood disparagement, for purposes of commercial liability insurance coverage, to mean a knowingly false or misleading publication that derogates another's property or business and results in special damages. (See, e.g., Cort v. St. Paul Fire and Marine Ins. Companies, Inc. (9th Cir. 2002) 311 F.3d 979, 986; Microtech Research, Inc. v. National Marine Fun, Inc. (9th Cir. 1994) 40 F.3d 968, 972; Aetna Casualty & Surety Co., Inc. v. Centennial Ins. Co. (9th Cir. 1988) 838 F.2d 346, 351 (Aetna); Burnett, Inc. v. American Zurich Ins. Co. (E.D. Cal. 2011) 830 F.Supp.2d 953, 962 (Burnett); Epiqsys, Inc. v. St. Paul Fire & Marine Ins. Co. (N.D. Cal. 2008) 550 F.Supp.2d 1244, 1252 (Epiqsys); Lindsey v. Admiral Ins. Co. (N.D. Cal. 1992) 804 F.Supp. 47, 52.)

C.

(9) In evaluating whether a claim of disparagement has been alleged, courts have required that the defendant's false or misleading statement have a degree of specificity that distinguishes direct criticism of a competitor's product or business from other statements extolling the virtues or superiority of the defendant's product or business. As explained below, disparagement involves two distinct but related specificity requirements. A false or misleading statement (1) must specifically refer to the plaintiff's product or business, and (2) must clearly derogate that product or business. Each requirement must be satisfied by express mention or by clear implication.

In California, these requirements guided the reasoning of our decision in Blatty v. New York Times Co. (1986) 42 Cal.3d 1033 [232 Cal.Rptr. 542, 728 P.2d 1177] (Blatty), where we held under the First Amendment that all injurious falsehoods "must specifically refer to, or be 'of and concerning,' the plaintiff in some way." (42 Cal.3d at p. 1042.) The plaintiff in Blatty, an author, sued the New York Times for damages, claiming the newspaper had improperly left the author's book off its best sellers list. The court held that the best sellers list could not "be reasonably understood to refer to Blatty or his novel by implication." (Id. at p. 1046.) We explained that where the "injurious false [publication] concerns a group — here, books currently in print and their authors — the plaintiff faces a 'difficult and sometimes insurmountable task. If the group is small and its members easily ascertainable, [the plaintiff] may succeed. But where the group is large ... the courts in California and other states have consistently held that plaintiffs cannot show that the statements were "of and concerning them."" (Ibid.) Further, the court said that Blatty's claims also fail to effectively allege falsehood because "the Times did not make the crucial false representation of which he complains — viz., that the list was an accurate compilation of actual book sales." (Id. at fn. 2.) Thus, the court held that Blatty failed to sufficiently allege an injurious falsehood because the best seller's list did not expressly or by clear implication (1) refer to Blatty's novel or (2) derogate Blatty's novel by suggesting it was not a best seller.

Although Blatty, which involved a media defendant, relied heavily on the First Amendment value of maintaining "a broad zone of protection" for the press (Blatty, supra, 42 Cal.3d at p. 1041), the court used some language that could be read to apply more broadly to ordinary commercial disputes. In response to Blatty's argument that First Amendment concerns were inapplicable because the best seller's list was commercial speech, the court said the list was not commercial speech and "[i]n any event, ... commercial speech is not excluded from First Amendment protections." (42 Cal.3d at p. 1048, fn. 3.) Further, the court said that "the various limitations rooted in the First Amendment are applicable to all injurious falsehood claims and not solely to those labeled "defamation" because
"although such limitations happen to have arisen in defamation actions, they do not concern matters peculiar to such actions but broadly protect free expression and free-press values." (Id. at p. 1043.)

Soon after Blatty was decided, its reasoning was applied to a disparagement claim against a nonmedia defendant. In Hofmann Co. v. E. I. Du Pont de Nemours & Co. (1988) 202 Cal.App.3d 390 [246 Cal.Rptr. 384] (Hofmann), the court applied Blatty to a suit by a developer alleging that employees of a toxic chemical plant had committed trade libel and intentional interference with prospective economic advantage by publicly criticizing a housing development that the developer had planned to build next to the plant. (Id. at p. 403.) The dispute in Hofmann did not involve free press values, although it did involve free expression on a matter of public concern and a plaintiff (the developer) who "possesse[d] the attributes of a public figure." (Id. at p. 404.)

Subsequently, the court in Total Call, citing Hofmann and Blatty, applied the specific reference requirement to a purely commercial dispute involving allegations of product disparagement, among other claims. (Total Call, supra, 181 Cal.App.4th at p. 170.) The issue in Total Call was whether an insurer owed a duty to defend against a suit by two competitors alleging that Total Call sold prepaid telephone cards that did not provide the number of minutes advertised. (Id. at p. 165.) The insurance policy at issue, like the Hartford policy here, "provide[d] coverage for 'product disparagement and trade libel as well as defamation.' [Citation.]" (Id. at p. 169.) In evaluating whether the suit had sufficiently alleged disparagement, the court took note of the specific "293 reference requirement set forth in Blatty and said: "[T]he court [in Blatty] explained that 'all injurious falsehood claims' sounding in defamation, however framed, are subject to requirements rooted in the First Amendment to the United States Constitution. ([Blatty, supra ] 42 Cal.3d at pp. 1043-1045, italics added.) These requirements cannot be avoided by 'creative pleading' that 'affix[es] labels other than defamation to injurious falsehood claims.' (Id. at p. 1045.) Among these requirements is the demand that the injurious falsehood 'specifically refer[ ]' to the derogated person or product. (Id. at p. 1046.) To meet this demand at the pleading stage, a plaintiff must allege that 'the statement at issue either expressly mentions him or refers to him by reasonable implication.' ([Ibid.])" (Total Call, at p. 170.)

The court in Total Call denied coverage after finding that Total Call's advertisements did not specifically refer to the plaintiffs in the underlying action expressly or by reasonable implication. (Total Call, supra, 181 Cal.App.4th at p. 171.) Although Total Call's advertisements falsely communicated to consumers the number of minutes they would receive, "[t]his sort of communication, by itself, carries no implication that [the competitors'] comparable cards cost more or less than [Total Call's] cards; to ascertain such information, a consumer would have to consult [the competitors'] own advertising." (Ibid.) Further, the court explained the allegation that "[Total Call's] falsehoods injured [the competitors'] reputation by reducing [their] market share and damaging the industry's collective reputation" was not sufficient to meet the specific reference requirement. (Ibid.)

(10) The court in Total Call did not examine whether the First Amendment concerns that limit restraints on false or misleading media speech apply with equal force to restraints on false or misleading commercial speech. (Cf. Central Hudson Gas & Elec. v. Public Serv. Comm'n (1980) 447 U.S. 567, 563 [65 L.Ed.2d 341, 100 S.Ct. 2343] ([T]here can be no constitutional objection to the suppression of commercial messages that do not accurately inform the public about lawful activity.").) Nevertheless, even if the result is not compelled by the First Amendment, we believe Total Call was correct to apply the specific reference requirement to a disparagement claim against a nonmedia defendant in a purely commercial dispute. In the commercial context, as in the media context, "[t]he 'of and concerning' or specific reference requirement limits the right of action for injurious falsehood, granting it to those who are the direct object of criticism and denying it to those who merely complain of nonspecific statements that they believe cause them some hurt." (Blatty, supra, 42 Cal.3d at p. 1044.) This limitation serves the important objective of forestalling "'vexatious lawsuits' over perceived slights that do not specifically derogate or refer to a competitor's business or product. (Ibid.) Applying the specific reference requirement would not cause false or misleading commercial statements to go undeterred, as such statements may still result in liability under various *294 claims other than disparagement, including patent or trademark infringement, false advertising, or unfair competition. (See, e.g., 35 U.S.C. § 271; 15 U.S.C. §§ 1114, 1125(a); Bus. & Prof. Code, §§ 17500, 17505, 17200.) What distinguishes a claim of disparagement is that an injurious falsehood has been directed specifically at the

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plaintiff's business or product, derogating that business or product and thereby causing that plaintiff special damages.

D.

(11) The specificity requirements discussed above significantly limit the type of statements that may constitute disparagement, especially since advertisements and promotional materials often avoid express mention of competitors. Nevertheless, courts have found certain kinds of statements to specifically refer to and derogate a competitor's product or business by clear implication.

In *Piphany, supra*, 590 F.Supp.2d 1244, the court held that an insurer had a duty to defend where a competitor had sued the insured, E.piphany, for falsely claiming to be "the 'only' producer of 'all Java' and 'fully J2EE' software solutions, which was an 'important differentiator' between competing products, even though some competitors offered products with these exact features." (Id. at p. 1253.) The court held that these false statements "clearly and necessarily implied the inferiority of Sigma's competing products" and that "[t]he fact that the 'injurious falsehoods' alleged were only directed at Sigma by implied comparison with [E.piphany's] products does not alter this outcome." (Id. at pp. 1253-1254.) Relying on *Piphany*, the court in *Burgett, supra*, 830 F.Supp.2d 953 similarly found that an insured was "potentially liable for disparagement by implication" when faced with a suit alleging it had made a false claim to be "the only owner" of a particular trademark. (Id. at p. 964.)

(12) These cases suggest that the related requirements of derogation and specific reference may be satisfied by implication where the suit alleges that the insured's false or misleading statement necessarily refers to and derogates a competitor's product. A publication that claims a superior feature of a business or product as distinct from all competitors, such as a claim to be the "only" producer of a certain kind of software or the "only" owner of a trademark, may be found to clearly or necessarily disparage another party even without express mention. To find specific reference in these circumstances is consistent with limiting disparagement claims "to those who are the direct object of criticism and denying it to those who merely complain of nonspecific statements that they believe cause them some hurt." (*Blatty, supra*, 42 Cal.3d at p. 1044.)

295 "295 The claim of disparagement recognized in *Charlotte Russe*, by contrast, appears to depart from the specificity requirements set forth above. There, an apparel manufacturer, People's Liberation, filed an action for fraud, breach of contract, and restitution against a clothing store, Charlotte Russe, which it had enlisted to be the exclusive retailer of the brand. The complaint alleged that Charlotte Russe's heavy discounts on its premium apparel suggested to consumers that People's Liberation products were of inferior quality. The court rejected the insurer's contention that coverage was defeated because the underlying pleadings did not allege an "'injurious false statement disparaging [the manufacturer's] products." (*Charlotte Russe, supra*, 207 Cal.App.4th at p. 979.) The court found sufficient the allegations that the People's Liberation brand was a premium good and that Charlotte Russe had "published prices" that implied they were not, thereby reasoning that the underlying complaint "pled that the implication carried by the Charlotte Russe parties' pricing was false." (Ibid.)

(13) In the case before us, the Court of Appeal disagreed with *Charlotte Russe* as follows: "We fail to see how a reduction in price — even a steep reduction in price — constitutes disparagement. Sellers reduce prices because of competition from other sellers, surplus inventory, the necessity to reduce stock because of the loss of a lease, changing store location, or going out of business, and because of many other legitimate business reasons. Reducing the price of goods, without more, cannot constitute a disparagement; a price reduction is not "an injurious falsehood directed at the organization or products, goods, or services of another . . ." [Citation.]" (Fn. omitted.) We agree with this reasoning. There is no question that Charlotte Russe's discounted prices on People Liberation's clothing specifically referred to People Liberation's product. But a mere reduction of price may suggest any number of business motivations; it does not clearly indicate that the seller believes the product is of poor quality. Disparagement by "reasonable implication" (*Blatty, supra*, 42 Cal.3d at p. 1046; see *Total Calf, supra*, 181 Cal.App.4th at pp. 170-171) requires more than a statement that may conceivably or plausibly be construed as

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derogatory to a specific product or business. A "reasonable implication" in this context means a clear or necessary inference. Charlotte Russe's prices did not carry an implication clear enough to derogate People Liberation's product for purposes of a disparagement claim. We disapprove Travelers Property Casualty Co. of America v. Charlotte Russe Holding, Inc., supra, 207 Cal.App.4th 969 to the extent it is inconsistent with this opinion.

III.

We now consider whether the Court of Appeal was correct to conclude that the Dahl action did not allege disparagement within the meaning of the 296 Hartford policy. In other words, did the facts and pleadings known or reasonably inferable by Hartford show a potential claim for express or implied disparagement? Ultimate appears to advance two separate theories of disparagement. The first focuses on Dahl's claim that the similarity of the Ulti-Cart's design and product name to the Multi-Cart's design and product name led consumers to confuse the Ulti-Cart with the Multi-Cart. The second contends that Ultimate's advertisements included false statements of superiority that implied the inferiority of the Multi-Cart. We address each theory in turn.

A.

(14) The Court of Appeal concluded that "[e]ven if the use of 'Ulti-Cart' could reasonably imply a reference to 'Multi-Cart,' ... Ultimate's advertisement contained no disparagement of 'Multi-Cart.'" We conclude that the Court of Appeal was correct. Consumer confusion resulting from the similarity of the Ulti-Cart to the Multi-Cart may support a claim of patent or trademark infringement or unfair competition in certain circumstances, but it does not by itself support a claim of disparagement. Even if the Ulti-Cart was named and designed to mimic the Multi-Cart, that fact does not derogate or malign the Multi-Cart in any way.

There is no coverage for disparagement simply because one party tries to sell another's goods or products as its own. In Astina, supra, 838 F.2d 346, for example, the complaint alleged that the policyholder had engaged in unfair competition by advertising a competitor's animal tags as its own. (Id. at p. 349.) The Ninth Circuit concluded that the underlying action failed to allege any publication "which directly cast aspersions" on the underlying plaintiff's product or business. (Id. at p. 351, citing Nichols, supra, 169 Cal.App.3d at p. 774.) Thus, the court found no duty to defend against a claim of disparagement where the gravamen of the claim was that the policyholder had "'palmed off'" the competitor's products as its own. (Astina, at p. 351.)

Similarly, a party's attempt to copy or infringe on the intellectual property of another's product does not, without more, constitute disparagement. In Homedics, Inc. v. Valley Forge Ins. Co. (9th Cir. 2003) 315 F.3d 1135, the Ninth Circuit considered whether a claim of patent infringement constituted disparagement triggering a duty to defend under California law. The underlying suit involved a claim by a company, Nikken, alleging that a competitor, Homedics, had infringed its patent on a therapeutic magnetic device used in alternative medical procedures. (Id. at p. 1137.) Finding no duty to defend, the court reasoned: "It does not follow that because an entity imitated the design of a product, it is, therefore, disparaging it. In point of fact, it's quite 297 "297 the opposite — as has been oft said: imitation is the highest form of flattery." (Id. at p. 1142.) Homedics also noted with approval the Court of Appeal's statement in Maxconn Inc. v. Truck Ins. Exchange (1999) 74 Cal.App.4th 1267 [88 Cal.Rptr.2d 759] that "'[t]he absence of any express reference to patent infringement in the policy would lead a reasonable layperson to the conclusion that patent infringement is not covered." (Id. at p. 1276.)

Ultimate relies on Michael Taylor Designs, Inc. v. Travelers Property Casualty Co. of America (N.D.Cal. 2011) 761 F.Supp.2d 904 (Michael Taylor), affd. (9th Cir. 2012) 495 Fed.Appx. 830, where the district court found a duty to defend against a disparagement claim. There, a furniture designer, Rosequist, claimed that a furniture retailer, Michael Taylor Designs (MTD), distributed promotional materials that included photographs of Rosequist's high-quality furniture and then sold low-quality "'cheap synthetic knockoffs" in its showroom. (Michael Taylor, supra, 761 F.Supp.2d at p. 907.) This "'bait-and-switch" routine allegedly confused and misled consumers as to the origin of

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the furniture and diluted and tarnished Rosequist's trade dress. \textit{(Ibid.)} The court observed that the allegation that customers would be "steered" to imitation products "fairly implies some further statements, presumably oral, were being made by MTD personnel to convey the information that the imitation products were the Rosequist furniture depicted in the brochures." \textit{(Id. at p. 912.)} Under these circumstances, the court concluded that Rosequist had sufficiently alleged a claim of disparagement, triggering a duty to defend under the insurance policy held by MTD. \textit{(Ibid.)}

(15) Whatever the merits of Michael Taylor's reasoning, the facts in this case do not include the kind of bait-and-switch tactics alleged in \textit{Michael Taylor}. There is neither any specific allegation in the Dahl action nor any fact reasonably known to Hartford that clearly implies the inferiority of the Ulti-Cart to the Multi-Cart. It is true that Dahl, in a February 12, 2010 memorandum in support of a motion for a temporary restraining order, claimed that the Multi-Cart had become "widely recognized as an industry leading utility cart in the music performance industry" and that Ultimate was now marketing a "knock-off" of the Multi-Cart. Dahl also noted Ultimate's intent "to expand into [Dahl's] markets with similar pricing and with millions of dollars [sic] worth of Chinese carts planned to be dumped in the United States with lower pricing." However, in claiming patent and trademark infringement, Dahl repeatedly asserted that the two products were "nearly identical, folding transport carts." Indeed, Dahl's claims relied heavily on the fact that the mark and design of the two products were nearly indistinguishable. A false or misleading statement that causes consumer confusion, but does not expressly assert or clearly imply the inferiority of the underlying plaintiff's product, does not constitute disparagement. Because the alleged likeness of the two products did not derogate the Multi-Cart, we reject Ultimate's theory of disparagement based on consumer confusion over the product name and design.

B.

Ultimate also contends that several phrases in its 2010 product catalog disparage the Multi-Cart by asserting the superiority of the Ulti-Cart. As Ultimate notes, the 2010 product catalog states that "Ultimate Support designs and builds innovative, superior products," that the company provides "unique support solutions that are crafted with unparalleled innovation and quality and accompanied by superior customer service," and that the Ulti-Cart has "patent-pending folding handles and levers." Ultimate suggests that these phrases imply that the Multi-Cart is inferior and that "patent-pending" suggests "that Dahl does not have proprietary rights to its product."

The Court of Appeal did not address these statements, instead noting that potential disparagement should be assessed by reference to the "allegations of the Dahl complaint, Dahl's application for a temporary restraining order, and Dahl's responses to interrogatories to the terms of the Hartford insurance policy." But, as discussed above, a duty to defend may be supported not only by the allegations in the complaint but also by facts alleged, reasonably inferable, or otherwise known to the insurer. Ultimate's new product catalog was produced by Dahl in the underlying action and referenced in his complaint. Thus, the contents of the catalog were reasonably known to Hartford and should be considered in determining whether the Dahl action set forth a possible claim of disparagement.

(16) Even so, however, no disparagement claim is apparent. Ultimate contends that the phrase "patent-pending" when combined with words like "innovative," "unique," "superior," and "unparalleled" suggests the superiority of the Ulti-Cart and, by implication, the inferiority of the Multi-Cart. But these words considered in their context do not support Ultimate's contention. Although the phrase "patent-pending folding handles and levers" appears on the page of the catalog describing the Ulti-Cart, the words "innovative," "unique," "superior," and "unparalleled" appear on pages providing general descriptions of the company, and they are most reasonably understood as generic assertions of the company's excellence. For example, "superior" does not necessarily imply a derogatory comparison; it may be used to describe something "of great value or excellence; extraordinary" \textit{(American Heritage Dict. (4th ed. 2000) p. 1737)} or "naturally excellent of its kind; surpassingly good" \textit{(Webster's 3d New Internat. Dic. (2002) p. 2294)}. Similarly, "patent-pending" does not guarantee that a patent will be granted or that the product is of higher quality. Contrary to Ultimate's claims, these statements are not specific enough to call
into question Dahl's proprietary rights in his product or to suggest that the Ulti-Cart has any unique feature that is an "important differentiator" between competing products. (Epiphany, supra, 590 F. Supp. 2d at p. 1253.) Rather, the phrases at issue appear to be more "akin to 'mere puffing,' which under long-standing law cannot support liability in tort." (Consumer Advocates v. Echostar Satellite Corp. (2003) 113 Cal.App.4th 1351, 1361, fn. 3 [8 Cal.Rptr.3d 221].)

Were we to adopt Ultimate's theory of disparagement, almost any advertisement extolling the superior quality of a company or its products would be fodder for litigation. Proliferation of such litigation would interfere with "the free flow of commercial information" (Va. Pharmacy Bd. v. Va. Consumer Council (1976) 425 U.S. 748, 765 [48 L.Ed.2d 346, 96 S.Ct. 1817]) and "the informational function of advertising" (Central Hudson, supra, 447 U.S. at p. 563), which are essential to informed choice in our free enterprise economy. In light of the important purposes of commercial speech, specificity requirements serve to narrow the range of publications in the marketplace that may rise to the level of a legally actionable injurious falsehood.

CONCLUSION

(17) Our holding clarifies and limits the scope of an insurer's duty to defend a policyholder against a possible claim of disparagement, as that term is used in a commercial general liability policy. Of course, an insurer and its insured may contract for any broader coverage to which they mutually agree. Here, because the facts and pleadings were not sufficient to support a possible claim of disparagement, there was no duty to defend under the Hartford policy. We affirm the judgment of the Court of Appeal.


[*] Retired Associate Justice of the Supreme Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.

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MURIEL JOHANSEN, Plaintiff and Appellant,

v.

CALIFORNIA STATE AUTOMOBILE ASSOCIATION INTER-INSURANCE BUREAU, Defendant and Respondent.

Docket No. S.F. 23229.

Supreme Court of California. In Bank.

August 11, 1975.

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OPINION

TOBRINER, J.

In a prior action for damages arising out of an automobile accident, plaintiff Muriel Johansen obtained a judgment of $33,889.30 against Gary and Joyce Dearing, a sum well in excess of the Dearings' automobile insurance policy limits. Although the Dearings' insurance carrier, defendant in the instant action, assumed the Dearings' defense in the earlier suit, it refused, during the course of that litigation, to accept a settlement offer within policy limits because it believed that the accident did not fall within the policy's coverage.

In a subsequent declaratory judgment action, however, the Court of Appeal determined that defendant's policy did in fact cover the accident. (Cal. State Auto. Assn. Inter-Ins. Bureau v. Dearing (1958) 259 Cal. App.2d 717 [66 Cal. Rptr. 852].) The insurer then paid plaintiff the portion of the judgment falling within the policy limits but refused to accept liability for the balance. The Dearings thereafter assigned their rights against the insurer to Ms. Johansen, who commenced the present action to recover the unpaid portion of her judgment. The superior court ruled in favor of defendant insurer, and plaintiff now appeals.

For the reasons discussed below, we conclude that the judgment must be reversed. (1a) California authorities establish that an insurer who fails to accept a reasonable settlement offer within policy limits because it believes the policy does not provide coverage assumes the risk that it will be held liable for all damages resulting from such refusal, including damages in excess of applicable policy limits. In the instant case, defendant contended and the superior court agreed that such liability does not attach if the insurer's denial of coverage was made in good faith.

As we explain, however, nearly 20 years ago, in Comunale v. "13 Traders & General Ins. Co. (1958) 50 Cal.2d 654 [328 P.2d 198, 68 A.L.R.2d 883], our court rejected an identical contention proffered by an insurer who, like the instant defendant, failed to accept a settlement offer because of doubts as to policy coverage. No decision in the
Intervening years has questioned the vitality of the Comunale holding or reasoning; nor has defendant presented any sound basis for departing from that authority.

On February 26, 1963, plaintiff Muriel Johansen and her husband suffered injuries in an automobile accident caused by the negligence of Gary Dearing, the minor son of Joyce Dearing. At the time of the accident, an insurance policy issued by defendant California State Automobile Inter-Insurance Bureau (insurer) covered the Dearings, affording policy limits of $10,000 for bodily injury for each person, $20,000 for each occurrence and $5,000 for property damage.

On December 27, 1963, Ms. Johansen sued the Dearings for personal injuries and property damage stemming from the accident. Although the insurer maintained that the policy did not provide coverage, it agreed to assume the defense of the Dearings but reserved its right to litigate the coverage issue. On May 1, 1964, the insurer, seeking to obtain a judicial determination as to whether the policy afforded coverage, instituted a declaratory relief action naming Ms. Johansen and the Dearings as defendants.

On December 10, 1964, Ms. Johansen, plaintiff in the third party suit, offered to settle her claim for $10,000, the full amount of the policy. Although defendant conceded the virtual certainty of a judgment against the Dearings in excess of the policy limits, it refused to adjust the matter, stating that it would only be willing to offer the policy limits if it were judicially determined that the policy did in fact provide coverage.\[1]\n
Despite defendant's efforts to expedite the declaratory relief action, the personal injury action ultimately went to judgment first, resulting in an award against the Dearings of $33,889.30, a sum far in excess of the insurance policy limits. In the declaratory relief action, although the trial court initially ruled in favor of defendant on the coverage issue, that determination was subsequently reversed on appeal. (Cal. State Auto. Assn. Inter-Ins. Bureau v. Dearing, supra, 269 Cal. App.2d 717.) Thus, a final judgment holding that the policy did extend coverage to the Dearings was entered only on September 5, 1968, over four years after the initial filing of the action.

The insurer subsequently paid Ms. Johansen $19,692.19. Since interest on the judgment in the personal injury suit accounted for $8,302.89 of this sum, an outstanding judgment of $22,500 remained against Gary Dearing. Thereafter, Gary Dearing assigned his rights against the insurer to Ms. Johansen in exchange for her promise to release him from personal liability on the outstanding judgment. Ms. Johansen then, as assignee of Gary Dearing, commenced the instant action against the insurer to collect the unpaid portion of her judgment.

The trial court, sitting without a jury, rendered judgment in favor of defendant insurer, concluding, in essence, that the insurer’s liability could only be predicated upon a finding that its denial of coverage emanated from bad faith, and that in this instance the insurer entertained a bona fide belief that coverage did not exist.\[2]\n
In analyzing this case, we note at the outset that the rights at issue here are those of Gary Dearing, the insured; plaintiff Johansen comes before us only as his assignee.\[3]\n
Thus, our inquiry necessarily focusses on the nature of the relationship between the defendant insurer and its insured, Dearing, and the nature and scope of the resultant obligations.

In Comunale v. Traders & General Ins. Co., supra, 50 Cal.2d 654, 658, this court, in a unanimous decision, held that "there is an implied covenant of good faith and fair dealing in every contract that neither party will do anything which will injure the right of the other to receive the benefits of the agreement," and that this principle is "applicable to policies of insurance." The implied covenant of good faith and fair dealing imposes a duty on the insurer to settle a claim against its insured "within policy limits whenever there is a substantial likelihood of a recovery in excess of those limits. (Id., at p. 659.)

In Comunale, two pedestrians (the Comunales) were struck and injured by a truck driven by Percy Sloan. At the time of the accident, Sloan was insured by defendant Traders & General Insurance Company under a policy that contained limits of liability in the sum of $10,000 for each person injured and $20,000 for each accident. When the Comunales filed suit against Sloan, defendant insurer refused to assume his defense; during the course of the

litigation it rejected the Comunales' offer to settle their claims for $4,000, maintaining that the accident did not fall within the policy's coverage. The action proceeded to trial and resulted in a judgment of $26,250 against Sloan.

In a subsequent action the court determined that the policy did in fact cover the accident; the Comunales recovered $11,250 from the insurer, the amount of the judgment which fell within the insurance policy limits. Sloan then assigned his rights against the defendant insurer to Comunale who sued the insurer to recover the unpaid portion of his judgment. This court held that the defendant insurer had breached its implied covenant of good faith and fair dealing when, despite the great risk of a recovery in excess of policy limits, it failed to compromise the claim against the insured. We held the insurer liable for the entire amount of the judgment against its insured.

Defendant asserts, however, that the Comunale principle does not apply to an insurer whose refusal to settle stems from a bona fide belief that the policy does not provide its insured coverage. In Comunale, the insurer asserted a virtually identical claim: "It is not claimed the settlement offer was unreasonable in view of the extent of the injuries and the probability that [the insured] would be found liable, and [the insurer's] only reason for refusing to settle was its claim that the accident was not covered by the policy." (Id., at p. 658.) This court nevertheless held the insurer liable for the excess judgment against its insured, stating: "An insurer who denies coverage does so at its own risk and although its position may not have been entirely groundless, if the denial is found to be wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligations of the contract." (Italics added.) (Id., at p. 660.) Accordingly, contrary to the defendant's suggestion, an insurer's "good faith," though erroneous, belief in noncoverage affords no defense to liability flowing from the insurer's refusal to accept a reasonable settlement offer.

Under the standards articulated by the controlling decisions of this court we cannot question the reasonableness of the offer of settlement. (2) We have held that whenever it is likely that the judgment against the insured will exceed 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." (Id., at p. 659; accord Crisci v. Security Ins. Co., supra, 66 Cal.2d 425, 429.)

Moreover, in deciding whether or not to compromise the claim, the insurer must conduct itself as though it alone were liable for the entire amount of the judgment. (Crisci v. Security Ins. Co., supra, 66 Cal.2d at p. 429.) Thus, the only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer. Such factors as the limits imposed by the policy, a desire to reduce the amount of future settlements, or a belief that the policy does not provide coverage, should not affect a decision as to whether the settlement offer in question is a reasonable one.

In the instant case, defendant has repeatedly conceded that in light of the serious character of Ms. Johansen's injuries and the overwhelming evidence that Gary Dearing had been negligent, plaintiff's $10,000 offer was eminently reasonable. As noted above, the final judgment against the Dearings actually amounted to almost $34,000. (3) "The size of the judgment recovered in the personal injury action when it exceeds the policy limits, although not conclusive, furnishes an inference that the value of the claim is the equivalent of the amount of the judgment and that acceptance of an offer within those limits was the most reasonable method of dealing with the claim." (Crisci v. Security Ins. Co., supra, 66 Cal.2d at p. 431.)

Defendant's admission of the certainty of liability finds further confirmation in the fact that the Dearings were advised to admit liability in the personal injury suit by counsel retained by defendant. Indeed, abundant evidence in the record indicates that if the Dearings had failed to admit liability, the verdict in the personal injury suit might well have been substantially higher. Accordingly, under the principles articulated in Comunale, defendant bore the obligation to accept the proffered settlement offer.

(1b) Defendant, however, seeks to avoid the Comunale rule by asserting that it only applies to an insurer who breaches its duty to defend in addition to failing to settle. Although in Comunale the insurer not only refused to
settle but also failed to defend, its liability for the excess judgment did not turn on this latter factor. As this court unequivocally stated: "The decisive factor in fixing the extent of [the insurer's] liability is not the refusal to defend, it is the refusal to accept an offer of settlement within policy limits." (Comunale v. Traders & General Ins. Co., supra, 50 Cal.2d at p. 659.)[12]

Defendant secondly asserts that the Comunale principle is limited in its application to causes of action arising in contract, and thus, cannot be "utilized in the instant case since plaintiff predicated her claim on a theory of tort liability. Moreover, defendant argues, this court has held since Comunale that a breach of the implied covenant of good faith and fair dealing gives rise to a cause of action in tort alone. Thus, according to defendant, its obligation stemmed solely from a tort duty to "act reasonably and in good faith" — a duty it fulfilled when it rejected plaintiff's settlement offer on the basis of honest doubts as to coverage. Defendant's argument displays a misconception of our decisions in this area and the facts in this case.

In the first place, the record does not indicate that plaintiff's cause of action rested on a theory of tort liability. Indeed, from the outset plaintiff has consistently asserted that her claim arises from the theory of liability articulated in Comunale. (4) In the second place, a breach of the insurer's obligation to accept a reasonable offer of settlement, a duty included within the implied covenant of good faith and fair dealing, "sounds in both contract and tort." (Crisci v. Security Ins. Co., supra, 66 Cal.2d at p. 432; accord Gruenberg v. Aetna Ins. Co. (1973) 9 Cal.3d 566, 575 [108 Cal. Rptr. 480, 510 P.2d 1032].) (5) Finally, the scope of the duty imposed upon the insurer by the covenant of good faith and fair dealing does not turn on whether we characterize its breach as contractual or tortious, since, in either case, the duty itself springs from the contractual relationship between the parties. Thus, defendant cannot avoid liability in this case by labeling plaintiff's cause of action as a cause in tort.[13]

Defendant's third assertion that the Comunale rule has been modified by two subsequent Court of Appeal cases (State Farm Mut. Auto. Ins. Co. v. Allstate Ins. Co. (1970) 9 Cal.App.3d 508 [88 Cal. Rptr. 246]; Donohue Constr. Co. v. Transport Indem. Co. (1970) 7 Cal.App.3d 291 [86 Cal. Rptr. 632]) cannot be sustained. In State Farm, the insurer State Farm was not under a duty to settle since its policy did not actually provide for coverage. Moreover, when the court ruled that defendant Allstate's liability for the excess judgment against its insured could only be imposed if Allstate had failed to settle in addition to refusing to defend, the court merely clarified its previous statement that ordinarily a refusal to defend in and of itself would not necessarily render the insurer "liable for the amount of the judgment in excess of the policy limits. (Id., at p. 528.) Thus, State Farm in fact reiterates the Comunale principle.

In Donohue, the insurer Transport Indemnity Company's asserted breach of its implied covenant of good faith and fair dealing was not even litigated by the parties, and indeed was raised for the first time on appeal. Moreover, since the critical issue in that case revolved around the relative obligations of two insurance carriers to the same insured, the court properly concluded that since "Donohue [the insured] was adequately protected under the U.S. Fire Policy [the primary insurance carrier] the refusal by Transport [the excess insurance carrier] to defend Donohue did not enhance Donohue's liability or exposure to liability." (Donohue Constr. Co. v. Transport Indem. Co., supra, 7 Cal. App.3d at p. 304.)[14]

Finally, we cannot accept defendant's complaint that the Comunale rule requires an insurer to settle in all cases irrespective of whether the policy provides coverage. Clearly, if defendant's belief that the policy did not provide coverage in the instant case had been vindicated, it would not be liable for damages flowing from its refusal to settle; all that Comunale establishes is that an insurer who fails to settle does so "at its own risk." (6) Moreover, contrary to defendant's assertion, an insurer in defendant's position retains the ability to enter an agreement with the insured reserving its right to assert a defense of noncoverage even if it accepts a settlement offer. If, having reserved such rights and having accepted a reasonable offer, the insurer subsequently establishes the noncoverage of its policy, it would be free to seek reimbursement of the settlement payment from its insured.

(7a) Accordingly, applying the principles of Comunale and Crisci, we conclude the insurer breached its duty to its insured when it failed to accept the reasonable settlement offer.
Defendant additionally argues, however, that even if it did breach its obligation to accept the settlement offer, it is not liable in this action because it is not "responsible" for the damages at issue here. Although defendant's final argument is drawn from various legal theories including the doctrines of proximate cause, mitigation of damages, failure of consideration and prevention of performance, at the heart of all these "20 hypotheses lies the contention that the excess judgment in this case was caused by the insureds' failure to deal in good faith with their insurer. (8) Although we recognize that the implied covenant of good faith and fair dealing inures to the benefit of both parties to a contract and thus requires that "neither party will do anything which will injure the right of the other to receive the benefits of the agreement" (italics added) (Comunale v. Traders & General Ins. Co., supra, 50 Cal.2d at p. 658; accord Crisci v. Security Ins. Co., supra, 66 Cal.2d at p. 429), we do not believe that the record supports defendant's contention that the excess judgment can be attributed to their insureds' conduct.

The only incident to which defendant can point that might conceivably have affected the outcome in this case is the insureds' refusal to permit counsel to move to continue the personal injury suit pending resolution of the coverage issue in the declaratory relief action. The gist of defendant's argument is that the insureds' failure to move for a continuance in the personal injury suit resulted in that action being resolved first in time, an event which in turn brought about a judgment in excess of policy limits.

Defendant predicates the argument on the assumption that the prior resolution of the coverage issue, irrespective of its outcome, would have prevented the personal injury suit from going to trial and thereby would have avoided an excess judgment. If the issue of coverage were resolved in favor of the insurer, argues defendant, Ms. Johansen would have abandoned the personal injury suit since the Dearings were impecunious; conversely, if the issue of coverage had been resolved against the insurer it would have settled the personal injury suit for the policy limits.

Although the excess judgment might have been avoided had the declaratory judgment action gone to judgment prior to the personal injury suit, the record completely fails to sustain defendant's assertion that the insureds can be held responsible for the prior determination of the personal injury litigation. In the first place, early in the personal injury litigation, counsel for the insureds did in fact make a motion to continue that suit pending resolution of the declaratory judgment action; plaintiff objected to any continuance and the trial court denied the motion. Thus, even if the insureds had persisted in their efforts to "21 continue the personal injury action, it appears unlikely that they would have prevailed.\[10\]

Moreover, the judgment in the declaratory relief action was entered almost three and a half years after the rendition of the judgment in the personal injury suit and almost five years after the filing of the personal injury suit. In light of the provisions of Code of Civil Procedure section 583 which authorize dismissal of actions that are not brought to trial within two years from filing, and mandate dismissal if the action is not brought to trial within five years, we cannot believe that the court would have permitted the insureds to postpone trial in the personal injury suit for almost five years. Thus, although the trial court in the instant case concluded as a matter of law that the prior resolution of the personal injury action resulted from the combined efforts of counsel for plaintiffs and the insureds, all the evidence in the record dictates a contrary conclusion.\[11\]

Although defendant attempts to raise the spectre of collusion between the insureds and Ms. Johansen, it has been unable to point to a single instance in which the insureds by their actions contributed to the size of the ultimate judgment in the personal injury suit.\[12\] Instead, our examination of the record demonstrates that the insureds' defense of the personal injury suit was exemplary.

\[22\] Defendant asserts, however, that the insureds at first resisted counsel's advice to admit liability in the personal injury action although such admission would have been the wisest course of action. We fail to see the significance of this contention. We are not concerned with what the insureds might have done but instead with what they in fact did. It is undisputed that in fact the insureds did admit liability. Moreover, it is perfectly understandable that an unsophisticated lay litigant would balk initially at the suggestion that he or she admit liability in a lawsuit. In light of the fact that the insureds did nothing to jeopardize their defense, we are unable to conclude that the personal injury lawsuit was a collusive one. (See Critz v. Farmers Ins. Group (1964) 230 Cal. App. 2d 788, 802-804 [41 Cal. Rptr.]

401. 12 A.L.R.3d 1142].) (7b) Thus, the excess judgment in this case must be attributed solely to defendant's failure to compromise the claim against its insured.

The judgment is reversed and the cause remanded for proceedings consistent with this opinion.


Respondent's petition for a rehearing was denied September 10, 1975. Richardson, J., was of the opinion that the petition should be granted.

[1] Subsequently, on March 18, 1966, defendant offered to place in escrow the amount of its policy, bearing interest at the rate of 7 percent pending resolution of the declaratory relief action, which would be paid to Ms. Johansen provided that the issue of coverage was resolved against defendant. The offer was rejected.

[2] The insurer claimed that the automobile driven by Gary Dearing had been acquired over 30 days before the date of the accident, but that its acquisition had not been reported to the insurer — facts which, if proven, would exclude the automobile from coverage under the policy. The Court of Appeal, however, determined that the 30-day limit for reporting the acquisition of the car had not run at the date of the accident.

[3] "An action for damages in excess of the policy limits based on an insurer's failure to settle is assignable, whether the action is considered as sounding in tort or in contract." (Comunale v. Traders & General Ins. Co., supra, 50 Cal.2d 654: 661.)

[4] Defendant seeks to avoid the import of this language by asserting that "wrongful" must be equated with "culpable," a proposal for which there is absolutely no support in Comunale. Indeed, the language immediately preceding this portion of Comunale expressly states that the insurer denies coverage at its own risk. Viewed in context, it becomes apparent that a "wrongful" denial of coverage as used in Comunale means merely an erroneous denial of coverage required by the policy.

[5] Although defendant asserts that its liability can only be predicated on a finding of specific instances of reprehensible conduct, we rejected this very contention in Crespi v. Security Ins. Co. (1967) 66 Cal.2d 425, 430 [58 Cal. Rptr. 13, 426 P.2d 173]: "Liability is imposed not for bad faith breach of contract but for the failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing. Moreover, ... recovery may be based on unwarranted rejection of a reasonable settlement offer and ... the absence of evidence, circumstantial or direct, showing actual dishonesty, fraud or concealment is not fatal to the cause of action." (Italics added.)

[6] Both plaintiff and amicus curiae on behalf of plaintiff urge that we hold that whenever an insurer receives an offer to settle within policy limits and rejects it, the insurer should be held liable in every case for the amount of any final judgment. We note that the New Jersey Supreme Court in a well reasoned opinion has adopted this rule. (Roya Farms Resort Inc. v. Investors Ins. Co. of Amer. (1974) 65 N.J. 474 [323 A.2d 495].) In light of our conclusion that defendant's liability for the excess judgment may be predicated on its rejection of a reasonable settlement offer, we need not resolve this issue.

[7] Indeed, the insurer in Comunale sought to use its failure to defend as a justification for its refusal to settle on the ground that it did not retain control over the litigation and thus lacked the authority to effectuate a settlement. The court determined that an insurer who not only refuses to settle but also refuses to defend should not be treated with any greater deference than an insurer who only refuses to settle leads to the inescapable conclusion that the insurer's liability for the excess judgment arises directly from its failure to settle within policy limits. (Id., at p. 660.)


[9] Defendant also cites cases from other jurisdictions in support of its position. Since these jurisdictions do not adhere to the Comunale rule, those cases are inapposite.

[10] Under similar circumstances this court has held that the insurer does not have a right to delay the trial of a personal injury action in which its insured is a defendant pending resolution of a declaratory relief action in which the issue of coverage is to be determined. (State Farm etc. Ins. Co. v. Superior Court (1956) 47 Cal.2d 428, 433 [304 P.2d 131].)

[11] Moreover, the language of the Nonwaiver or Reservation of Rights Agreement entered into by the insureds and defendant supports plaintiff's contention that the agreement itself appeared to require that the personal injury action be resolved first: "[B]oth parties desire to cooperate to ... postpone the determination of their respective rights and liabilities under the policy until the
questions of the insured's legal liability for damages arising out of such accident and the amount thereof, if any, has been definitely determined."

[12] Defendant relies heavily on the conduct of Hawkins, counsel for the Dearings in the declaratory relief action, to support its position. The record sustains defendant's contention and the trial court's finding that Hawkins and Federspiel, counsel for the Johansens, entered into a fee-splitting arrangement prior to the trial of the personal injury action whereby they would share equally in a portion of any judgment in the personal injury suit against the Dearings. The record indicates, however, that the Dearings were unaware of this arrangement. In the instant case we have no occasion to pass on the propriety of Hawkins' questionable conduct, since our inquiry here is confined to determining whether the insureds contributed to, or were responsible for, the excess judgment against them. The record is utterly devoid of any evidence which would support such a conclusion.

[13] In Crtiz, the defendant insured assigned his rights against the insurer to plaintiff before the personal injury suit was tried. In exchange plaintiff agreed not to hold the insured personally liable for the ultimate judgment. The insurer argued that the assignment agreement resulted in the personal injury suit assuming a collusive character by virtue of the fact that the insured would no longer have to bear the consequences of an adverse judgment. The court rejected this contention because the record in that case demonstrated that the insured had neither done nor said anything which jeopardized his defense of the lawsuit.

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261 Cal. Rptr. 273

MERCED MUTUAL INSURANCE COMPANY, Plaintiff and Respondent,

v.

BOBBY MENDEZ et al., Defendants and Appellants.

Docket No. F010623.

Court of Appeals of California, Fifth District.

August 11, 1989.

"43 COUNSEL

Ralph S. Temple, Jr., Canelo, Hansen & Wilson and James H. Wilson for Defendants and Appellants.

Marderosian & Swanson and James W. Swanson for Plaintiff and Respondent.

"44 OPINION

ARDAIZ, J.

This is an appeal from the entry of summary judgment in favor of respondent Merced Mutual Insurance Company. The trial court determined respondent had no duty to defend or indemnify Mendez for damages caused by engaging in acts of oral copulation and attempted oral copulation allegedly against Ms. Peery’s will. We shall affirm.

On October 16, 1985, Helen and Claude Peery filed a complaint against Bobby Mendez and the County of Merced, claiming Mendez had sexually assaulted Ms. Peery several times at their mutual place of employment. The complaint alleged causes of action for both intentional and negligent assault and battery. The complaint further alleged causes of action for both intentional and negligent infliction of emotional distress stemming from the incidents.

Depositions of both Mendez and Peery, submitted with the motion for summary judgment, reveal radically divergent versions of the events. Mendez’s version portrays a consensual sexual encounter between the parties. Peery’s recital of events reveals a brutal physical attack culminating in forced oral copulation and three attempts by Mendez to repeat the act.

At the time the acts occurred and at the time the Peery complaint was filed, Mendez was covered under a homeowners policy issued by respondent. With respect to personal liability, the policy provides in relevant part: “If a claim is made or a suit is brought against any insured for damages because of bodily injury or property damage caused by an occurrence to which this coverage applies, we will: [¶ 1]. pay up to our limit of liability for the damages for which the insured is legally liable; and [¶ 2]. provide a defense at our expense by counsel of our choice, even if the allegations are groundless, false or fraudulent.” The policy defines “occurrence” as “an accident, including exposure to conditions, which results, during the policy period, in: [¶ a]. bodily injury; or [¶ b]. property damage.” The policy then excludes coverage for: “bodily injury or property damage: [¶ a]. which is expected or intended by the insured.”

Mendez tendered his defense to respondent. Respondent filed an action for a declaratory judgment that it had no obligation to indemnify or defend Mendez in the action brought by the Peerys. Respondent argued Mendez’s acts were intentional and thus not within the general coverage provisions of the homeowners policy. Alternatively, respondent argued the conduct complained "45 of was excluded under policy provisions and Insurance Code section 533."

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After hearing on respondent's motion for summary judgment, the court issued the following decision: "Plaintiff has moved for a Summary Judgment declaring that it has no obligation to defend Bobby Mendez nor to indemnify him for damages he is alleged to have caused Helen Peery and Claude Peery.

"Plaintiff had issued one or more homeowners insurance policies to Mendez at least one of which was in effect at the relevant time.

"The policy provided coverage to Mendez if a claim is made or suit brought against him because of bodily injury caused by an occurrence. The word 'occurrence' means an accident which results in bodily injury. The policy coverage does not apply to injury which is expected or intended by the insured. The conclusion to be drawn from the testimony of Mendez relied on in this proceeding was that his sexual advances to Peery were consensual and there was no wrongdoing.

"If Mendez misunderstood or misinterpreted the words and acts of conduct of Peery and continued his advances he, nevertheless, intended those acts and the consequences of those acts. Peery's claim of harm does not make those acts of Mendez accidental."

Appellants filed timely notices of appeal.

DISCUSSION

(1) Summary judgment is proper where no triable issue of fact is presented and the sole question is one of law. (Neinstein v. Los Angeles Dodgers, Inc. (1988) 185 Cal. App.3d 176, 179 [229 Cal. Rptr. 612].) (2) Where the underlying facts are not disputed, construction of an insurance policy presents a question of law. The appellate court is not bound by the trial court's interpretation. Rather, it must independently interpret the language of the insurance contract. (Royal Globe Ins. Co. v. Whitaker (1986) 181 Cal. App.3d 532, 536 [226 Cal. Rptr. 435].)

(3a) At the outset, we recognize that the "insurer's duty to defend [Mendez] is broader than its duty to indemnify ... because the duty to defend arises if the underlying civil claim is potentially covered by insurance. [Citations.] But where there is no possibility of coverage, there is no "duty to defend" [citation] and the insurer is entitled to declaratory relief if the underlying civil action will not resolve issues affecting coverage." (Fire Insurance Exchange v. Abbott (1988) 204 Cal. App.3d 1012, 1029 [251 Cal. Rptr. 620].)

We further note at the outset that the cases relied on by appellant in urging a duty to defend are distinguishable and thus not controlling, in Gray v. Zurich Insurance Co. (1986) 65 Cal.2d 263 [54 Cal. Rptr. 104, 419 P.2d 168], the policy in question provided for payment "... on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage, ..." (Id. at p. 267.) The policy further provided: "[T]he company shall defend any suit against the insured alleging such bodily injury or property damage and seeking damages which are payable under the terms of this endorsement, even if any of the allegations of the suit are groundless, false, or fraudulent...." (Ibid.) The policy excluded coverage for bodily injury damages caused intentionally by the insured. (Ibid.)

Similarly, the policy language in Allstate Insurance Company v. Overton (1984) 160 Cal. App.3d 843 [206 Cal. Rptr. 823] provided broad coverage for "... all sums arising from the same loss which an insured person becomes legally obligated to pay as damages because of bodily injury or property damage covered by this part of the policy. [¶] We may investigate or settle any claim or suit for covered damages against an insured person. If an insured person is sued for these damages, we will provide a defense with counsel of our choice, even if the allegations are not true...." (Id. at pp. 845-846.) The policy then excluded losses "... intentionally caused by an insured person...." (Id. at p. 846.)

As respondent notes, the language of the policy in Gray and Overton is clearly distinguishable from the policy language in the present case. As previously noted, the policy here affords coverage and a duty to defend only "[i]f a
claim is made or a suit is brought against any insured for damages because of bodily injury or property damage caused by an occurrence to which this insurance applies." (Italics added.) "Occurrence" is elsewhere defined as an "accident."

The policy in Gray did not include, as does the subject policy, the words "caused by an occurrence to which this insurance applies." The importance of this distinction is discussed in Royal Globe Ins. Co v. Whitaker, supra, 181 Cal. App.3d 532 as follows: "[H]ere [unlike Gray], the insurer only promises to indemnify or defend actions involving bodily injury caused by an accident resulting in bodily injury neither expected nor intended by the insured." (Id. at p. 537, italics added.)

47 As the court in Giddings v. Industrial Indemnity Co. (1980) 112 Cal. App.3d 213 [169 Cal. Rptr. 278] (hg. den. Jan. 14, 1981) explains: "The present case is readily distinguishable from Gray and many of the cases following it, which have broadly interpreted the insurer's duty to defend. [Citations.] In each of these cases, damages of the type covered by the policy had undisputably occurred, and the insurer relied on an unclear exclusionary clause in asserting it was not obligated to defend its insured. Here, on the other hand, the question concerns the scope of the basic coverage itself...." (Id. at p. 218.)

(4a) Thus, the threshold question in the present case is not whether an exclusion applies, but rather the scope of coverage itself: whether the conduct in question constitutes an accident within the meaning of the policy provision. (5) In a declaratory relief action to determine the insurer's obligations under the policy, the burden is on the insured initially to prove an event is a claim within the scope of the basic coverage. (Royal Globe Ins. Co v. Whitaker, supra, 181 Cal. App.3d at p. 537.) The burden then shifts to the insurer to prove the claim falls within an exclusion. (Clemmer v. Hartford Insurance Co. (1978) 22 Cal.3d 865, 880 [151 Cal. Rptr. 285, 587 P.2d 1098].)

The established principles applicable to the interpretation of insurance policies are set forth in Reserve Insurance Co v. Pisciotta (1982) 30 Cal.3d 800 [180 Cal. Rptr. 628, 640 P.2d 764]; (6a) "Words used in an insurance policy are to be interpreted according to the plain meaning which a layman would ordinarily attach to them. Courts will not adopt a strained or absurd interpretation in order to create an ambiguity where none exists. [Citations.]

(7) "On the other hand, 'any ambiguity or uncertainty in an insurance policy is to be resolved against the insurer and ... if semantically permissible, the contract will be given such construction as will fairly achieve its object of providing indemnity for the loss to which the insurance relates.' [Citations.] The purpose of this canon of construction is to protect the insured's reasonable expectation of coverage in a situation in which the insurer-draftsman controls the language of the policy." (Id. at pp. 807-808.)

(6b) A policy provision is ambiguous if it is capable of two or more constructions, both of which are reasonable. (Producers Dairy Delivery Co. v. Sentry Ins. Co. (1986) 41 Cal.3d 903, 912 [226 Cal. Rptr. 558, 718 P.2d 920]; Island v. Fireman's Fund Indemnity Co. (1947) 30 Cal.2d 541, 548 [184 P.2d 153, 173 A.L.R. 896].)

(4b) The policy in the present case provides coverage and a defense for injury caused by an occurrence. An occurrence is defined as an "accident, including exposure to conditions, which results, during the policy period, in (a) bodily injury; ..."

The parties appear to agree that in order for coverage and a duty to defend to exist, the acts of oral copulation and attempted oral copulation must be deemed an "accident" within the meaning of the policy. They also agree Mendez intentionally engaged in the acts in question. The dispute centers on the meaning of the term "accident." Respondent contends the acts do not constitute an accident because they were intentionally performed by Mendez. Conversely, appellants contend an accident occurs even if the acts causing the alleged damage were intentional as long as the resulting damage was not intended. The argument urged by appellants has been repeatedly rejected by the appellate courts.

In St. Paul Fire & Marine Ins. Co v. Superior Court (1984) 161 Cal. App.3d 1199 [208 Cal. Rptr. 5], the underlying suit against the insured involved an action for wrongful discharge. The court was called on to construe policy
language similar to that in the present case: there the policy covered the insured against claims for "... bodily injury or damage to tangible property resulting from an accidental event." (Id. at p. 1201.) The court noted: "In its plain and ordinary sense, 'accidental' means 'arising from extrinsic causes;' [1] occurring unexpectedly or by chance; or happening without intent or through carelessness.' (Webster's Ninth New Collegiate Dict. (1983) p. 49.) The policy itself states that 'the accidental event ... must be something [the insured] didn't expect or intend to happen.' (Id. at p. 1202.) The court concluded the employee's termination did not constitute an "unintentional, unexpected, chance occurrence" (ibid.) and thus there was no potential liability under the policy. Accordingly, the court held the insurer had no duty to defend. 49 (Id. at pp. 1202-1203.)

In *Commercial Union Ins. Co. v. Superior Court* (1987) 196 Cal.App.3d 1205 [242 Cal.Rptr. 454] (rev. den. Feb. 24, 1988), the policy provided coverage and a defense for damages as a result of bodily injury or property damaged "caused by an occurrence." (Id. at p. 1206, italics in original.) "Occurrence" was then defined by the policy as "an accident, including, "49 continuous or repeated exposure to conditions, which results in bodily injury or property damage. This injury or damage must be neither expected nor intended by you. ..." (Id. at p. 1207, italics in original.) As in *St. Paul*, the underlying action against the insured involved a claim of wrongful discharge. Relying on *St. Paul*, the court concluded the trial court erred in applying the "term `accident' to the consequences of the act rather than to the happening of the act itself." (Id. at p. 1208.) The court held: "An intentional termination is not an `occurrence' under the policy because it is not an accident. The definition of `accident' halts any argument that real party intended his act but not the resulting harm." (Id. at p. 1209.)

In *Hogan v. Midland National Ins. Co.* (1970) 3 Cal.3d 553 [91 Cal.Rptr. 153, 476 P.2d 825], the Supreme Court construed the term "accident" with respect to a policy providing coverage for property damage "caused by accident." (Id. at p. 558, italics in original.) There, a saw manufactured by the insured was defective in that it cut the lumber more narrowly than it was supposed to. This defect in the saw was not discovered until after a substantial amount of the lumber had been processed. After the buyer discovered the defect, he deliberately cut lumber wider than ordered to compensate for the defect in the saw.

Focusing on the foreseeability of the damages, the insurance company argued damage to the boards resulting from cutting the widths too narrow was not the result of an accident within the meaning of the policy because all of the damages "were not only foreseeable and expectable but were in fact unforeseen since Kaufman knew from the outset that the saw was defective and would not cut lumber to the precise size desired." (Id. at p. 559.) Quoting *Geddes & Smith, Inc. v. St. Paul Mercury Indemnity Co.* (1959) 51 Cal.2d 558 [334 P.2d 881], the court stated: "No all-inclusive definition of the word "accident" can be given ... "as a source and cause of damage to property, within the terms of an accident policy, [accident] is an unexpected, unforeseen, or undesigned happening or consequence from either a known or unknown cause."" (Hogan v. Midland National Ins. Co., supra, 3 Cal.3d at p. 559.)

The court then concluded: "The damage to the boards which were undercut resulted from an accident within the meaning of the policy, but the lumber deliberately cut too wide was not damaged as the result of an accident." (Hogan v. Midland National Ins. Co., supra, 3 Cal.3d at p. 558.) The court reasoned: "The circumstances, and the legal consequences, differ as to the boards cut too wide. By design, Kaufman processed the boards wider than required for his orders in order to avoid rejection for undercutting. The damages awarded by the trial court were for the additional cost of the lumber necessary for the larger widths and the added freight cost. Whatever the motivation, there is no question that these boards were deliberately "50 cut wider than necessary; the conduct being calculated and deliberate, no accident occurred within the Geddes I definition." (Id. at p. 560, italics in original.)

We reject appellants' argument that in construing the term "accident," chance or foreseeability should be applied to the resulting injury rather than to the acts causing the injury. (8) In terms of fortuity and/or foreseeability, both "the means as well as the result must be unforeseen, involuntary, unexpected and unusual." (Unigard Mut. Ins. Co. v. Argonaut Ins. Co. (1978) 20 Wn.App. 261 [579 P.2d 1015, 1018], fn. omitted, italics added.) We agree coverage is not always precluded merely because the insured acted intentionally and the victim was injured. An accident, however, is never present when the insured performs a deliberate act unless some additional, unexpected,
independent, and unforeseen happening occurs that produces the damage. *(Ibid.)* Clearly, where the insured acted deliberately with the intent to cause injury, the conduct would not be deemed an accident. Moreover, where the insured intended all of the acts that resulted in the victim's injury, the event may not be deemed an "accident" merely because the insured did not intend to cause injury. Conversely, an "accident" exists when any aspect in the causal series of events leading to the injury or damage was unintended by the insured and a matter of fortuity.

The following is illustrative. When a driver intentionally speeds and, as a result, negligently hits another car, the speeding would be an intentional act. However, the act directly responsible for the injury — hitting the other car — was not intended by the driver and was fortuitous. Accordingly, the occurrence resulting in injury would be deemed an accident. On the other hand, where the driver was speeding and deliberately hit the other car, the act directly responsible for the injury — hitting the other car — would be intentional and any resulting injury would be directly caused by the driver's intentional act.

(4c) In the present case, Mendez admits intentionally engaging in sexual activity with Ms. Peery. This sexual activity, which Ms. Peery alleges occurred against her will, forms the basis of her action against Mendez. All of the acts, the manner in which they were done, and the objective accomplished occurred exactly as appellant intended. No additional, unexpected, independent or unforeseen act occurred. "Whatever the motivation," because Mendez's conduct was "calculated and deliberate" *(Hogan, supra, 3 Cal.3d at p. 560)*, it was not an "accident" and thus not an "occurrence" within the meaning of the policy provision. Because the conduct was not an "occurrence" the insurer has no duty to defend an action arising out of this conduct.

51 Appellants further contend because the policy also contains an exclusion for damages for bodily injury or property damage "which is expected or intended by the insured," an insured could reasonably expect "intended bodily injury is not covered, while unintended or negligent bodily injury is covered." A similar argument was rejected in *Commercial Union* as follows: "The trial court's mistake is in interpreting the policy's definition of 'occurrence.' The policy requires an 'accident ... which results in bodily injury or property damage.' The next sentence then explains that the 'injury or damage must be neither expected nor intended.' This sentence does not change the meaning of accident or remove the requirement that any injury or damage be accidentally caused. It merely explains that expected or intended injuries or damage are not 'accidents' within the meaning of the policy.

"The court has read the sentence '[t]his injury or damage must be neither expected nor intended by you' to imply (through silence, apparently) that coverage may exist even though the act leading to the injury or damage is expected or intended. No such inference may be drawn because it would contradict the plain and ordinary meaning of the word 'accident.' (See *St. Paul Fire & Marine Ins. Co. v. Superior Court,* supra, 161 Cal. App.3d at p. 1202.)" *(Commercial Union Ins. Co. v. Superior Court, supra, 196 Cal. App.3d at p. 1209)*

Appellants' argument also fails because the construction offered results in a strained interpretation of the word "accident." Appellants below agreed that if the jury solely believed Mendez then there would be no coverage; if the jury solely believed Mendez then there would be no liability; if the jury found Mendez acted under an honest and reasonable but mistaken belief in Peery's consent there would be no liability. The possibility of coverage exists only if the jury should find Mendez acted with an honest but unreasonable belief in consent. The argument, in effect, is that Mendez's purported honest but unreasonable belief in consent would constitute negligence. According to appellants, this mistaken belief "alter[s] the very character of the act itself" and renders it accidental. However, such a state of mind clearly constitutes a felony violation of Penal Code section 288 and/or "assault with intent to commit oral copulation (Pen. Code, § 220)." Although the law recognizes one might have a nonculpable state of mind if one has a reasonable bona fide belief in consent *(People v. Mayberry (1975) 15 Cal.3d 143, 155 [125 Cal. Rptr. 745, 542 P.2d 1337]), the law would impose criminal responsibility where the belief in consent was unreasonable. We find it an anomaly that appellant could claim insurance coverage under the guise of an "accident" by claiming his conduct constituted a felony.

We decline to construe the term "accident" to include conduct constituting the crime of forcible oral copulation and/or assault with intent to commit forcible oral copulation. We further are unable to posit any factual construction where such conduct might be interpreted as accidentally occurring.

As the court stated in Giddings v. Industrial Indemnity Company, supra, 112 Cal. App.3d 213, 218: (3b) "[T]he insurer's obligation is not unlimited; the duty to defend is measured by the nature and kind of risks covered by the policy [citations]."

(6c) "... In construing the language of an insurance policy, a court should give the words used their plain and ordinary meaning, unless the policy clearly indicates to the contrary [citations]. When the language is clear, a court should not give it a strained construction to impose on the insurer a liability which it has not assumed [citations]." (4d) For us to accept the construction of the term "accident" offered by appellants would strain credulity.

Moreover, our refusal to adopt appellants' construction of the term "accident" does not violate the general rule that ambiguous terms should be construed to protect the insured's reasonable expectation of coverage. We cannot seriously conclude any reasonable insured would expect the term "accident" included acts constituting the felony crime of forcible oral copulation.

53 The conduct giving rise to the underlying action against defendant is not an "accident" and thus not an "occurrence" within the coverage provision. Because there is no potential basis for coverage, there is no duty to defend.

The judgment is affirmed. Costs to respondent.

Best, Acting P.J., and Stone (W.A.), J., concurred.

[1] Insurance Code section 533 provides: "An insurer is not liable for a loss caused by the willful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others."

[2] Clemmer is concerned with exclusion from coverage because of the provisions of Insurance Code section 533, which states: "An insurer is not liable for a loss caused by the willful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others."

We address here what constitutes included acts within the policy definition of "occurrence." We do not address what is a statutorily excluded act under section 533 and as expounded on by Clemmer.


[4] Penal Code section 288a provides in pertinent part: "(a) Oral copulation is the act of copulating the mouth of one person with the sexual organ or anus of another person. [¶]... (d) Any person who, while voluntarily acting in concert with another person, either personally or by aiding and abetting that other person, commits an act of oral copulation (1) when the act is accomplished against the victim's will by means of force or fear of immediate and unlawful bodily injury on the victim or another person, or (2) where the act is accomplished against the victim's will by threatening to retaliate in the future against the victim or any other person, and there is a reasonable possibility that the perpetrator will execute the threat, or (3) where the victim is at the time incapable, because of a mental disorder or developmental or physical disability, of giving legal consent, and this is known or reasonably should be known to the person committing the act shall be punished by imprisonment in the state prison for five, seven, or nine years. Notwithstanding the appointment of a conservator with respect to the victim pursuant to the provisions of Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), the prosecuting attorney shall prove, as an element of the crime described under paragraph (3), that a mental disorder or developmental or physical disability rendered the alleged victim incapable of giving legal consent."

[5] Penal Code section 220 provides: "Every person who assaults another with intent to commit mayhem, rape, sodomy, oral copulation, or any violation of Section 284.1, 288 or 289 is punishable by imprisonment in the state prison for two, four, or six years."
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PAUL REID, Plaintiff and Appellant,  

v.  

MERCURY INSURANCE COMPANY, Defendant and Respondent.  

No. B241154.  

Court of Appeals of California, Second District, Division Eight.  

October 7, 2013.  

265 The Yarnall Firm, Delores A. Yarnall; Ammirato & Palumbo, Bruce Palumbo; Dewitt Algorri & Algorri and Mark S. Algorri for Plaintiff and Appellant.  

Hager Dowling Lim & Slack, Alison M. Bernal and John V. Hager for Defendant and Respondent.  

OPINION  

GRIMES, J.—  

SUMMARY  

This case involves an insurer's duty to its insured to settle a third party claim within policy limits, when liability is clear and there is a substantial likelihood of a recovery in excess of policy limits. The question is whether the insurer, in the absence of any demand or settlement offer from the third party claimant, must initiate settlement negotiations or offer its policy limits, and if so how quickly it must do so, to avoid a claim of bad faith failure to settle.  

266 In this case, the insured's liability was clear almost immediately after the collision. The insurer's claims manager had decided, within a little over six weeks, that while the insurer needed medical records, the insurer must tender the policy limits to the third party claimant "as soon as we have enough [information] available to do so." No settlement demand was made by the claimant, who filed suit against the insured three and one-half months after the collision. The medical records were not forthcoming from the claimant until seven months after the collision, and another three months passed before the insurer offered its policy limits. Under these circumstances, the trial court found the insurer not liable to its insured for bad faith failure to settle and granted the insurer's motion for summary judgment.  

We affirm. An insurer's duty to settle is not precipitated solely by the likelihood of an excess judgment against the insured. In the absence of a settlement demand or any other manifestation the injured party is interested in settlement, when the insurer has done nothing to foreclose the possibility of settlement, we find there is no liability for bad faith failure to settle.  

FACTS  

1. The Chronology of Events  

Defendant Mercury Insurance Company insured Zhi Yu Huang under an automobile policy with bodily injury policy limits of $100,000 per person and $300,000 per accident. On June 24, 2007, Ms. Huang was involved in a
multivehicle collision. The police report showed Ms. Huang failed to stop at a red light and collided with a car driven by plaintiff Shirley Reid. That collision caused plaintiff's car to collide with a third car driven by Chinele Ogbogu. Plaintiff sustained major injuries and could not provide police with a statement. Plaintiff's passenger, Edith Looschen, was also injured, as were Ms. Ogbogu and her passenger, Mercy Ngoka. All four made claims to defendant for their injuries.

On July 18, 2007, defendant called plaintiffs insurer and Ms. Ogbogu's insurer to tell them defendant "was accepting liability and that there may be a 'limits issue.'" The next day, defendant's adjuster, Patricia Feng, recommended defendant accept 100 percent liability. That same day, Paul Reid, plaintiff's son, who had authority to act for his mother, told Ms. Feng his mother was still in intensive care and asked if defendant could disclose policy limits. Defendant could not, without written permission from Ms. Huang. A few days later, Ms. Feng wrote to plaintiff saying defendant's investigation was incomplete and "therefore we are not in a position to resolve liability or settlement of this claim," and to do so required a recorded interview with plaintiff and other information. Another letter from Ms. Feng asked plaintiff to "complete authorizations for defendant's review of the pertinent medical records, so that defendant could "properly verify and evaluate your injury ...." Defendant sent similar letters to Ms. Looschen and to a lawyer representing Ms. Ogbogu and Ms. Ngoka.

On July 26, 2007, another adjuster for defendant, Adam Schram, told Ms. Huang the preliminary investigation indicated the claims for damages "may exceed your policy limits" and "you have the right to consult legal counsel, at your own expense, to advise you concerning your uninsured interest" but that defendant would "continue our attempts to conclude this matter within your policy limits and will keep you informed as to the status of settlement offers, demands, and negotiations." Mr. Schram also talked to Mr. Reid that day, who told him his mother was still in intensive care. Mr. Schram told Mr. Reid he still could not disclose the policy limits.

The day after he spoke with Mr. Schram, Mr. Reid hired a lawyer, Joseph West, because he "felt [he] was being jerked around by [defendant]" because they would not disclose the policy limits and said "they couldn't determine liability at that time, and that was a month after the accident." He later testified he told Mr. West his mother had $250,000 in underinsured motorist coverage. He had notified his mother's insurer, State Farm, of the collision and was told about the underinsured motorist coverage but that plaintiff first had to resolve the claim against Ms. Huang before she could recover on her underinsured motorist coverage. Mr. Reid testified he "authorize[d] Mr. West to settle the case on behalf of [his] mother," he did not authorize any specific amount, and he (Mr. Reid) "wanted to settle it as quickly as possible."

On July 28, 2007, Mr. West wrote to defendant confirming his representation of plaintiff "with respect to the devastating automobile accident ... caused by your insured." Mr. West's letter stated plaintiff had been "horribly injured" and remained in the hospital in intensive care. Mr. West asked for disclosure of the whereabouts of Ms. Huang's vehicle, all applicable policy limits, and whether Ms. Huang was protected by an umbrella policy. The letter stated the request was made pursuant to section 790.03, subdivision (h)(1) and (2) of the Insurance Code.^[1]

On August 2, 2007, defendant's claims manager noted the "[o]nly excess [bodily injury] exposure at this time appears to be [plaintiff]; [w]e will need complete medical records/billings for all [claimants]; and [w]e will need to tender [policy limits] to [plaintiff] as soon as we have enough [information] available to do so." The claims manager recommended bodily injury reserves be set at $100,000 for plaintiff, $50,000 for Ms. Looschen, $12,000 for Ms. Ogbogu, and $7,500 for Ms. Ngoka.^[2]

On August 15, 2007, Mr. Schram responded to Mr. West's letter, stating first, "[i]n order to complete a thorough investigation, I must obtain a detailed statement from your client and inspect the vehicle." Mr. Schram again requested plaintiff's signature on medical authorizations "[i]n order to properly verify and evaluate your client's injury ...." The letter disclosed the policy limits, confirmed Ms. Huang was not "in the course of employment" and carried no excess insurance coverage, and asked for proof of plaintiff's liability insurance.
According to Mr. Reid, Mr. West told him in August 2007 the policy limits were $100,000, and defendant was not prepared to settle or offer the policy limits. Mr. Reid testified that in August 2007, he would "definitely" have accepted the policy limits to settle his mother's case, and by "definitely," he meant that "[i]n order to get to the $250,000] total [using State Farm's underinsured motorist coverage], I had to get the $100,000] from [defendant]." (In mid-September 2007, plaintiff's insurer advised defendant's adjuster, Mr. Schram, that plaintiff's underinsured motorist coverage exceeded defendant's policy limits.) Mr. Reid also testified he would have accepted the policy limits in July, after he ran an asset check on Ms. Huang, as that would have permitted him to look to the underinsured motorist coverage, and also that was before he hired Mr. West and he "wouldn't have had to give [West] a portion of it."

When Mr. West was asked why he did not write a demand letter to defendant, Mr. West said defendant had been adjusting the case for a month and, despite knowing Ms. Huang ran the red light and plaintiff was still hospitalized, responded to his letter by requesting a statement from plaintiff and "saying that they don't have enough information to resolve," which Mr. West found disheartening. So, Mr. West said, "there was no point in ... this type of [demand] letter ...." "Not only did they request a statement, but they're saying that they don't have enough information to resolve. They know—they knew enough to be able to resolve this case early on or at least to make an offer to resolve it."

On October 10, 2007, plaintiff sued Ms. Huang.

On October 29, 2007, defendant wrote to Mr. West saying that, to resolve plaintiff's claim, defendant was "still pending" a recorded interview and various medical records.

On November 8, 2007, defendant's claims documents show, under the heading "Final Approval," adjuster authority to offer $100,000 and "claim recommendation approved" by a claims manager.

On December 6, 2007, defendant again wrote to Mr. West, again saying, to resolve plaintiff's claim, defendant was "still pending" a recorded interview and various medical records.

On January 29, 2008, Mr. West sent plaintiff's medical records to defendant.

On May 2, 2008, defendant wrote to Mr. West, stating it "has agreed to tender its $100,000.00 policy limit to your client in order to resolve this matter in its entirety." Plaintiff rejected the offer.

More than two years later, after a bench trial in plaintiff's suit against Ms. Huang, judgment was entered against Ms. Huang for more than $5.9 million. During that lawsuit, on March 11, 2009, Ms. Huang declared bankruptcy, and the bankruptcy trustee later assigned to plaintiff any potential rights Ms. Huang had against defendant.

Plaintiff then filed this suit against defendant for breach of the covenant of good faith and fair dealing and for breach of contract, essentially on a theory of bad faith failure to settle. The complaint alleged defendant not only failed to make a reasonable offer within a reasonable time, but rejected and discouraged any efforts at settlement. Further, plaintiff alleged defendant refused to make a prompt and thorough investigation, failed to communicate and respond to communications in a timely manner, and insisted on receiving information and materials that were already provided and known, or were immaterial and were therefore unnecessary to defendant's evaluation. The complaint alleged that as a consequence of defendant's breaches, "Huang was exposed to and suffered an excess judgment," and sought recovery of more than $6.9 million.

**2. The Motion for Summary Judgment**

The sole basis for defendant's motion for summary judgment was plaintiff could not prove breach of contract or bad faith "because plaintiff never made a demand for settlement within the policy limits."
*270 Defendant's evidence consisted of undisputed facts relating the chronology of events described above. Defendant also relied on Mr. West's deposition testimony. Mr. West was asked if he made a policy limit demand on defendant. He replied by saying in his July 28 letter, "some of the pertinent and significant facts were set forth and [defendant's] response was that ... they needed to take a statement from my client and my client was in the hospital with a tube in her throat. It wasn't at that point in time clear that she was going to live. This was $100,000 and [defendant] elected, rather than to offer the policy, to request a statement from her. I viewed that as a refusal [to offer up the policy]." Mr. West was then asked, "Had you said either orally or in writing that your client would settle for the policy limit if they offered it?" and answered, "I don't believe I ever said that, no."

Defendant also asserted facts that plaintiff disputes, but these were essentially argumentative assertions and responses, and the disputes are immaterial.

Plaintiff's opposition to defendant's summary judgment motion included her own statement of undisputed facts, many of which defendant disputed in its reply. Defendant also objected to much of plaintiff's evidence as irrelevant. The court did not rule on these objections. In addition to evidence already described, plaintiff offered the following evidence.

First, defendant's adjusters understood, when a third party claimant makes a request for policy limits information, "it is an attempt to determine what is available for settlement."

Second, defendant's adjuster, Mr. Schram, knew defendant's training manual directs its employees to "[c] ontinuously keep [our insured] informed of all exposures and settlement negotiations. [Our insured] may want us to settle a higher exposure separately, particularly in serious injury cases. Bad Faith has been found when the insured contended that he would have wanted the carrier to pay the per person limit to settle the worst case. When the company is faced with multiple claims whose value exceeds the policy limit, communication with the insured is essential. Especially where one claim is significantly worse than the others, the insured should be consulted about the possibility of settling the severe injury claim separately." Mr. Schram did not discuss this possibility with Ms. Huang, but sent Ms. Huang the July 26, 2007 letter notifying her damages might exceed policy limits and of her right to counsel at her own expense.

Third, defendant's adjuster, Nancy Murad, testified she "couldn't accept a demand from [plaintiff] until all the other claims were analyzed and evaluated as being within Huang's policy limits," and even after plaintiff provided medical records on January 28, 2008, she "didn't have all of the records yet," "271 meaning the records "on all the claimants," so she did not believe she was "in a position to make an offer to [plaintiff] of policy limits."

Fourth, plaintiff asserted "[a]t no time did [defendant] inform [plaintiff] or West that the reason they were not prepared to settle was because there were three other claimants."

3. The Trial Court's Ruling

The trial court granted defendant's motion for summary judgment. The court reasoned the evidence did not show plaintiff ever made a settlement demand or otherwise told defendant that Mrs. Reid would accept the policy limits in full settlement. The court found the evidence did not show Mr. Reid's initial conversation with Ms. Feng, or Mr. West's initial letter of July 28, 2007, constituted "opportunities to settle" within the meaning of that phrase as it has been discussed in the cases. The court had found no California authority "standing for the proposition that there is a duty to settle when there is a claim that is vastly in excess of the policy limits regardless of whether a settlement demand has been made." The court observed Mr. West's deposition "does not show that the [July 28] letter was an initiation of a settlement" and "doesn't have any comments about other attempts to settle .... Mr. West actually comes out and says flatly that he didn't say either orally or in writing that Ms. Reid would settle for the policy limits if—if those are made available to her." Judgment was entered and plaintiff filed a timely appeal.272

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DISCUSSION

1. Standard of Review

A defendant moving for summary judgment must show "that one or more elements of the cause of action ... cannot be established, or that there is a complete defense to that cause of action." (Code Civ. Proc., § 437c, subd. (p)(2).) Where summary judgment has been granted, we review the trial court's ruling de novo. (Aquilar v. Atlantic Richfield Co. (2001) 25 Cal.4th 826, 860 [107 Cal.Rptr.2d 841, 24 P.3d 493].) We consider all the evidence presented by the parties in connection with the motion (except that which was properly excluded) and all the uncontradicted inferences that the evidence reasonably supports. (Merrill v. Navegar, Inc. (2001) 26 Cal.4th 465, 476 [110 Cal.Rptr.2d 370, 28 P.3d 116].) We affirm summary judgment where the moving party demonstrates that no triable issue of material fact exists and that it is entitled to judgment as a matter of law. (§ 437c, subd. (c).)

2. Bad Faith Liability Cannot Be Founded Solely Upon an Insurer's Failure to Initiate Settlement Discussions or Offer Its Policy Limit

(1) For bad faith liability to attach to an insurer's failure to pursue settlement discussions, in a case where the insured is exposed to a judgment beyond policy limits, there must be, at a minimum, some evidence either that the injured party has communicated to the insurer an interest in settlement, or some other circumstance demonstrating the insurer knew that settlement within policy limits could feasibly be negotiated. In the absence of such evidence, or evidence the insurer by its conduct has actively foreclosed the possibility of settlement, there is no "opportunity to settle" that an insurer may be taxed with ignoring.

(2) In this case, there was no settlement offer from plaintiff, and no evidence from which any reasonable juror could infer that defendant knew or should have known plaintiff was interested in settlement. Nor does plaintiff accurately characterize defendant's conduct when he asserts that defendant "affirmatively refused to settle" or otherwise rejected "opportunities to settle" or discouraged settlement overtures. Accordingly, defendant cannot be liable for bad faith failure to settle.

The general contours of an insurer's liability for breach of its duty to settle in an appropriate case have been established for a long time.

(3) "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." (Comunale v. Traders & General Ins. Co. (1958) 50 Cal.2d 654, 659 [328 P.2d 198] (Comunale); accord, Johansen v. California State Auto. Assn., Inter-Ins. Bureau (1975) 15 Cal.3d 9, 14-15, 91 [123 Cal.Rptr. 288, 538 P.2d 744] (Johansen) ["The implied covenant of good faith and fair dealing imposes a duty on the insurer to settle a claim against its insured within policy limits whenever there is a substantial likelihood of a recovery in excess of those limits."]; Crisci v. Security Ins. Co. (1967) 66 Cal.2d 425, 430 [58 Cal.Rptr. 469, 426 P.2d 173] (Crisci) ["liability based on an implied covenant exists whenever the insurer refuses to settle in an appropriate case and ... liability may exist when the insurer unwarrantedly refuses an offered settlement where the most reasonable manner of disposing of the claim is by accepting the settlement"]).

As Crisci tells us, liability is imposed "not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlements, a "273 duty included within the implied covenant of good faith and fair dealing." (Crisci, supra, 66 Cal.2d at p. 430, italics added.) Comunale, Johansen and Crisci all involved an offer of settlement at or below policy limits. In such a case, "the only permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, the ultimate judgment is likely to exceed the amount of the settlement offer." (Johansen, supra, 15

http://scholar.google.com/scholar_case?case=5727484394170593069&q=220+cal.app.4t... 10/23/2017
Cal.3d at p. 16.) The Courts of Appeal have explained "the problem is one of conflict of interest ....," and "whenever a conflict of interest breaks out the carrier becomes obligated to protect the interests of the assured equally with its own." (Merritt v. Reserve Ins. Co. (1973) 34 Cal.App.3d 858, 875, 868 [110 Cal.Rptr. 511] (Merritt.).

(4) According to Merritt, "normally the interests of carrier and assured are parallel, and ... only with the tender of a settlement offer within policy limits do the interests of the assured and the carrier diverge." (Merritt, supra, 34 Cal.App.3d at p. 875.) Merritt tells us: "[I]t is apparent ... (1) the legal rules relating to bad faith come into effect only when a conflict of interest develops between the carrier and its assured; (2) a conflict of interest only develops when an offer to settle an excess claim is made within policy limits or when a settlement offer is made in excess of policy limits and the assured is willing and able to pay the excess." (Id. at p. 877; see id. at pp. 877, 879 [where the plaintiff made no offer to settle and never "advance[d] any suggestion that settlement could be profitably discussed," the case "does not involve a conflict of interest and does not present a situation in which the carrier can be found to have acted in bad faith toward its assured"]).

Other Courts of Appeal have disagreed with Merritt's statement that a conflict of interest develops "only" when a formal settlement offer has been made. In a number of circumstances, courts have found a conflict of interest can arise, and an insurer may be liable for bad faith refusal to settle, without a formal settlement offer. But none of these cases suggests that an insurer has a duty to initiate settlement discussions—or an "opportunity to settle"—in the absence of any indication from the injured party that he or she is inclined to settle within policy limits (or at some higher figure where the insured is willing to pay the excess over policy limits).

In Boicourt v. Amex Assurance Co. (2000) 78 Cal.App.4th 1390 [93 Cal.Rptr.2d 763] (Boicourt), the insurer had a blanket rule against disclosing its policy limits to a claimant before litigation. The court concluded such a rule "creates a conflict of interest between liability insurers and their insureds," giving the insurer "a tactical advantage vis-à-vis the claimant by forcing the claimant to make any prelitigation offers 'in the dark.'" (Id. at p. 1392.) Boicourt thus reversed a grant of summary judgment to the insurer "that was based on 'the idea that there could be no conflict of interest absent a formal settlement offer.'" (Ibid.) Noting the relevance of disclosure of policy limits to the settlement of a claim, and the potential "real world effect of 'foreclosing' the possibility of a quick settlement within policy limits" (id. at pp. 1393, 1397), Boicourt concluded: "In short, insurers do have a 'selfish' interest (that is, one that is peculiar to themselves) in imposing a blanket rule which effectively precludes disclosure of policy limits, and that interest can adversely affect the possibility that an excess claim against a policyholder might be settled within policy limits. Thus, a palpable conflict of interest exists in at least one context where there is no formal settlement offer. We therefore conclude that a formal settlement offer is not an absolute prerequisite to a bad faith action in the wake of an excess verdict when the claimant makes a request for policy limits and the insurer refuses to contact the policyholder about the request." (Id. at pp. 1396-1399; see id. at p. 1398 ["the claimant's request for the policy limits might have been a settlement opportunity which was arbitrarily foreclosed by the insurer for its own advantages to the insured's detriment"]).

Several other cases also describe circumstances where no formal demand for settlement within policy limits is necessary for bad faith liability to attach. With the possible exception of one Ninth Circuit case, also described below, all the cases involve circumstances where the claimant has conveyed to the insurer an interest in settlement, and the insurer has rejected or ignored the opportunity to negotiate a settlement.

First, where multiple insurers are involved, the absence of a formal demand within the policy limits of one of the multiple insurers does not preclude a bad faith claim against that insurer. (Howard v. American National Fire Ins. Co. (2010) 187 Cal.App.4th 498 [115 Cal.Rptr.3d 42] (Howard.).) But in Howard, there was a settlement demand "well within the primary insurance policy limits of the multiple insurers on the risk ...." (Id. at p. 525.) That fact was relevant "in evaluating whether an insurer, in a multiple-insurer case, had an opportunity to settle." (Ibid.) If defendant and the other insurers had responded to the offer with policy limits, they "could have settled the litigation"; the law "cannot excuse one insurer for refusing to tender its policy limits simply because other insurers likewise acted in bad faith." (Ibid.)
Second, several federal court cases have said there is no need, under certain circumstances, for a formal settlement demand from the claimant in order for bad faith liability to attach. But those cases too involved evidence the insurer knew of the claimant's interest in settlement and ignored it. For example, in *Gibbs v. State Farm Mutual Ins. Co.* (9th Cir. 1976) 544 F.2d 423, the insurer was apprised that the plaintiff had stated on numerous occasions that "he wanted coverage only to the limits of the insurance policy." (Id. at p. 427.) The plaintiff's statements, the court held, "gave [the insurer] a reasonable opportunity to settle the claim within the policy limits." (Ibid.) In *Continental Casualty Co. v. United States Fidelity & Guaranty Co.* (N.D. Cal. 1991) 516 F. Supp. 384, the injured party made a demand above policy limits, but the insurer "made no effort to ascertain whether [its insured] was willing to contribute" the amount above policy limits, and instead decided "it would not even consider the demand and would proceed to trial." (Id. at p. 388.) This conduct "frustrated the purpose of the duty of good faith and fair dealing." (Ibid.)

Third, plaintiff relies on a New Jersey case, *Rova Farms Resort, Inc. v. Investors Ins. Co. of America* (1974) 65 N.J. 474 [323 A.2d 495]. But *Rova Farms* involved the insurer's intransigence in the face of a clearly attainable settlement. Rejecting the insurer's contention that, "as a matter of law, it had no obligation to offer its policy limit in settlement without a firm, authorized and explicit demand within that figure ...", the *Rova Farms* court said: "The better view is that the insurer has an affirmative duty to explore settlement possibilities. [Citation.] At most, the absence of a formal request to settle within the policy is merely one factor to be considered in light of the surrounding circumstances, on the issue of good faith." (Id., 323 A.2d at pp. 504, 505.) While no formal demand had been presented (id. at p. 504), there were "a multitude of circumstances which should have impelled [the insurer] to energize a clearly attainable settlement" of the claim (id. at p. 501), yet the insurer "[a]t no time" increased an offer it made to settle at a fraction of its policy limit (id. at p. 499). As the *Rova Farms* court said, "the opportunities for settlement were so viable that it took a special genius at intransigence to kill them." (Id. at p. 506.)

Fourth, plaintiff argues Insurance Code section 790.03 (section 790.03), subdivision (h)(5) "expressly imposes" on insurers an "affirmative duty to settle" when liability is reasonably clear. Plaintiff reads the statute far too broadly.

[276] Section 790.03 defines certain practices as "unfair methods of competition and unfair and deceptive acts or practices in the business of insurance." These include "[k]nowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices," including "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear." (§ 790.03, subd. (h)(5).)

(5) There is no private civil cause of action "against an insurer that commits one of the various acts listed in section 790.03, subdivision (h)" (Moradi-Shalal v. Fireman's Fund Ins. Companies (1988) 46 Cal.3d 287, 304 [250 Cal. Rptr. 116, 758 P.2d 58]), although violations of the section "may evidence the insurer's breach of duty to its insured" under the implied covenant of good faith and fair dealing (Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc. (2000) 76 Cal.App.4th 847, 916 [93 Cal. Rptr.2d 364], quoting Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 1999) ¶ 14:45.21, pp. 14-15; see Jordan v. Allstate Ins. Co. (2007) 148 Cal.App.4th 1062, 1078 [56 Cal.Rptr.3d 312] ["evidence of an insurer's violations of the statute and the corresponding regulations" was properly admitted to support the plaintiff's contention the insurer had breached the implied covenant by its actions].

(6) But section 790.03 does not purport to define the circumstances that give rise to a breach of the insurer's obligation to "attempt[] in good faith to effectuate prompt, fair, and equitable settlements" (id., subd. (h)(5)) and nothing in the statute requires or suggests the conclusion that an insurer's failure to initiate settlement negotiations, in the absence of any expression of interest in settlement from the claimant, may give rise to a bad faith claim.

Finally, in *Du v. Allstate Ins. Co.* (9th Cir. 2012) 697 F.3d 753 (Du), the plaintiff made the same claim plaintiff makes in this case: that the insurer acted in bad faith when it "did not attempt to reach a settlement of [the plaintiffs] claims after [the insured's] liability in excess of the policy limit became reasonably clear." (Id. at p. 755.) The appeal in *Du* raised the question "whether the duty to settle described in CACI 2337 can be breached absent a settlement.
demand from the third party claimant...." [697 F.3d at *277 p. 757.] But Du did not resolve the plaintiff's claim, since the Du court agreed with the trial court that there was no evidentiary basis for the instruction. (Id. at pp. 755, 758.]

(7) In short, nothing in California law supports the proposition that bad faith liability for failure to settle may attach if an insurer fails to initiate settlement discussions, or offer its policy limits, as soon as an insured's liability in excess of policy limits has become clear. Nor will this court make such a rule of law, for which neither precedent nor sound policy considerations have been offered.

We find no merit in plaintiff's argument that defendant's conduct brings it within the case precedents that permit bad faith liability without a formal settlement offer from the claimant. Plaintiff's claims that defendant "affirmatively refused to settle, rejected opportunities to settle, and discouraged [plaintiff's] settlement overtures" are entirely without support in the evidence. While plaintiff's brief consistently refers to Mr. Reid's "settlement inquiries," and to his and Mr. West's attempts "to open a settlement dialogue," and to defendant's "repeatedly" telling them it "could not even accept liability," none of those characterizations comports with the evidence.

(8) Mr. Reid asked for disclosure of the policy limits, and defendant disclosed those limits four weeks later, after it obtained the necessary permission from the insured to do so. We will not construe a bare request to know the policy limit as an opportunity to settle. Nor could any reasonable juror construe Mr. West's July 28, 2007 letter as "an initiation of settlement" *278 or a settlement opportunity. And Mr. Reid's willingness to settle for policy limits in July or August, as he testified, was not communicated to defendant. (Even that testimony was contradicted by his own testimony that, while he wanted to settle, he did not authorize his lawyer to do so for policy limits. Plaintiff did not even know the policy limits until defendant disclosed them [through no fault of the insurer].)

Nor could any reasonable juror find defendant "discouraged" settlement by "repeatedly" telling plaintiff it could not accept liability. The only two relevant items of evidence, a July 23 letter and a July 26 phone conversation, cannot be construed as a repeated "refus[a]l to even admit liability." Indeed, it is undisputed defendant told plaintiff's insurer on July 18 it was accepting liability, and no other communications to plaintiff suggest otherwise.

Finally, plaintiff argues the insurer's persistent letters asking for medical records and a recorded interview—in plaintiff's words, "demand[in]g recorded statements from persons in intensive care"—operated to discourage plaintiff from making a settlement demand. No reasonable juror reviewing the evidence could reach that conclusion either. The letters are status reports of pending items, to which there is no evidence of any response by plaintiff, and cannot be the foundation for a bad faith claim.

(9) In summary, when a claimant offers to settle an excess claim within policy limits, an opportunity to settle exists and a conflict of interest arises, because a divergence exists between the insurer's interest in paying less than the policy limits and the insured's interest in avoiding liability beyond the policy limit. (Merritt, supra, 34 Cal.App.3d at p. 873.) And a conflict may also arise, without a formal settlement offer, when a claimant clearly conveys to the insurer an interest in discussing settlement but the insurer ignores the opportunity to explore settlement possibilities to the insured's detriment, or when an insurer has an arbitrary rule or engages in other conduct that prevents settlement opportunities from arising. (Boicourt, supra, 78 Cal.App.4th at p. 1399.) But nothing like that happened here.

An "opportunity to settle" does not arise simply because there is a significant risk of an excess judgment. And none of the evidence presented to *279 the trial court, disputed or not, allows an inference that plaintiff at any time conveyed to defendant any interest in settlement, at policy limits or otherwise, at any time before defendant offered its policy limits. In short, there was no evidence of a bad faith failure to settle in this case. Accordingly, there was no foundation for a claim of breach of contract or breach of the insurer's covenant of good faith and fair dealing.

**DISPOSITION**

The judgment is affirmed. Defendant shall recover its costs on appeal.
Bigelow, P. J., and Flier, J., concurred.

A petition for a rehearing was denied November 6, 2013, and the opinion was modified to read as printed above. Appellant’s petition for review by the Supreme Court was denied January 21, 2014, S214666.

[1] Insurance Code section 790.03 defines certain unfair claims settlement practices, including “[m]isrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue” and “[t]ailing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.” (Ins. Code, § 790.03, subd. (h)(1) & (2).)

[2] The reserves for Ms. Looschen, Ms. Ogbogu and Ms. Ngoka were ultimately raised to $100,000, $15,000 and $10,000 respectively, and they eventually settled for $100,000, $22,500 and $10,000 respectively.

[3] Shortly after judgment was entered, plaintiff died, and the trial court ordered Paul Reid substituted as the plaintiff instead of Shirley Reid.

[4] Plaintiff cites Ivy v. Pacific Automobile Ins. Co. (1958) 156 Cal.App.2d 652, 659 [320 P.2d 140] (Ivy), as holding “a conflict of interest arises, not only when plaintiffs demand settlement, but, rather, whenever ‘excess liability may be involved.’” Ivy does not stand for that proposition. It does say when liability in excess of policy limits is involved, the insurer’s duty to act in good faith “becomes important,” and further: “All of the cases agree that in order to act in good faith the company, as a minimum, must make a diligent effort to ascertain the facts upon which a good faith judgment may be predicated, where possible excess liability is involved, must communicate the result of such investigation to the insured, and must inform him of any settlement offers that may affect him, so that the insured may take proper steps to protect his own interests.” (Id. at p. 660, italics added.)

[5] CACI No. 2337 describes factors a jury may consider in evaluating an insurer’s conduct in a bad faith action. It states: “In determining whether [name of defendant] acted unreasonably or without proper cause, you may consider whether the defendant did any of the following: [1] [2][3][4][5][6][7] Did not attempt in good faith to reach a prompt, fair, and equitable settlement of [name of plaintiff]’s claim after liability had become reasonably clear?] The instruction lists 15 other factors (none of which is relevant in this case), and states “[the presence or absence of any of these factors alone is not enough to determine whether [name of defendant]’s conduct was or was not unreasonable or without proper cause. You must consider [name of defendant]’s conduct as a whole in making this determination.” The “directions for use” for CACI No. 2337 state that, while there is no private cause of action under section 790.03, “this instruction may be given in an insurance bad-faith action to assist the jury in determining whether the insurer’s conduct was unreasonable or without proper cause.”

[6] Du does have some similarities to this case. Here, as in Du, the insurer made a policy limits offer— in Du, about a year after the accident and here, 10 months after the accident — that was rejected. And here, as in Du, the substance of plaintiff’s bad faith claim is that “the case would have been settled within policy limits had [the insurer] initiated earlier settlement negotiations.” (Du, supra, 697 F.3d at p. 758.) In Du, where the court was reviewing a jury verdict for the insurer, the court found there was no evidence that the insurer “should or could have made an earlier settlement offer to [the plaintiff].” (Id. at p. 759.) This was because the insurer “lacked corroborating proof of the extent of [the plaintiff’s] injuries and medical expenses”; until the insurer offered its policy limits, “the only information [the insurer] had regarding [the plaintiff’s] injuries and medical bills were the uncorroborated and conflicting assertions by [the plaintiff] and her counsel.” (Ibid.) In Du, the plaintiff’s expert conceded that the insurer “could not base a settlement offer solely on the representations of claimant and claimant’s lawyer,” and that the insurer (who made repeated efforts to obtain the information) “could not have obtained [the plaintiff’s] medical records without getting them from [the plaintiff’s] lawyers.” (Ibid.) And, in Du the insurer had no proof of the injuries of the other three individuals injured in the accident prior to its offer of policy limits, and paying the plaintiff the limits “could have left [the insured] unprotected” if the other three claims exceeded the remaining limits. (Ibid.)

[7] A letter of July 23, 2007, from defendant’s adjuster, Ms. Feng, to plaintiff says: “This is to advise you that our investigation into the above referenced incident is still incomplete at this time and therefore we are not in a position to resolve liability or settlement of this claim. In order to do so, we need the following,” then listing a recorded interview, “medical specials,” and two other items from plaintiff’s insurance company. Then, a few days later on July 26, Mr. Reid spoke to adjuster Mr. Schram. Mr. Reid testified the “gist” of the conversation was about property damage to the car, “and they weren’t at a point where they could determine liability at that time.” Assuming the letter or Mr. Schram’s conversation with Mr. Reid amount to a “refusal to even admit liability,” they are the only such statements, and they occurred only one month after the accident.

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THEODORE H. SMYTH, Plaintiff and Appellant,  

v.  

USAA PROPERTY AND CASUALTY INSURANCE COMPANY et al., Defendants and Respondents.  


Court of Appeals of California, Second District, Division Six.  

April 30, 1992.  

Mullen & Henzell, Charles S. Bargiel, Joel C. Baiocchi and Matthew J. Long for Plaintiff and Appellant.  


OPINION  

STONE (S.J.), P.J.  

In this insurance coverage dispute, Theodore H. Smyth (Smyth) appeals from the order of the trial court dismissing his action against respondents, USAA Property and Casualty Insurance Company and United Services Automobile Association (collectively, USAA), after the court sustained demurrers to his amended complaints without leave to amend. (See Code Civ. Proc., § 581d — written, signed and filed order of dismissal is appealable; 9 Witkin, Cal. Procedure (3d ed. 1985) Appeal, § 75, p. 99.)  

Smyth contends that his homeowners insurer, USAA, had a duty to defend him against a suit for damages for personal injuries and deaths suffered in a massive fire in a hotel in San Juan, Puerto Rico (the Fire Suit). Smyth was named in the Fire Suit in his capacity as an outside director of the corporation which owned the hotel.  

He asserts the terms of his policies are ambiguous regarding whether his service as a director of the corporation is covered, raising questions of fact which may not be resolved on demurrer.  

He also contends that the statutes of limitations do not bar his causes of action for bad faith and negligent misrepresentation, and that USAA is estopped to assert the limitations statutes. We affirm the dismissal of his suit.  

(1) In reviewing the sufficiency of a complaint against a demurrer, we deem true all material and properly pleaded facts; however we may not consider opinions, contentions, deductions or conclusions of fact or law alleged. (Blank v. Kirwan (1985) 39 Cal.3d 311, 318 [216 Cal. Rptr. 718, 703 P.2d 58]; Casella v. City of Morgan Hill (1991) 230 Cal. App.3d 43, 48 [280 Cal. Rptr. 876].)  

Smyth's amended complaints alleged, inter alia, that USAA breached its insurance contracts with him and wrongly forced him to defend and settle claims raised against him in the Fire Suit by falsely stating he had no insurance policies in effect.  

Smyth pled and incorporated by reference two primary and one excess umbrella insurance policies he asserts afford him coverage. One of the primary policies covers his personal residence in Santa Barbara, the other covers vacation property in Palm Desert. The umbrella policy refers to his Santa Barbara residence.
Smyth alleges that these policies afford him coverage because his service as a director did not constitute a trade, profession or occupation, but rather was an activity which is usual as a nonbusiness pursuit.

Upon review, we accept as true his specific factual allegations that: 1) he sat on the board as a favor to an old friend, 2) he received no compensation "1474 for his participation on the board, 3) his involvement as a director was not a continuous or regular activity for the purpose of earning a profit or livelihood, 4) he did not engage in this activity for part-time or supplemental income, 5) he was not motivated to become a director of the corporation because of profit or gain from that activity, 6) he did not and does not sit on any other boards, and 7) his involvement as an outside director was minimal.

(2a) He claims that his status and these activities fall outside the exclusions stated in the policies for "business pursuits" because he was not motivated by profit in becoming a director of the hotel.

(3) "The interpretation of an insurance policy, like any other contract, is a matter of law as to which a reviewing court must make its own independent determination." [Citation.] (NN Investors Life Ins. Co. v. Superior Court (1989) 208 Cal. App.3d 1070, 1072 [256 Cal. Rptr. 598].) (4) "Coverage provisions are construed broadly in favor of the insured, while exclusion provisions are construed strictly against the insurer. [Citation.] However, strict construction does not mean strained construction; under the guise of strict construction, we may not rewrite a policy to bind the insurer to a risk that it did not contemplate and for which it has not been paid. [Citation.]" (National Union Fire Ins. Co. v. Lynette C. (1991) 228 Cal. App.3d 1073, 1077 [279 Cal. Rptr. 394].) (5) An insurer's duty to defend arises only where there is potential coverage under the policy. (Marglen Industries, Inc. v. Aetna Casualty & Surety Co. (1992) 4 Cal. App.4th 414, 422 [5 Cal. Rptr.2d 659].) The determination of whether an insured's expectation of coverage is a question of law. (Dyer v. Northbrook Property & Casualty Ins. Co. (1989) 210 Cal. App.3d 1540, 1549 [259 Cal. Rptr. 298]; Marglen, supra, at p. 422.)

(6) "In analyzing a policy for uncertainties, the language used must be read in its ordinary sense, according it the meaning which would ordinarily be attached to it by a layman." (NN Investors Life Ins. Co. v. Superior Court, supra, 208 Cal. App.3d at p. 1072.) "Any doubts, uncertainties, or ambiguities in policy language must be resolved in favor of the insured. However, this principle of construction comes into play only if it is first determined that an ambiguity exists, which is also a question of law." (Ibid.) "Finally, the policy is construed as a whole, each clause helping to interpret the other. [Citation.]" (National Union Fire Ins. Co. v. Lynette C., supra, 228 Cal. App.3d at p. 1078.)

(2b) Smyth incorrectly alleges that the exclusion of coverage for directors in the umbrella policy is ambiguous. It states, "we do not insure liability arising from: ... a covered person's activities as an officer or director of "1475 any organization; this does not apply to religious, charitable or civic nonprofit organizations." There is no allegation that the corporation, or the San Juan hotel, is a religious, charitable or civic nonprofit organization. The complaint in the Fire Suit, of which the trial court took judicial notice, alleges that the hotel is a large, international resort hotel and convention center.

It is also of no consequence that there is no exclusion for directors stated in the primary policies because all the policies exclude business activities. The business activities exclusions are clear and preclude coverage of Smyth for this occurrence as a matter of law.

The exclusion regarding business activities in the umbrella policy states, "we do not insure liability arising from: ... a business activity or property on which a business is conducted." "Business" is defined in that policy to include "trade, occupation, profession or business." We find as a matter of law that a hotel involves a trade or business and is a property on which trade and business are conducted.

The primary policies exclude coverage for liability "arising out of business pursuits of an insured...." The policies then state that "[t]his exclusion does not apply to: ... (1) activities which are usual to non-business pursuits. ..." (Italics added.) "Business" is defined in the primary policies to include "trade, occupation or profession." That this definition is not identical in the primary and excess policies does not create an ambiguity. Again, the language is clear.
The critical question raised is whether or not an insured has any possible reasonable expectation of coverage under these homeowners policies for engaging in activities of a directorship of a corporation owning a large resort hotel. The answer is no. Such activities cannot be considered "usual to non-business pursuits."

In sum, no person could reasonably believe that these homeowners policies provide coverage or require any duty to defend Smyth from any acts or omissions in his capacity as a director of a corporation which owns a large resort hotel. (Fire Ins. Exchange v. Jiminez (1986) 184 Cal. App. 3d 437, 441 [229 Cal. Rptr. 83]; West American Ins. Co. v. California Mutual Ins. Co. (1987) 195 Cal. App. 3d 314, 323 [240 Cal. Rptr. 540].)

Smyth's reliance on language in State Farm Fire & Casualty Co. v. Drasin (1984) 152 Cal. App. 3d 864 [199 Cal. Rptr. 749], is misplaced. The Drasin court states that trade, under a standard business pursuits exclusion, is defined as business being "carried on for the purpose of profit or gain or livelihood." (Id., at pp. 869-870, citing City of Los Angeles v. Rancho Homes, Inc. (1953) 40 Cal.2d 764, 767 [256 P.2d 305].) The Drasin court concluded that the gist of the exception concerns "regular activity with the motivation for profit or gain." (Drasin, supra, at p. 870.) Smyth argues that because his personal motivation was altruistic, USAA must defend. We disagree. Regardless how benevolent Smyth's own motivations were or how minimal his involvement, the activity involved is a business activity subject to exclusion under these policies.

**Statutes of limitations**

Smyth contends that the trial court improperly sustained demurrers without leave to amend to the causes of action for breach of the duty of good faith and fair dealing and for negligent misrepresentation and concealment stated in his second amended complaint. The court ruled that these causes of action are barred by the statute of limitations. He also asserts that USAA is estopped to assert a limitations defense.

**Bad faith cause of action**


Where both the pleadings and the theory relied upon appeal sound in contract and in tort, the plaintiff ordinarily may elect the theory of the case. (Frazier v. Metropolitan Life Ins. Co., supra, 169 Cal. App. 3d at p. 101.)

Courts consider "the nature of the right sued upon, not the form of action or the relief demanded" to determine the applicable statute of limitations. (Jefferson v. J.E. French Co. (1960) 54 Cal.2d 717, 718 [7 Cal. Rptr. 899, 355 P.2d 643], quoted in Richardson v. Allstate Ins. Co. (1981) 117 Cal. App.3d 8, 12 [172 Cal. Rptr. 423].)

Whether the cause sounds in tort or in contract, therefore, depends upon the facts of the particular case. (Eisenberg v. Insurance Co. of North America (9th Cir.1987) 815 F.2d 1285, 1292.)

*1477* Where, as here, Smyth alleged and has maintained on appeal that USAA sought to shield itself from liability by denying that the contract exists, the action sounds in tort. (Seaman's Direct Buying Service, Inc. v. StandardOilCo. (1984) 36 Cal.3d 752, 769 [206 Cal. Rptr. 354, 686 P.2d 1158]; cf. Frazier v. Metropolitan Life Ins. Co., supra, 169 Cal. App. 3d at pp. 98, 101, in which the trial court regarded the hybrid action as sounding in contract for limitations purposes and where plaintiff's theory on appeal "is entirely based upon a contract cause of action;" and see Foley v. Interactive Data Corp. (1988) 47 Cal.3d 654, 684, 687 [254 Cal. Rptr. 211, 755 P.2d 373], limiting such tort actions to ones involving a "special relationship" such as insurance contracts.)
Smyth's second amended complaint alleges, in pertinent part, that "[i]n early 1987, plaintiff made an investigation of his files ... for the purpose of discovering any insurance policies that he had which might afford him coverage for liabilities arising out of the Fire Case.... [P]laintiff discovered an old copy of defendants' excess insurance policy no. 219 54 38 70U. When plaintiff subsequently telephoned defendants' offices in or about February 1987, he falsely was informed by defendants' personnel that the policy was not current and that there was no other current policy in effect.

"On or about March 20, 1987, plaintiff again telephoned defendants' offices to inquire whether plaintiff had current policies in effect. Defendants again falsely represented that plaintiff had no current policies in effect."

On appeal, Smyth emphasizes that "the complaint alleges that defendants denied the very existence of a current contract of insurance on more than one occasion."

Although the actual filing date for this action was January 10, 1990, the parties stipulated that the action be deemed filed on November 10, 1989, for purposes of determining whether the statutes of limitations apply. Therefore, the complaint alleges that USAA denied the existence of these policies as of February or March 1987, approximately two years and seven months before he filed the complaint. The trial court properly sustained the demurrer to the bad faith cause because the complaint was deemed filed well over the two-year statute of limitations for such torts set forth in Code of Civil Procedure section 339, subdivision 1.

**Negligent misrepresentation**

The facts sued upon in the cause for "Negligent Misrepresentation" are the same. Smyth alleged that USAA repeatedly denied the existence of current policies without exercising reasonable diligence to ascertain the truth of this "1987" assertion. The essence of such allegations is that USAA tortiously invaded his property right to be secure from the risk of financial loss. Under the facts alleged, the applicable statute of limitations is, again, two years. (See *Richardson v. Allstate Ins. Co.*, supra, 117 Cal. App.3d at p. 13.)

**Estoppel to assert statute of limitations**

(8) Smyth argues that USAA is estopped to raise the statute of limitations as a defense. One of the elements of estoppel is prejudicial reliance on the other party's conduct. (*Muraoka v. Budget Rent-A-Car, Inc.*, (1984) 160 Cal. App.3d 107, 116 [206 Cal. Rptr. 476]) Here, Smyth had to allege facts showing he reasonably relied on USAA's statements or conduct so that he would not timely sue.

Unlike the *Muraoka* case, Smyth alleged that USAA repeatedly denied the existence of current policies.

Smyth alleged, inter alia, that he "was entitled to rely without further inquiry and did reasonably rely upon such representations." He alleges that these misrepresentations and suppressions of material fact "induced plaintiff from bringing this action until plaintiff became aware of the true facts and plaintiff relied upon defendants' misrepresentations to his prejudice."

The facts alleged do not show reasonable reliance. Because the allegations state that USAA repeatedly told Smyth he had no current policies in effect, USAA may not be said to have lulled Smyth into waiting to sue. (Cf. *Muraoka v. Budget Rent-A-Car, Inc.*, supra, 160 Cal. App.3d at p. 116) USAA did not induce Smyth into believing that they might provide a defense to the Fire Suit.

"The obligation to defend is predicated upon liability for a loss covered by the policy." [Citation.] (State Farm Fire & Casualty Co. v. Drasin, supra, 152 Cal. App.3d at p. 868, italics in text.) Because there is no conceivable theory which would raise an issue bringing Smyth's directorship activities within the ambit of these homeowners policies, USAA had no duty to defend him in the Fire Suit. (Id., at p. 869; *Coe v. Farmers New World Life Ins. Co.*, (1989) 209 Cal. App.3d 600, 608 [257 Cal. Rptr. 411]; *Margien Industries, Inc. v. Aetna Casualty & Surety Co.*, supra, 4 Cal.
App. 4th at p. 422 [determination there is no contractual basis for liability under the policy is fatal to bad faith theories].

The judgment is affirmed. Costs to USAA.

Gilbert, J., and Yegan, J., concurred.

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STATE FARM FIRE AND CASUALTY COMPANY, Plaintiff and Respondent, v. LAWRENCE DRASIN et al., Defendants and Appellants.

Docket No. 69354.

Court of Appeals of California, Second District, Division Five.

March 7, 1984.

COUNSEL
Kessler & Drasin and Timothy P. McNulty for Defendants and Appellants.
Belcher, Henzie, Biegenzahn, Chertok & Walker and Mark D. Wenzel for Plaintiff and Respondent.

OPINION

STEPHENS, J.

This is an appeal from the granting of a summary judgment entered in favor of plaintiff/respondent State Farm Fire and Casualty Company (hereafter State Farm), and against defendants/appellants Lawrence Drasin and Marlene Drasin (hereafter the Drasins) in a declaratory relief action. The effect of the judgment is an order declaring that State Farm has no duty to defend or indemnify appellants in a presently pending malicious prosecution action filed against the Drasins, entitled Lyman Covell v. Lawrence Drasin et al.

The Drasins entered into a limited partnership agreement with Lyman Covell (hereafter Covell), the general partner, to acquire mining leases in El Dorado County, California. The purpose of acquiring the mining leases was to enjoy the production of income, profits and write-offs incidental to the mining operations. Shortly thereafter, a dispute arose between various limited partners, the Drasins and Covell resulting in the filing of a civil action by the Drasins and others against Covell. In this action, it was alleged that various misdeeds by Covell and others respecting the subject of the limited partnership agreement resulted. Relief in the form of rescission of the limited partnership agreement, restitution of investments, accounting, and dissolution of the partnership was sought. Judgment, however, was obtained in favor of Covell. Subsequently, Covell instituted an action for malicious prosecution against the Drasins.

For defense of this matter, the Drasins submitted the action to their homeowner's insurance carrier, State Farm. State Farm conditionally accepted the Drasins' defense request subject to a reservation of rights. In the letter announcing State Farm's reservation of rights, the Drasins were informed that certain exclusions in the policy possibly negated coverage for defense and indemnity of the lawsuit brought by Covell. State Farm then filed an action for declaratory relief.

At a later date, State Farm filed a motion for summary judgment, seeking a judgment and order from the court on the action for declaratory relief. In granting State Farm's requested summary judgment, the court determined that State Farm was under no duty to defend or indemnify its insured against the presently pending malicious prosecution action brought by Covell. This appeal followed.

The Drasins contend that an issue of material fact exists as to whether the acts involved in the malicious prosecution action fall within the definition of "occurrences" and that the court therefore erred in granting summary judgment. The instant policy, they argue, defines "occurrence" as "an accident, including injurious exposure to
conditions which result ... in bodily injury or property damage.” Since the policy does not define the term “accident,” 
“accident,” as judicially defined, is a casualty — something out of the usual course of events and which happens 
suddenly and unexpectedly and without design of the person injured including any event which takes place without 
the foresight or expectation of the person acted upon or affected by the event. (See Maples v. Aetna Cas. & Surety 
Co. (1978) 83 Cal. App. 3d 641, 649 [148 Cal. Rptr. 80].) Therefore, the Drasins come to the “logical deduction” 
that, based upon the foregoing definition, an issue of fact exists as to what the term “occurrence” means and 
whether the occurrence alleged in the malicious prosecution action is afforded coverage under the State Farm 
policy. We do not subscribe to such logic.

(1a) This case is controlled by Maxon v. Security Ins. Co. (1963) 214 Cal. App.2d 603 [29 Cal. Rptr. 586]. In Maxon, 
the court held that the insurance company was not liable under its personal liability policy for the cost of defending a 
malicious prosecution action brought against its insured. This holding was reached despite the fact that the court 
found the insured's actions were in good faith and nonmalicious. (2) See fn. 2.) The court concluded that to recover 
for malicious prosecution there must be a finding of malice. Accordingly, since there is no civil liability for the 
negligent but good faith prosecution of an action, there is no potential for a recovery under the policy. Thus, no 
potential recovery of damages covered by the policy exists and there is no obligation to defend. (Id., at p. 617.) The 
court in Maxon goes on to indicate that not only is there no obligation to defend, but also no obligation to indemnify 
an insured on an action for malicious prosecution. “[T]he respondent insurer cannot under the public policy of 
this state indemnify the insured against liability for his own willful wrong. That policy is a part of every insurance 
App.2d at p. 615; see also Civ. Code, § 1668.4d) (3) The term "willful act" as used in Insurance Code section 533 
means "something more blameworthy than the sort of misconduct involved in ordinary negligence, and something 
more than the mere intentional doing of an act constituting such negligence." (Russ-Field Corp. v. Underwriters at 
Lloyd's (1958) 164 Cal. App.2d 83, 96 [330 P.2d 432].) "The tort of malicious prosecution connotes something more 
blameworthy than an act of negligence... The chief element of a cause of action for malicious prosecution is 
malice. To constitute malice there must be a motive or purpose, and it must be an improper one.... Malice imports 
willfulness; and, accordingly, ... is a ‘willful act’ within the meaning of [Insurance Code] section 533." (Maxon v. 

The Drasins' arguments relating to State Farm’s duty to defend are very similar to those of the appellant insured in 
the Maxon case. In Maxon, the appellant contended that "... while the respondent insurance company may not be 
required to indemnify for the damages assessed in a malicious prosecution action, it is, nevertheless, required to 
defend such an action. The argument is made by the appellant that [Insurance Code] section 533 merely states that 
the insurer is not liable for a loss caused by the willful act, but that it does not state that the insurer is not obligated 
to defend an action which is founded on a willful act. The gist of the argument is that the willfulness of the act 
cannot be determined until the action is tried and a determination made with respect thereto." (P. 616; italics in 
original.)

(1b) The malicious prosecution complaint filed against the Drasins does not potentially seek damages that come 
within the coverage of the subject policy. If the Drasins' original action against Covell is held to be without malice 
and therefore not willful, then there is no liability under the policy. Similarly, if the Drasins' original action against 
Covell is held to be willful and with malice, again there is no liability under the policy. (See Ins. Code, § 533.) "The 
obligation to defend is predicated upon liability for a loss covered by the policy." (Maxon v. Security Ins. Co., supra, 
214 Cal. App.2d at p. 616; italics added.) Therefore, since State Farm could not "be liable under the policy for 
damages predicated upon the tort of prosecution, it is not obligated to defend such an action.

The Drasins cite Gray v. Zurich Insurance Co. (1966) 65 Cal.2d 283 [54 Cal. Rptr. 104, 419 P.2d 168] in support of 
their argument that they are entitled to a defense in their malicious prosecution action. They contend that, as set 
forth in Gray, an insurance company must look beyond the four corners of a third party complaint against the 
insured and show facts in its possession which would indicate that there is no potential for liability under the policy.
In Gray, the California Supreme Court held that an insurer's duty to defend litigation brought against its insured is broader than its duty to indemnify. It stated that the insurer "must defend a suit which potentially seeks damages within the coverage of the policy...." (Id., at p. 275; italics in original.) However, this duty to defend is measured by the nature and kind of risks covered by the policy. (Id.) It further stated: "[t]he insurer need not defend if the third party complaint can be by no conceivable theory raise a single issue which could bring it within the policy coverage. Hence the obligation to defend does not mature ... if the nature of the alleged intentional tort compels a finding of intentional wrongdoing such as malicious prosecution." (Id., at p. 276, fn. 15, citing Mason v. Security Ins. Co., supra, 214 Cal. App.2d 603; italics added.)

We fail to see how Gray supports the Drasins' arguments. They contend that State Farm has to establish facts showing that its insured's conduct compels a finding of intentional wrongdoing. On the contrary, the carrier need only show that the nature of the alleged tort has an element of intentional wrongdoing to satisfy its burden. State Farm has satisfied its burden by showing the alleged action is for malicious prosecution.

(4) Next, the Drasins argue that issues of fact exist as to whether their action falls within the business pursuit exclusion to coverage under the policy. State Farm contends that the Drasins' partnership activities are considered business pursuits and as such do not fall under the coverage of the policy. The Drasins contend that the partnership activities are not business pursuits because Lawrence Drasin's occupation is that of an attorney and his involvement in the partnership activities is not in his capacity as an attorney. The policy defines business as "a trade, profession, or occupation...." We agree that Lawrence Drasin's partnership activities do not relate to his profession as an attorney. However, the policy says "trade, profession or occupation." The California Supreme Court has defined "trade" as any business carried on for the purpose of profit or gain or livelihood. (City of Los Angeles v. Rancho Homes, Inc. (1953) 40 Cal.2d 764, 767 [256 P.2d 305], quoting Babcock v. Laidlaw, 113 N.J. Eq. 318, 321 [166 A. 632]) It has defined "occupation" as "an extremely broad term sufficient to include any business, trade, profession, pursuit, vocation, or calling." (City of Los Angeles v. Rancho Homes, Inc., supra, 40 Cal.2d at p. 767, quoting State v. Van Deelen, 69 S.D. 486, 474 [11 N.W.2d 523].)

We find no California case law directly analogous to the facts in the present case. Therefore, we turn to alternative authorities. In his treatise on insurance law, Applemann indicates that applicability of the business pursuit exclusion turns on the motivation for the pursuit. He contends the presence of the profit motive carries considerable weight, and that the business engaged in need not be the sole occupation. Part-time business activities are also included under business pursuits exclusions. (7A Applemann, Insurance Law and Practice (1979) § 4501.10.)

Other jurisdictions have defined a business pursuit as a regular activity engaged in for the purpose of earning a profit. This includes part-time or supplemental income projects. (See Shapiro v. Glen Falls Insurance Co. (1975) 47 App.Div.2d 856 [365 N.Y.S.2d 892, 893]; State Farm Fire & Cas. Co. v. Moore (1981) 102 Ill. App.3d 250 [430 N.E.2d 641, 643]; Gaynor v. Williams (Fla.App. 1979) 366 So.2d 1243; Kring v. Safeco Ins. Co. of America (1981) 6 Kan. App.2d 391 [628 P.2d 1071, 1074].) "Business," as defined in Revenue and Taxation Code section 6013, "includes any activity engaged in by any person or caused to be engaged in by him with the object of gain, benefit, or advantage, either direct or indirect." The central theme being espoused by said authorities is regular activity with the motivation for profit or gain. The Drasins, as stated in their own words, are engaged in the partnership for profit and had been engaged in such partnership for more than a year. As such, they were engaged in a business pursuit. Therefore, the business pursuit exclusionary clause applies.

Finally, the Drasins assert that their mental state is in issue. This point is irrelevant and devoid of merit. The judgment is affirmed.

Feinerman, P.J., and Asby, J., concurred.

[1] Section II of the homeowner's insurance policy under coverage E, personal liability, provides:

"This Company agrees to pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages because of bodily injury or property damage, to which this insurance applies, caused by an occurrence." (Italics ours.)
The intentional acts exclusion and business pursuit exclusion clauses provide:

"Section 2, Exclusions, Coverage E, Personal Liability and Coverage F, Medical Payments to Others do not apply:

WEST AMERICAN INSURANCE COMPANY, Plaintiff, Cross-defendant and Respondent,

v.

CALIFORNIA MUTUAL INSURANCE COMPANY, Defendant, Cross-complainant and Appellant.


Court of Appeals of California, Second District, Division Six.


COUNSEL


Alan E. Wisotsky and Martin J. McDonagh for Plaintiff, Cross-defendant and Respondent.

OPINION

GILBERT, J.

Two insurance companies, West American and California Mutual, sought a declaratory judgment assigning responsibility for defending and indemnifying the insured in a personal injury suit. The trial court determined that an employment exception in West American's policy relieved it of any duty to defend or indemnify, but that a business pursuit exception in the California Mutual policy did not apply under the circumstances of the injury. California Mutual was therefore held to have the sole responsibility to defend and indemnify the insured.

California Mutual appeals, arguing that there was insufficient evidence before the trial court to find that the employment exclusion was triggered, relieving West American of its contractual duties. California Mutual also argues that there was insufficient evidence to support the trial court's conclusion that its business pursuit exclusion did not apply. We agree.

At the time of his injury the employee was engaged in voluntary social activities which did not arise out of and in the course of his employment, but which did fall within the business pursuits of the insured. The judgment is reversed. West American, rather than California Mutual, must defend and indemnify the insured.

Factual and Procedural History

John A. Clapham is a cement and masonry contractor who operates his business out of his Simi Valley home. His employees would assemble at his home at approximately 6 a.m., gather the trucks, tools and plans necessary for the day's construction jobs, and then drive to the jobsites. At the end of the workday, Clapham's employees would return to the Clapham residence before quitting.

Clapham had converted his garage into a den, equipped with a pool table and a refrigerator. On Fridays, which was payday, Clapham would leave the jobsite early to come home and make out his payroll. His employees would gather in the den while waiting for their pay, playing pool and dice games and drinking beer furnished by Clapham. Once paid, the employees were free to leave, and many did. Others remained to continue drinking and playing pool and dice. Clapham used this weekly gathering to foster better relations with his employees.
May 18, 1984, was a typical payday. Clapham paid his employees between 3:30 and 4 p.m. Among the employees remaining after receiving their pay that day were Rafael Iriarte and Iriarte's brother, Jesus. Also present were Francisco Gamboa, a former employee of Clapham, and his brother, Ismael.

Shortly after 8 p.m., during a dice game in the den, a fight broke out between Gamboa's brother, Ismael, and Iriarte's brother, Jesus. Both Gamboa and Iriarte became involved in the fray and suffered personal injuries. Gamboa and Iriarte each filed lawsuits against Clapham, alleging, inter alia, that Clapham negligently served alcohol and failed to control the people on his premises.

Clapham retained counsel, filed answers to the two suits, and made demand upon California Mutual Insurance Company (Cal Mutual) and West American Insurance Company (West American) to defend and indemnify him in these actions.

In 1983, Cal Mutual issued to Clapham a homeowners insurance policy covering liability for bodily injury and obligating the company to defend against a claim or suit for damages because of bodily injury. The policy specifically excludes coverage for bodily injury "arising out of business pursuits" of Clapham.

West American issued a comprehensive general liability insurance policy in 1983 covering Clapham's liability for bodily injury in respect to the conduct of his sole proprietorship cement and masonry business. The West American policy also includes an obligation to defend against any bodily injury suit. This policy expressly excludes coverage for "bodily injury to any employee of the insured arising out of and in the course of his employment by the insured."

West American filed a complaint for declaratory relief against Cal Mutual, and Cal Mutual cross-complained. Each denied an obligation to defend or indemnify Clapham in either action.

In its statement of decision, the trial court found that, disregarding the exclusions, the policies of both West American and Cal Mutual provide coverage to Clapham against Iriarte's and Gamboa's claims, and that Gamboa's claim was covered by both policies.

The court concluded that Iriarte's injury arose out of and in the course of his employment, but not out of Clapham's business pursuits. Applying these findings to the exclusion clauses of both policies, the court found (1) West American was relieved of any duty to defend and indemnify Clapham in regard to the Iriarte injury and (2) Cal Mutual had the sole responsibility to do so.

On appeal, Cal Mutual contends that the evidence was insufficient to support the lower court's findings. Cal Mutual argues that Iriarte was injured while drinking and gambling on Clapham's premises after work hours, not while rendering service for his employer pursuant to the terms of employment. Thus, the injuries did not arise out of and in the course of Iriarte's employment by Clapham, but they did arise out of Clapham's business pursuit. If true, the obligation to defend and indemnify Clapham would not lie with Cal Mutual, but with West American.

Alternatively, Cal Mutual argues that if Iriarte's injury did arise out of his employment, then it must necessarily also have arisen out of Clapham's business pursuit. This would result in neither insurance policy covering Clapham for the Iriarte injury. (The lower court's findings regarding the Gamboa suit were not appealed.)

**DISCUSSION**

**I. Did Iriarte's injury arise "out of and in the course of" his employment?**

(1) Cal Mutual correctly points out that merely because Iriarte was Clapham's employee and was on Clapham's business premises at the time of the altercation, does not establish that Iriarte was engaged in Clapham's...
employment when injured, or that his injuries arose out of and were "incurred in the course of his employment. (Artukovich v. St. Paul-Mercury Indem. Co. (1957) 150 Cal. App.2d 312, 324 [310 P.2d 461]; 12 Couch on Insurance (2d ed. 1981) § 44A:68, p. 108.) "Everyone who is engaged in the employment of the insured would be its employee, but not every employee is engaged in the employment of the insured all the time." (Artukovich, supra, at p. 324.)

This principle of law, however, does not end our inquiry. The fight resulting in Iriarte's injuries did not take place during working hours nor in the course of providing services to Clapham. (2a) Still unanswered is the question whether at the time of the injury Iriarte was in some other manner "engaged in the employment of the insured...." (Ibid.)

Cal Mutual argues that to come within the employment exclusion, the injured party must, at the time of injury, "be rendering service for his employer pursuant to the terms of his employment" and must be "engaged in activities necessary and incidental to the work" the employee was hired to do.

Cal Mutual cites no authority for this purported rule, and West American, in arguing that Cal Mutual's proposition is antiquated and overrestrictive, relies on workers' compensation and respondeat superior cases. We agree with the parties' implicit concession that there is no case law defining the phrase "arising out of and in the course of employment" as it appears in private liability insurance policies. Even though this phrase appears in workers' compensation and respondeat superior law, West American's reliance on these cases is misplaced. The policies and rules of construction underlying private liability insurance law differ from those in workers' compensation and respondeat superior situations. The phrase must be interpreted in its correct context.

A. Workers' Compensation Law

The employment exclusion clause at issue here is identical to the statutory language establishing a workers' compensation claim. In order to be compensable under workers' compensation, the injury must "[a]rise out of and [be] in the course of the employment...." (Lab. Code, § 3600; State Compensation Ins. Fund v. Workers' Comp. Appeals Bd. (1982) 133 Cal. App.3d 643, 652 [184 Cal. Rptr. 111]) (3) "In the course of employment" generally refers to the time and place of the injury, and means that the injured must be engaged in the work he has been hired to perform, while the phrase "arise out of employment" refers to a causal connection between the injury and the employment. (State Compensation Ins. Fund v. Workers' Comp. Appeals Bd., supra, at p. 652; 2 Witkin, Summary of Cal. Law (9th ed. 1987) Workers' Compensation, § 185, p. 749.)

In McCarty v. Workmen's Comp. Appeals Bd. (1974) 12 Cal.3d 677 [117 Cal. Rptr. 65, 527 P.2d 617], the Supreme Court construed this terminology so as to award workers' compensation to the survivor of an employee who died in a car wreck after becoming intoxicated at an office Christmas party.

The court considered whether the employee's intoxication "arose in the course of employment," and concluded that "[e]mployee social and recreational activity on the company premises, endorsed with the express or implied permission of the employer, falls within the course of employment if the 'activity was conceivably of some benefit to the employer ...' [citations, fn. omitted]" or otherwise was a "customary incident of the employment relationship." (Id., at pp. 681-682.) The McCarty court noted that by purchasing intoxicants with company funds and permitting after-hours drinking parties on business premises, employers benefit by fostering company camaraderie and the discussion of company business. (Ibid.)

The holding of McCarty is cast in doubt by Labor Code section 3600, subdivision (a)(9) (formerly (a)(8)), which excludes from liability under workers' compensation those injuries which "arise out of voluntary participation in any off-duty recreational, social, or athletic activity not constituting part of the employee's work-related duties, except where these activities are a reasonable expectancy of, or are expressly or impliedly required by, the employment." (Ezzy v. Workers' Comp. Appeals Bd. (1983) 146 Cal. App.3d 252, 259 [194 Cal. Rptr. 90]; see 2 Witkin, supra, at pp. 783-786.) As will be seen, the McCarty test survives in the realm of respondeat superior.
B. Respondeat Superior

(4) The doctrine of respondeat superior holds an employer liable for torts of an employee committed within the scope of his employment, and the rationale underlying the doctrine is, in some respects, similar to that underlying workers' compensation. (Perez v. Van Groningen & Sons, Inc. (1986) 41 Cal.3d 962, 967 [227 Cal. Rptr. 106, 719 P.2d 676].)

The test for determining whether an employer is vicariously liable for the torts of his employee is "closely related to the test applied in workers' compensation cases for determining whether an injury arose out of or in the course of employment." (Rodgers v. Kemper Constr. Co. (1975) 50 Cal. App.3d 608, 619 [124 Cal. Rptr. 143].) Under California law, an employer "is liable for risks "arising out of the employment."" (Perez v. Van Groningen & Sons, Inc., supra, 41 Cal.3d at p. 968.)

In Rodgers, supra, the court announced two tests for determining whether a risk arises out of employment. One test is foreseeability, that is, whether "in the context of the particular enterprise an employee's conduct is not so unusual or startling that it would seem unfair to include the loss resulting from it among other costs of the employer's business." (Rodgers v. Kemper Constr. Co., supra, 50 Cal. App.3d at p. 619; Perez v. Van Groningen & Sons, Inc., supra, 41 Cal.3d at p. 968.)

The second test Rodgers "borrowed" from McCarty. It states that "where social or recreational pursuits on the employer's premises after hours are endorsed by the express or implied permission of the employer and are "conceivably" of some benefit to the employer or, even in the absence of proof of benefit, if such activities have become a customary incident of the employment relationship," an employee engaged in such pursuits after hours is still acting within the scope of his employment. [Citation.]


Even though the McCarty test no longer applies in construing workers' compensation liability because of Labor Code section 3600, subdivision (a)(9), it has been adopted as a test in establishing liability under respondeat superior. (Childers v. Shasta Livestock Auction Yard, Inc., supra, 190 Cal. App.3d 792, 804.)

C. Private Liability Insurance

Both McCarty and Rodgers broadly construe the phrase "arise out of or be in the course of employment." Such construction is mandated by statute or by policy. Section 3202 of the Labor Code requires that all reasonable doubts as to whether the injury arose out of employment for workers' compensation purposes are to be resolved in favor of the employee. (Lab. Code, § 3202; Garza v. Workmen's Comp. Bd. (1970) 3 Cal.3d 312, 317 [90 Cal. Rptr. 355, 475 P.2d 451].)

(5) As for respondeat superior, the "principal justification for the doctrine "is ... that the employer may spread the risk through insurance and carry the cost thereof as part of his costs of doing business." (Perez v. Van Groningen & Sons, Inc., supra, 41 Cal.3d at p. 967 quoting Johnston v. Long (1947) 30 Cal.2d 54, 64 [181 P.2d 645].)

(6) Different criteria apply, however, in interpreting private liability insurance policy exceptions. These exceptions should be construed narrowly so to favor the insured, in order to protect the insured's reasonable expectation of coverage. (Reserve Insurance Co. v. Pisciotta (1982) 30 Cal.3d 800, 808 [180 Cal. Rptr. 628, 640 P.2d 764]; Artukovich v. St. Paul-Mercury Indem. Co., supra, 150 Cal. App.2d at p. 324.)

(2b) With this rule of construction in mind, the evidence here is insufficient to support the trial court's determination that the injury arose out of and in the course of Iriarte's employment. It may be true that but for Iriarte's employment he would not have been at Ciapham's that night, and in that sense the injury "arose out of" the employment.
relationship. But the exclusion also requires that Iriarte be acting "in the course of" his employment when injured, and this prong is not met.

Iriarte was not working, nor was he required to be on Clapham's premises when the injury occurred. He was free to leave, and there is no evidence that continued employment or better working conditions depended on his being at the Friday night parties. Clapham testified at trial that he gave the parties to foster good relations with his employees. This may establish that the gatherings furthered Clapham's business purposes, but not that the employee's were on the job at the time of the injury.

An employee who is doing acts "in the course of [his] employment" is working. It is when the employee is working that the exclusion applies. It would be reasonable for Clapham, the insured, to expect that the employment exclusion in the West American policy not apply to an injury resulting from an argument during a Friday night game of dice. The West American employment exclusion therefore does not apply.

II. Did Iriarte's injury arise out of a "Business Pursuit"?

(7a) The trial court found that Cal Mutual's "business pursuit" exception did not apply to Iriarte's injury, because Clapham had a "dual purpose" — both business and social — in allowing his premises to be utilized for drinking and gambling. The court found that because the activity giving rise to the injury was not "wholly dependent" on Clapham's business pursuits, the exclusion did not apply.

"In State Farm Fire & Casualty Co. v. Drasin (1984) 152 Cal. App. 3d 864, 870 [199 Cal. Rptr. 749], it is noted that applicability of the business pursuit exclusion turns on the motivation for the pursuit[,]... the presence of the profit motive carries considerable weight, and that the business engaged in need not be the sole occupation.... Other jurisdictions have defined a business pursuit as a regular activity engaged in for the purpose of earning a profit.... "Business," as defined in [California] Revenue and Taxation Code section 6013, "includes any activity engaged in by any person or caused to be engaged in by him with the object of gain, benefit, or advantage, either direct or indirect." The central theme being espoused... is regular activity with the motivation for profit or gain." (Fire Ins. Exchange v. Jimenez (1986) 184 Cal. App. 3d 437, 442-443 [229 Cal. Rptr. 83].)

There is no doubt that Clapham was engaged in a business pursuit when he invited his employees onto his premises and provided them with beer and recreation. A business pursuit exception is broader than an employment exception. An employer's business pursuit logically includes any activity which arises from and is in the course of an employee's employment.

Clapham testified that his sole purpose in permitting the Friday night custom was to foster better relations with his employees. A happy work force is a benefit to any business undertaking.

Even if the Friday night gathering was partially motivated by social interests, the result would be the same. Nothing in the insurance policy requires that the business pursuit be wholly business related for the exception to apply. West American's reliance on the "concurrent causation" doctrine is misapplied. (8) That doctrine provides for coverage when the injury is caused by a combination of an insured risk and an excluded risk. (State Farm Mut. Auto. Ins. Co. v. Partridge (1973) 10 Cal.3d 94, 105 [109 Cal. Rptr. 811, 514 P.2d 123]) It concerns multiple causes. (Farmers Ins. Exchange v. Adams (1985) 170 Cal. App. 3d 712, 716 [216 Cal. Rptr. 287].) (7b) A double social and business nature of the Friday night activities is not the same as independently operating causes of the injury.

West American's contention that the business pursuit exception is not conspicuous within Cal Mutual's policy is without merit.
We hold that the employment exclusion in the West American policy does not apply, and that the Cal Mutual business pursuit exception does apply. West American, and not Cal Mutual, has the responsibility to defend or indemnify Clapham in the Friarte suit.

The judgment is reversed. Each party to bear its own costs on appeal.

Stone, P.J., and Abbe, J., concurred.

On October 30, 1987, the opinion was modified to read as printed above.

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