THE IDC MONOGRAPH:

Proper Claims Practices to Preserve Defenses

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The best defense starts at the very beginning of any claim. During the initial evaluation and analysis of a claim, there are not only opportunities to deny coverage but also pitfalls by which a defense can be lost. Regardless of the type of claim, from the point of notice forward the insurer needs to take certain steps to preserve both coverage and liability defenses. The Hippocratic Oath's requirement of "first do no harm" applies as well to claims handlers as to doctors. With a better understanding of the law regarding notice of claims, the duty to investigate, spoliation, and estoppel, claims handlers and attorneys will be better positioned to preserve those defenses so that claims can be addressed on their merits.

I. Notice to the Insurer

A. Introduction

The timing of the notice to the insurer, as well as the source and content of that notice, may provide an insurer the opportunity to deny coverage. In order to be able to properly assert such a defense, however, the insurer must be aware of the law regarding late notice and also must have procedures in place that will enable the insurer to prevail on a late notice claim. The claims handler must be aware of the law and be able to apply it to recognize defenses.

The initial questions to be asked include:

a. Was notice provided to the insurer in a manner consistent with the requirements of the policy; and

b. Was it provided timely?

The answer to those questions, of course, is to some degree determined by specific policy language. Nonetheless, Illinois courts consistently apply similar reasoning and analysis, regardless of minor policy language variations.

For reasons discussed below, insurers need to develop clear rules as to the proper sources of notice of claims. Illinois law is in flux as to whether a provision that requires the insured to provide notice directly to the insurer (as opposed to providing that notice to the agent or producer) will be enforced. That is further complicated by the fact that insurers often blur that line by accepting notice from the producer without objection and, in doing so, waive potential defenses based on the source of the notice. Further, to prevent the analysis of any such defenses from being purely subjective, insurers should establish internal triggers for late notice claims.

B. Notice to the Insurer and Apparent Agency

The initial issue for the insurer is whether the notice came from an appropriate source. The typical CGL policy on its face provides that the *insured* must give the insurer notice. Over the past 20 years, however, Illinois courts first stepped back from that requirement and, in doing so, made it easier for insureds to establish notice. Then, within the past year, the courts seemingly moved to a more rigorous standard for that notice.

For all intents and purposes, the Illinois Supreme Court first addressed the question of the appropriate source of notice to an insurer in 1991 in *State Security Insurance Co. v. Burgos*.[1] In that case, the Illinois Supreme Court ruled that the insurance producer[2] was the apparent agent of the insurer, and, as such, notice to the producer was notice to the insurer.[3]

In *Burgos*, the policy language provided "notice shall be

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given by or for the insured to the company or any of its authorized agents as soon as practicable."[4] The Illinois Supreme Court initially noted that notice provisions in insurance policies are valid prerequisites to coverage.[5] The question for the court was whether the insured gave such notice to the insurer or its agent within a reasonable amount of time.[6] Further, the court examined the issue of whether the conduct of the insurer and the producer made the producer the apparent agent of the insurer.[7]

In analyzing the matter, the court looked to the facts regarding the conduct by the insured, the conduct by the insurer, and the law regarding apparent agency. The conduct by the insurer in *Burgos* should be read by insurers as a list of things to avoid if the insurer is to insist on strict enforcement of the notice provisions.

Burgos arose from a shooting outside a store.[8] Immediately following that shooting, the insured called the producer from whom he had purchased the policy and advised the broker of the shooting.[9] Within the next day, the insured and the producer had two more conversations, including one at the store where the shooting occurred.[10] The producer advised that he would take care of the situation and, further, that it was his view that the insured would not be liable for the shooting.[11]

Two years later, suit was filed against the insured.[12] The insured gave the summons and complaint to the producer, who forwarded it to the insurer.[13] It was undisputed that the summons and complaint were the first notice actually received by the insurer.[14]

The court examined the relationship between insured, producer, and insurer. The producer had been handling the insured's "insurance needs" for over 20 years.[15] The policy was delivered to the insured by the producer.[16] The insured paid for the policy by paying the producer, who then forwarded the payments to a wholesale broker who then paid the insurer.[17] All communication between the insurer and insured as conducted through the producer.[18] The producer's name was put on the declarations page via a sticker.[19] When the policy was delivered to the insured, the producer included a letter advising the insured to contact the insurer in the event of a loss.[20]

The producer's conduct was supported by the insurer and the testimony of the insurer's claims manager. That claims manager testified that his company received notice from producers as well as insureds.[21] He testified that the "general procedure" was that insureds would report the loss to the person to whom they paid for the policy.[22] In addition, the producer testified that he routinely forwarded notice to the insurer, and the insurer never objected to that procedure.[23]

In analyzing the issue of apparent agency, the court recognized that, generally, one who sells insurance is the agent of the insured, rather than of the insurer. According to the court, the test for apparent agency is not whether the producer actually had authority, but whether the producer appeared to have such authority.

In analyzing the issue of apparent agency, the court recognized that, generally, one who sells insurance is the agent of the insured, rather than of the insurer.[24] According to the court, the test for apparent agency is not whether the producer actually had authority, but whether the producer appeared to have such authority.[25] Apparent authority is created by actions of the principal (here, the insurer).[26] The test is whether "a reasonably prudent person, in view of the principal's conduct, would naturally suppose" that the agent would have such authority.[27] If the insurer is aware of the producer's conduct but does nothing to prevent it, then such knowing or permitting leads to apparent agency.[28] These principles are significant for insurers, because treating the producer in that manner might lead to the court finding that notice to the producer is notice to the insurer. As seen in *Burgos*, however, producers commonly act as if they are agents of the insurer for things like payments and notice. When insurers allow producers to act in that manner, insurers will be held to that standard.

On the facts presented, the Illinois Supreme Court ruled that the insurer's manner of dealing with the insured and the producer created the appearance that the producer had au-

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thority to accept notice of occurrences.[29] Accordingly, the court found notice to be timely.[30] It is important to note that the court did look at the policy language, which included the word "agent." Needless to say, an argument could be made that policy language without the word "agent" might have put the insurer in a stronger position. Except for *West American Insurance Company v. Yorkville National Bank*[31] (discussed in detail below), however, in the 20 years since *Burgos*, no Illinois court has ruled that the inclusion of the word "agent" was dispositive in the discussion of whether a producer can accept notice.

As discussed in more detail below, insurers need to decide internally whether they want to benefit from the client-service actions of their producers, and in doing so accept that a court might find that a producer is an agent for notice of occurrence. Alternatively, the insurer must decide if it wants to take a more hands-on approach with the insureds itself, and thus, also demand strict compliance with the notice provisions.

In the year following the *Burgos* decision, the Illinois Appellate Court First District examined the issue. In *Dumenric v. Union Oil Company of California*,[32] the court was faced with the conflict between actual and apparent authority of an insurance producer. That case involved the issue of an allegedly improper certificate of insurance issued by a producer.[33] The producer testified that he had been a practicing insurance "broker" since 1962 and that he had placed insurance for three or four different companies, including Aetna.[34] He believed that, as a broker, he did not have to contact Aetna before signing a certificate of insurance.[35] The producer obtained a policy of insurance from Aetna for Mid States, and then issued a certificate of insurance stating that Union Oil Company of California (Union Oil) was an additional insured under that policy.[36] In fact, Union Oil was not named as an additional insured under that policy.[37]

The court found that the producer acted in contravention of the express direction of the insurer.[38] Nevertheless, the court concluded that the producer had apparent agency, so the insurer was estopped from denying coverage.[39] The significance of *Dumenric* is that the question in that case was not one of actual agency, but rather one of apparent agency. Insurers seeking to require strict compliance with a requirement of notice from the insured must take specific action to require it.

In 1998, the Illinois Supreme Court again looked at the issue of proper notice to an insurer in *Cincinnati Companies v. West American Insurance Company*.[40] The issue presented was "whether an insurer's duty to defend its insured arises upon its receipt of *actual notice* of the suit against its insured, or whether the duty to defend is triggered only upon the insured's *tender* of its defense to the insurer."[41]

That decision served to confirm the holding of *Burgos* in that, for purpose of notice to an insurer, the source of the notice is not relevant.[42] Instead, actual notice from any source is sufficient in order to trigger the insurer's duty to defend and indemnify, except where the insured has specifically advised the insurer that it does not want the insurer's assistance.[43]

In *Cincinnati Companies v. West American Insurance Company*, on the eve of trial, defendant Baird Land Surveyors (Baird) learned that coverage was available from West American Insurance Company (West American), which was defending another party to the suit.[44] At that time, Baird, through counsel retained by another insurer that had been defending it, attempted to obtain coverage from West American, but the tender was rejected.[45] There is no indication in the opinion that Baird was aware of the potential for coverage from West American prior to the time of the tender, but it was undisputed that West American was aware of the suit since the very beginning of the litigation.[46]

The Illinois Supreme Court phrased the issue as follows: "Whether West American's duty to defend Baird was triggered when [West American] had actual notice of the suit against Baird, even though Baird did not tender its defense to West American."[47] The Illinois Supreme Court answered that question as follows:

> We believe that the better rule is one which allows actual notice of a claim to trigger the insurer's duty to defend, irrespective of the level of the insured's sophistication, except where the insured has knowingly forgone the insurer's assistance.[48]

Importantly, part of the basis for the court's decision was perceived public policy. The court found that the state has an interest in having insureds adequately represented at trial (while apparently also believing that making people comply with contracts is not an interest of the state) and that a rule that requires "only actual notice to trigger the duty to defend will protect that interest."[49]

As a result, following the Illinois Supreme Court's decision in *Cincinnati Companies v. West American Insurance Company*, it appeared unlikely that an insurer could deny notice if notice was provided by or to just about anyone some-

how related to the insurance policy. In 2009, however, the Illinois Appellate Court Third District in *West American Insurance Company v. Yorkville National Bank*[50] took a look at the issue and found that under certain circumstances, notice must be provided in full compliance with the insurance policy terms. Notably, the Illinois Supreme Court has accepted the Petition for Leave to Appeal in that matter.

In *Yorkville National Bank*, the appellate court was faced with the issue of whether an insured must comply with a policy provision requiring written notice, or whether "actual notice" was acceptable.[51] The underlying case was a defamation suit filed against Yorkville National Bank and its vice president.[52] Yorkville National Bank obtained a West American insurance policy from Zeiter-Dickson Insurance Agency.[53] That policy provided, in part: "You must see to it that we receive written notice of the claim or 'suit' as soon as practicable."[54]

To some degree, the facts of the alleged notice were in dispute. The underlying complaint was filed on September 24, 2001, and notice was provided to the insurer in writing on January 19, 2004, with a March 15, 2004 trial date pending.[55]

According to the insured, the insurer had received notice of the occurrence on six separate occasions prior to the time of the written notice.[56] The first was in late 2001 or early 2002 between the bank's president and an agent of the producer.[57] At that time, the producer allegedly told the bank president that the policy probably would not cover the loss.[58] There were a series of other such alleged conversations between the bank's representatives and the producer's representatives, some of which the producer denied occurred.[59] On those facts, the trial court, relying on *Cincinnati Companies v. West American Insurance Company*, found that the insurer had actual notice, and as such was obligated to defend.[60]

The facts of the case were similar to *Burgos*, in that there was no dispute that notice was not timely provided to the insurer directly, but there was an issue of whether it was provided to an apparent agent. Significantly, however, the court in *Yorkville National Bank* did not focus on either the issue of apparent agency or on the issue of actual notice as described in *Cincinnati Companies v. West American Insurance Company*. Instead, the court narrowly looked at the provision requiring that notice be in writing.

According to the court in *Yorkville National Bank*, the Illinois Supreme Court in *Cincinnati Companies v. West American Insurance Company* addressed only the question of whether a formal tender was necessary, and did not address the issue of whether other policy terms must be met.[61] The court in *Yorkville National Bank*, however, looked only at the written notice, and not at actual notice.[62] The court decided that the 27-month delay in providing written notice was unreasonable, so the insurer was not obligated to defend or indemnify.[63] Importantly, the court determined that the word "written" in the policy must be enforced, and thus, the purported notice to the apparent agent was not relevant.[64]

Whether this decision stands depends of course on the Illinois Supreme Court's anticipated decision. The end result is that although the insurers that wish to demand strict compliance with the policy terms on notice have a tough road, the *Yorkville National Bank* decision does provide some potential avenues to enforce those terms. Initially, the insurer will need policy language requiring written notice. Had that term not been in the Yorkville National Bank policy, it is very likely that the case would have gone the other way. Without that term, *Cincinnati Companies v. West American Insurance Company* would make it difficult for insurers to insist on strict compliance. Under that case, notice from any source, especially the producer, is sufficient to trigger the duty. It is difficult, under that decision, to see how an insurer could reject notice from a producer.

Further, insurers will need to examine their relationships with their producers and their insureds. A court examining the issue of notice likely will look at the conduct of the insurer in the case at issue and generally. The court will ask whether the insurer ever objected to the procedure of notification from the producer. The court will ask about what the insurer considered routine methods of obtaining notice. Where an insurer admits that it typically received notice from the producer, it will have a difficult time establishing that such notice was improper in any particular case. Insurers seeking to require direct reporting will have to insist on it (as some workers' compensation carriers already do). They also will need to establish direct contact with the insureds, which should include at the very least delivering the policies to the insureds. Billing, of course, is problematic because the premiums on commercial policies often are financed. Nonetheless, apart from the language of the policy, the key concern for a court will be the nature and extent of the direct contacts between insurer and insured.

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C. The Timing of the Notice and Prejudice

After the source and content of the notice is established, the next issue will be whether the notice was timely. As described below, the path taken by Illinois courts is somewhat confusing, as the courts seem to say both that the timeliness is entirely subjective based upon the individual facts, and at the same time, courts have looked at the narrow facts presented and found that notice was untimely. Finally, whether prejudice plays any role in determining the timeliness of notice is still a cause for some confusion.

The analysis of notice must begin with *Barrington Consolidated High School v. American Insurance Co.*,[65] which set the broad standards for late notice cases. The insurance policy in that case, as in most other cases involving the issue, required notice "as soon as practicable."[66] In that case, the issue presented was whether notice to the insurer approximately three years after the occurrence met the notice requirements of the policy.[67]

Initially, the Illinois Supreme Court ruled that a notice provision in an insurance policy is reasonable, as it provides the insurer with an opportunity to make a timely investigation of the case.[68] According to the court, those provisions generally have been held to "require notification of the company within a reasonable time, considering all the facts and circumstances of the particular case."[69] As such, the court has appeared to build in a subjective component to the discussion, in which any analysis of "reasonable" must be seen in the context of the other facts regarding the notice.

Applying that standard to the facts presented, the court found that the three-year notice was reasonable.[70] Although the school was aware of the injury, nothing indicated that the school knew that a claim against it might arise.[71] The court noted that the policy did not intend "that every occurrence or accident had to be reported."[72] If no reasonable person expected a claim under the policy, then notice was excused.[73]

As a result, following *Barrington Consolidated High School*, Illinois was left with a fact-specific analysis that took into consideration whether the insured thought that it might be a good idea to report a matter. In the following years, Illinois courts re-examined that issue in an effort to establish some concrete standards for notice.

Two years later, in *Sowinksi v. Ramey*,[74] the First District took another look at the issue of notice. That case arose from an October 1965 automobile accident.[75] Suit was filed, and the defendant eventually was served through the Secretary of State.[76] The defendant filed a special appearance, service was quashed, the defendant was again served through the Secretary of State, and a default judgment was entered in October 1970.[77] In the ensuing garnishment action, the insurer sought to deny coverage on the basis that suit was never forwarded to it.[78] In that garnishment action, it was stipulated that the insurer had notice of the filing of the complaint as of July 1967 (less than two years after the accident).[79] Further, it appears that the insurer had notice of the accident from the plaintiff's counsel within three months of the accident.[80] The evidence, however also showed that the insurer attempted to contact the insured for details on the accident, but the insured did not respond to those letters.[81]

The court reiterated that the insured had the duty to provide the insurer with complete notice of the accident, including the particulars, "as soon as practicable."[82] The court took a very strong line for the insurer in the matter, ruling that notice two months after the accident did not constitute reasonable notice.[83] In doing so, the court did not provide any guidance other than the subjective view that the notice was unreasonable.

Insurers seeking to deny claims based on late notice should attempt to establish that an investigation would routinely have been done and potentially that investigation would have provided information necessary to the defense.

Three years later, in *Illinois Valley Minerals Corp. v. Royal-Globe Insurance Co.*,[84] the Third District again looked at standards for notice. In that case, the court started to provide some guidance as to the factors to be considered in determining whether notice was appropriate. That case involved a dispute over damage to a dock, which occurred on January 11, 1975.[85] Less than a week later, the insured was advised that the dock company would seek to hold the insured liable for the property damage.[86] The first notice to the insurer was

on July 18, 1975.[87] By that time, all the repairs had been completed.[88]

The court looked at the fact that, due to the delay, the insured was deprived of the opportunity "to make a timely and thorough investigation."[89] Further, the court noted that the insured had no valid excuse for the delay.[90] As a result, the court found that notice was not timely.[91]

As discussed below, the Illinois Supreme Court has since ruled that prejudice is not necessary in order to establish late notice as a defense. Nonetheless, *Illinois Valley Minerals Corp.* does provide valuable guidance that remains valid, in that where prejudice can be established and no reasonable excuse can be provided, a claim can be denied. Insurers seeking to deny claims based on late notice should attempt to establish that an investigation would routinely have been done and potentially that investigation would have provided information necessary to the defense. If such evidence can be established, then the insurer will have an easier time in proving the late notice case.

In 1983, the First District in *Equity General Insurance Company v. Patis*[92] looked at a five-month delay. That case arose from an action for malpractice against an insurance broker. The broker allegedly failed to secure fire insurance for a building.[93] On February 19, 1980, the broker was aware of the loss and of the lack of coverage.[94] However, he did not notify his insurer of his errors and omissions until July 10, 1980, after suit was filed against him.[95] The broker offered no reason for the delay in providing notice.[96] The court's ruling foreshadowed the eventual result of the Illinois Supreme Court case, *Country Mutual Insurance Co. v. Livorsi Marine, Inc*.[97] in finding that the insurer need not establish prejudice in order to prevail on a late notice claim.[98] Nonetheless, the court still found that the late notice did prejudice the insurer.[99] The court also looked at the experience of the broker.[100] Given the court's ruling that prejudice does not matter, it appears that in this case the appellate court simply decided that five months' delay was too long as a matter of law. Although phrasing the opinion as being based on whether notice was reasonable, the finding that prejudice was irrelevant appears to point to a decision based simply on the time from occurrence to notice.

In 1988, the First District in *Brotherhood Mutual Insurance Co. v. Roseth*[101] again looked at notice. That case involved a shooting at a home.[102] The incident occurred on April 23, 1983, but was not reported to the insurer until April 25, 1985, which was two days after suit was filed.[103] Judged by the standards of *Patis*, the decision appeared to be clear. After all, far more than five months had gone by, and if an insurer was unable to conduct its investigation in five months, surely the passage of two years would cause prejudice. The two insureds, however, were the owners of the home.[104] They were both college graduates, with one being a graduate of Northwestern University's Business School, and as such, it would be difficult to establish that they were entirely unsophisticated in the ways of business or insurance.[105] Nonetheless, the court focused on the fact that the victim was a person with whom they had a close relationship and their belief that the insurance policy would not provide coverage.[106] Based on that relationship, the court decided that there was no reason to believe that suit might be filed.[107] As a result, the court believed that, because the insureds thought that no suit would be filed, and at the same time believed that if suit was filed, the policy would not provide coverage, the two-year delay was not unreasonable. In contrast to prior cases, the decision brought the focus squarely on the insured, without regard to the impact on the insurer.

In 1999, in *River v. Commercial Life Insurance*,[108] the United States Court of Appeals for the Seventh Circuit examined the issue of late notice and found that even a lengthy passage of time would not be an absolute bar to coverage. *River* involved a doctor's claim for disability benefits.[109] The doctor alleged that he bumped his head in 1980 and later began exhibiting psychiatric symptoms necessitating hospitalization.[110] In June 1985, the problems became worse, the doctor terminated his practice, and then submitted a disability claim.[111] The policy distinguished "sickness" and "injury."[112] "Sickness" provided seven years of benefits, while "injury" provided benefits for life.[113] In 1994, with the benefits running out, the doctor alleged that his condition resulted from the head bump of 1980, and as such, he was entitled to lifelong benefits due to "injury."[114] The policy of insurance required that written notice be provided within 20 days following a covered loss, or as soon as reasonably possible.[115]

In examining the issue of the timing of the notice, the court looked to four factors: a) the policy language; b) the sophistication of the insured; c) awareness by the insured of an occurrence; and d) the diligence in providing notice.[116] Not surprisingly, the court found that the 10-year delay was not reasonable.[117]

In 2000, the First District returned to the late notice issue in *Northbrook Property & Casualty Insurance Co. v. Applied Systems, Inc*.[118] That case involved a claim alleging

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copyright infringement.[119] The suit was filed in November 1992.[120] In March 1994, Applied Systems, Inc. tendered its defense to its insurers.[121] That notice indicated that Applied initially did not think that the loss fell under the policy terms and so had not tendered the defense sooner.[122]

According to the court, the primary focus in a late notice case is the insured's reason for delay.[123] The court looked to the four-point test noted above.[124] Examining the offered reason for delay – the belief that the loss would not be covered – the court found that the belief was unreasonable as a matter of law.[125] As a result, the court held that notice was not timely. Again, however, the court appeared to insert a subjective component into the analysis, by stating what a reasonable person might or might not believe as to the details of coverage in a complex matter.

In *Montgomery Ward and Company, Inc. v. Home Insurance Co.*,[126] the First District was faced with an eight-month delay in providing notice of an environmental loss. Interestingly, the court simply concluded that Montgomery Ward did not provide a sufficient excuse for delay and as such, without almost any analysis found that the notice was late.[127] It appears that the court simply put a time frame in mind and somewhat arbitrarily applied it to the case.

In 2006, after 32 years, the Illinois Supreme Court returned to the late notice issue in *Country Mutual Insurance Company v. Livorsi Marine, Inc.*,[128] which is the Illinois Supreme Court's most recent discussion of that matter. That case has been read by some (including the West headnotes, which are somewhat misleading) as abolishing prejudice to the insurer as a factor in deciding whether notice was timely. The actual opinion itself though explicitly concludes the opposite—that prejudice is in fact a factor in making the determination as to whether notice was reasonable. The opinion states for its holding:

> Accordingly, we hold that the presence or absence of prejudice to the insurer is one factor to consider when determining whether a policyholder has fulfilled any policy condition requiring reasonable notice. We also hold that once it is determined that the insurer did not receive reasonable notice of an occurrence or a lawsuit, the policyholder may not recover under the policy, regardless of whether the lack of reasonable notice prejudiced the insurer.[129]

As such, the court's ruling is that prejudice is to be considered, but that the lack of prejudice alone will not defeat a late notice defense.

Livorsi Marine involved a dispute over trademark violations (in a bizarre coincidence, both parties filed similar suits against each other and both had the same insurer and insurance producer).[130] The suits were filed on December 1, 1999, but notice was not provided until August 2001.[131] After Country Mutual denied both claims for untimely notice, both sides claimed that there was a lack of prejudice and as such, notice was timely.[132]

Initially, *Livorsi Marine* stated that the determination of whether notice was reasonable depends upon the facts and circumstances of each case.[133] The court examined the history of conflicting Illinois decisions on whether prejudice is required, and concluded that lack of prejudice to the insurer will not "dispense with the requirement of reasonable notice."[134] As noted above, however, prejudice to the insurer is one factor that will be looked at in determining whether notice was timely.[135]

In reaching its ruling, the court noted that the insureds were "sophisticated commercial parties who were represented by counsel from the inception."[136] The court did not specifically state that the sophistication of the insureds must be considered, but it did say that sophisticated insureds cannot raise the argument of the balance of power between insurer and insured.[137] The court pointedly did not address the issue of whether the other factors involved in the matter made notice reasonable or unreasonable, but simply addressed the issue of whether prejudice must be proven.[138] As a result, the decision leaves unanswered what standards, other than prejudice, should be applied and whether a black-line rule should ever be applied.

Approximately 18 months later, in *IMC Global v. Continental Insurance Co.*,[139] the First District examined the issue of late notice in light of *Livorsi Marine*. In that case, there was a 13-month delay in providing notice of the first suit and a six-month delay in providing notice of 907 additional suits.[140] Apparently, the Director of Risk Management inadvertently had sent the suits to the wrong insurer.[141] The court ruled that the time was too long and that the insured's own mistake in providing notice will not excuse a delay.[142] In so ruling, the court seemed to indicate that a six-month delay, without excuse, will bar coverage.

Finally, in *Yorkville National Bank*, the appellate court rejected the insured's claim that notice was properly provided to the insurer's apparent agent and instead looked at the 27 months from the time of the occurrence until the time that written notice was received.[143] Focusing on the fact that dis-

covery was closed and that trial was eight weeks away at the time of notice, the court found that the delay was too long. Interestingly, the court did not consider the fact that the insured thought it could provide notice to the broker as any sort of mitigating factor.[144]

Illinois courts have made clear that where the facts regarding notice are undisputed, the question of whether notice was timely may be decided as a matter of law.[145] Nonetheless, despite litigation of the issue over the past 40 years, the standards to be applied still seem somewhat arbitrary. The Illinois Supreme Court has ruled that prejudice is not necessary, but that it may be a factor. No case has ever put a line in the sand and declared: "Once this period of time has passed, notice is improper." The analysis must proceed on a case by case basis, with the decisions of the court potentially somewhat random.

Despite the lack of a black-line rule, insurers still can protect themselves. Although the particular issue has not been litigated, it seems that if insurers internally have triggers for late notice defenses, then those internal triggers might be found to have relevance. For instance, if an insurer was to decide that, after four months, notice was presumed to be late, then the insurer would be in a position to make an argument such as "this case was passed through our internal standards, and the insured provided no reason that our usual standards should not apply." In litigating these matters, the representatives of the insurers often are not able to address that question, that is, why was notice on this case found to be late, while the insurer did not seek to deny coverage in cases with similar timing.

Further, the insurer should put in place standard procedures for investigating claims (see below for a further discussion of this matter), and thus, should be able to make an argument such as the following: "Within one week of notice, we attempt to contact all witnesses in order to obtain accounts of the incident while memories are fresh, and we do so for the reason that we recognize that memories fail with time." Those sorts of standards would enable the insurer to better establish that prejudice existed. As the Illinois Supreme Court has ruled that prejudice is not required to determine the timeliness of a notice, but rather is a factor, any steps taken to establish prejudice would be to the benefit of the insurer.

Finally, the worst thing that an insurer could do is to have no set procedures or standards. In that situation, the insurer would not be able to establish anything objectively, and consequently, would be at the mercy of whether a judge's subjective analysis of the insured's conduct warranted a denial of coverage.

II. The Duty to Investigate, Spoliation, and Using Extrinsic Evidence to Deny Coverage

After analyzing whether notice was proper, the insurer needs to look at its duties both to investigate the claim and to prevent the loss of evidence. In addition, insurers should be aware of what evidence can be obtained during the investigation that can enable it to deny coverage.[146] An insurer's right to use extrinsic evidence is still somewhat at issue in Illinois. Nonetheless, insurers should be aware of that potential during the initial claim evaluation.

A. The Duty to Investigate

An insurer is obligated to investigate a claim before denying it. As described below, the scope of an insurer's investigation is a factor to be considered in determining whether an insurer acted in bad faith in denying a claim. Further, in any construction litigation involving additional insureds, the insurer should promptly obtain a copy of the construction contract. Construction contracts have been held to be admissible in determining whether there was a duty to defend an additional insured.

O'Neill v. Gallant Insurance Company[147] provides an outstanding example of how not to handle a claim.[148] That matter arose from an unusual set of circumstances. The insured drove her vehicle into a parking lot and had her two-year-old granddaughter with her. That child was not properly restrained. Rather than being placed in a harnessed child seat, the child was unrestrained in a booster seat. The insured got out of the car to talk to friends, leaving the child in the car, the keys in the ignition, and the engine running. The child jumped into the front seat, put the car in gear, and caused catastrophic injuries to a person in the parking lot.[149] Gallant's policy limit was only $20,000.00. Counsel for the plaintiff demanded the full policy limit in exchange for a full release, but Gallant repeatedly ignored or refused the demand until just weeks before trial.[150]

The plaintiff's allegations against the insured included the allegation that the insured failed to use a proper child restraint system. As such, according to the court, that booster seat was a critical piece of evidence. Nonetheless, Gallant took no steps to inspect the seat or to have it preserved.[151] Further, during the litigation, defense counsel recommended deposing thirteen witnesses. The insurer gave permission to depose only two.[152]

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A verdict in excess of the policy limits was entered at trial. Following trial, the insured assigned her rights against Gallant to the plaintiff. The result of that claim was a verdict that included punitive damages. The court, based upon those facts, found that the plaintiff was entitled to punitive damages for the bad faith claims handling.[153] The court found that the lack of investigation was a factor to be considered in making that determination as to bad faith and as to punitive damages.[154]

However, there is authority to suggest that the duty to investigate is not universal and, in particular, would not apply to excess carriers that have no duty to defend. *North River Insurance v. Grinnell Mutual Insurance*[155] involved the question of an excess insurer's obligations. That case noted that where the excess insurer was not obligated by policy terms to either investigate or defend, it could not be estopped from denying coverage on the basis of failing to do either.[156]

B. Duty to Preserve Evidence and Spoliation

Illinois imposed a duty on both parties and their insurers to retain evidence that might be relevant to litigation. In 1995, in *Boyd v. Travelers Insurance Company*,[157] the Illinois Supreme Court first recognized "spoliation of evidence" as an independent cause of action. In *Boyd*, the plaintiff allegedly sustained injuries due to a defective heater. His wife provided that heater to two employees of Travelers, who claimed to need it for testing. The heater was later lost. The plaintiff alleged that, due to the loss of the heater, the plaintiff could not pursue a product liability action.[158]

In 2004, the Illinois Supreme Court returned to the topic in *Dardeen v. Kuehling*.[159] That case arose from an accident in which a newspaper carrier fell, allegedly due to defective bricks in a sidewalk in front of a home. After learning of the accident, the insured contacted her insurance broker, advised that the bricks might pose a risk to others, and asked if she could remove them. The insurance producer advised that she could. That same day, the plaintiff returned to the scene, but did not photograph the bricks. A few days later, the defendant removed them.[160] Subsequently, the injured party sued State Farm alleging spoliation of evidence.

The Illinois Supreme Court rejected the claim. According to the Court, there is a two-prong test for spoliation claims. First, the court must determine "whether such a duty arises by agreement, contract, statute, special circumstance, or voluntary undertaking."[161] If such a duty arises, then the court must "determine whether that duty extends to the evidence at issue – i.e., whether a reasonable person should have foreseen that the evidence was material to a potential civil action."[162]

In *Dardeen*, the plaintiff had no contractual relation with State Farm which would have obligated State Farm to preserve the evidence.[163] Further, as the plaintiff never contacted State Farm to request that evidenced be preserved, there was no special relationship that would impose such a duty.[164]

The bottom line should remain, however, that although potentially there may be ways to defeat a spoliation claim, defendants and their insurers should err on the side of caution. Evidence gathered should be retained and documented. Doing so would be the best way to prevent a claim for spoliation of evidence.

C. Evidence Beyond the Four Corners of the Complaint and Its Impact on Coverage

In addition to avoiding bad faith and to preserving evidence for trial, there is an additional incentive for insurers to conduct an early and thorough investigation of claims. Despite the fact that the four corners rule is still allegedly the law of the land, there is authority for the proposition that extrinsic evidence may be used to either expand or potentially defeat coverage.

The general provisions of the four corners rule were stated by the Illinois Supreme Court in *Employers Mutual Insurance of Wausau v. Ehlco Liquidating Trust*:[165]

> Illinois law is well established that where an underlying complaint alleges facts within or potentially within policy coverage, "the insurer is obliged to defend its insured even if the allegations are groundless, false, or fraudulent." . . . The insurer may not refuse to defend "unless it is *clear* from the face of the underlying complaint[] that the allegations fail to state facts which bring the case within, or potentially within, the policy's coverage." (Emphasis in original.) . . . The underlying complaint and the policy must be construed in favor of the insured, with all doubts resolved in the insured's favor.[166]

Despite those seemingly clear rules, Illinois appellate courts often will venture beyond the four corners of the complaint and the policy of insurance.

Illinois law remains in flux as to the matter of whether, in addition to considering the complaint, third-party complaints may be considered. Between 2002 and 2009, the Illi-

nois Appellate Court has bounced from ruling that third-party complaints should not be considered to ruling that they should be considered, and then to ruling that they should not. For reasons stated below, it appears that no black line rule is going to exist, unless and until the Illinois Supreme Court declares one. Instead, courts likely will continue to look at whether the party filing the pleading had an incentive to do so in order to create allegations regarding coverage. Where it appears that coverage matters might have motivated the allegations, the pleading will not be considered.

In 2002, the Illinois Appellate Court Second District examined the issue in *National Union Fire Insurance Co. v. R. Olson Construction Contractors, Inc*.[167] In that case, National Union Fire Insurance Co. ("National Union") insured a policy in which a subcontractor was the named insured and another contractor was an additional insured for work arising out of the subcontractor's work.[168] An employee of that subcontractor was injured and filed suit against the contractor. The contractor tendered the defense to National Union, which denied the tender. The contractor also filed a third-party complaint for contribution against the named insured subcontractor.[169]

In the declaratory action, National Union argued that the additional insured contractor could be found liable for its own negligence only and not for that of the named insured subcontractor. The policy excluded coverage for the contractor's own liability.[170] The contractor argued that, because employees cannot sue their own employers, the complaints filed by employees are not likely to make allegations against their employers. The court rejected the contractor's argument, and found that the court must look to the allegations of the complaint only.[171] Basically, the court declared the rule is the rule, and in the absence of "some unusual or compelling circumstances," it should be followed.[172] The court did not state any reasons either from the insurance policy or from public policy in support of its declaration, but effectively just declared that a rule is a rule and should be blindly followed.

In 2008, the First District reviewed the issue in *American Economy Insurance Co. v. Holabird & Root.*[173] In that case, the court reached a contrary result, ruling that the allegations of the third-party complaint should be considered. In that case, a general contractor, Holabird & Root (H&R), sought coverage under the additional insured endorsement of a policy issued to an electrical subcontractor, Metrick Electric Co. ("Metrick"), for injuries arising from exposure to improper lighting. The additional insured endorsement provided coverage "'but only with respect to liability arising out of "your work" for [H&R] by or for [Metrick.]'" The complaint, however, did not mention Metrick, and the project owner, DePaul University, filed a third-party complaint against Metrick. H&R sought to rely upon the third-party complaint in arguing for status as an additional insured under Metrick's policy. The court allowed consideration of the third-party complaint, ruling:

> [W]e conclude that consideration of a third-party complaint in determining a duty to defend is in line with the general rule that a trial court may consider evidence beyond the underlying complaint if in doing so the trial court does not determine an issue critical to the underlying action ....[174]

American Economy Insurance Co. v. DePaul University,[175] is a companion case to *Holabird and Root*. In that case, DePaul University sought coverage and also sought to rely upon the third-party complaint that it had filed against Metrick.[176] The court evaluated the same set of facts as it did in *Holabird and Root.* The court, however, noted that the third-party complaint was filed by the party seeking coverage, and implicitly admitted that the pleading should be viewed with some suspicion.[177] Nonetheless, the court concluded that there was enough evidence to find a duty to defend.[178]

A year later, in *National Fire Insurance of Hartford v. Walsh Construction Co*.,[179] the First District returned to the issue and concluded that the third-party complaint filed by the party seeking coverage was unreliable, and as such, refused to consider it. The court noted that there was nothing that could be stated in that pleading that could not be otherwise argued in the declaratory proceeding. Further, the court noted that the pleading was filed after the filing of the declaratory matter. Consequently, it was not to be considered.[180]

In addition to considering pleadings, there are other exceptions to the four corners rule. Chief among them is an exception known as the "true but unpleaded facts doctrine." That doctrine made its first official appearance in 1979 in *Associated Indemnity Co. v. Insurance Co. of North America*, decided by the First District.[181] That case involved an accident in which an automobile struck a pedestrian.[182] At the time of the filing of suit by the pedestrian, the insurer knew of true but unpleaded facts showing that the accident was potentially within the coverage.[183]

According to the court, the fact that the complaint may

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not provide detail to bring the matter within coverage is not relevant where the insurer is aware of true but unpleaded facts that, taking into consideration the matters in the complaint, would show a duty to defend.[184] According to the court, "[t]o hold otherwise would allow the insurer to construct a formal fortress of the third party's pleadings and to retreat behind its walls, thereby successfully ignoring" facts that would indicate a duty to provide coverage.[185] The court, however, refused to rule on the scenario of where the true but unpleaded facts actually conflicted with those alleged in the complaint.[186]

According to the court, where an insurer files a complaint for declaratory judgment, "it may properly challenge the existence of . . . a duty to defend by offering evidence to prove that the insured's actions fell within the limitations of the policy's exclusions." The only exception is where the evidence is crucial to a matter at issue in the underlying litigation.

The following year, in *LaRotunda v. Royal Globe Insurance Co.*,[187] the First District was asked to rule on whether there is coverage where the insurer's own investigation uncovers facts supporting coverage. In that case, it was alleged that smoke from a fire was the cause of an automobile accident.[188] The property was owned by the insured, and Royal Globe Insurance Co. ("Royal Globe") issued a homeowners policy.[189] The land in question contained a junk yard and a waste dump, but was partially empty.[190]

The policy of insurance included an exclusion for businesses. Royal Globe's investigation, however, revealed that the fire might have started from an area of the land that was vacant.[191] The court ruled that, in making the determination as to the duty to defend, the insurer should have relied upon its own investigation, which disclosed the potential for coverage.[192]

In 1983, in *Fidelity & Casualty Co. of New York v. Envirodyne Engineers, Inc.*,[193] the First District again looked at the issue of extrinsic evidence and found that, in some circumstances, extrinsic evidence can be used to deny coverage. That case arose from a construction accident. Envirodyne Engineers, Inc. ("Envirodyne") was the project's consulting engineer. It was insured by Fidelity & Casualty Co. of New York, under a policy that included an exclusion for damages resulting from the failure to render any professional services.[194] The trial court examined the Envirodyne contract with the Illinois State Toll Highway Authority, concluded that Envirodyne's role was limited to that of consulting engineer, and found that the exclusion applied. On appeal, Envirodyne alleged that the court should not have gone beyond the four corners of the complaint and should not have considered the contract.[195]

The court found no support for Envirodyne's contention that the court may not look beyond the complaint. According to the court, where an insurer files a complaint for declaratory judgment, "it may properly challenge the existence of . . . a duty to defend by offering evidence to prove that the insured's actions fell within the limitations of the policy's exclusions."[196] The only exception is where the evidence is crucial to a matter at issue in the underlying litigation.[197] With its decision, the court issued the broadest rule allowing a court to consider extrinsic evidence in making the determination as to the duty to defend.

In 1989 in *Millers Mutual v. Ainsworth Seed Co.*,[198] the Illinois Appellate Court Fourth District reiterated the rule that extrinsic evidence may be used to defeat coverage, except where the evidence bears on the underlying litigation. In that case, for reasons that are not clear, an employee of an alleged insured prepared an affidavit regarding some of the allegations of the underlying complaint. That affidavit, however, allegedly also established that the loss fell within the completed operations exclusion of the policy.[199] According to the court, that affidavit could be considered in analyzing the duty to defend.[200] Thus, the court appears to have carved out an exception to the exception, albeit without well-defined parameters.

In 1995, in *Oakley Transport, Inc. v. Zurich Insurance Co.*,[201] the First District strongly suggested that findings by the trial court in the underlying litigation should not be con-

sidered in evaluating the duty to defend. In a hearing on summary judgment in a declaratory matter, the trial court asked counsel about an order of partial summary judgment in the underlying case.[202] The appellate court ruled that such facts were not relevant to the duty to defend, but also ruled that there were other grounds to support the trial court's ruling.[203]

In 1996, the First District, in *Transcontinental Insurance Co. v. National Union Fire Insurance Company of Pittsburgh*,[204] again looked at the issue of what sort of extrinsic evidence may be admissible in analyzing a duty to defend. That case was a routine construction insurance dispute, arising from an accident in which an employee of a subcontractor on the project sustained injuries due to a scaffolding collapse.[205] Transcontinental Insurance Co. ("Transcontinental") insured the contractor, while National Union Fire Insurance Company of Pittsburgh ("National Union Pittsburgh") insured a subcontractor.[206] The contractor tender its defense to National Union Pittsburgh, claiming that it qualified as an additional insured under the subcontractor's policy, but National Union Pittsburgh denied that tender.[207] Subsequently, Transcontinental sought a declaration that National Union Pittsburgh was obligated to defend and further sought reimbursement for sums spent defending the contractor.[208]

The case involved the interpretation of a blanket additional insured endorsement, which provided coverage as an additional insured to "anyone for whom you have agreed prior to the loss to provide insurance, but only as respect [*sic*] liability arising out of your premises or 'your work'."[209] The contract itself required the subcontractor to obtain certain insurance policies and to keep them in effect. It also included an indemnification provision. There was no express term in the contract that required the subcontractor to name the general as an additional insured, however.[210] In reaching its decision, the court examined that contract and ruled on whether the provision was valid under Illinois law. In finding that the indemnity provision violated an Illinois statute, the court made clear that such evidence and such analysis were relevant to the duty to defend.[211]

Courts, however, have placed limitations on the use of such evidence. In 2001, the Second District in *Shrivers Insurance Agency v. Utica Mutual Insurance Co.*,[212] was faced with a claim by an insurance producer against its errors and omissions (E&O) carrier. The E&O policy contained an exclusion for claims arising form "any liability for money received by an insured or credited to an insured for fees, premiums, taxes . . . ."[213] In support of its claim for coverage, Shriver Insurance Agency had provided the affidavit of its president to the insurer.[214]

Initially, the court ruled that, comparing the allegations of the complaint to the policy, the clear and unambiguous exclusion applied.[215] Shriver argued that the affidavit of its president should be considered. The court rejected that argument. According to the court, where the insured supplied the only extraneous evidence, and the insurer had no information to support the information provided the insured, that extraneous evidence should not be considered in determining the duty to defend.[216]

In *Cincinnati Insurance Co. v. River City Construction Co.*,[217] the Third District expanded the use of extrinsic evidence to allow its use to determine whether an insurance policy term might have latent ambiguities. That evidence must have some indicia of reliability. The evidence must be "objective" and must be able to be supplied by a disinterested third party.[218]

In 2008, the First District in *Clarendon America Insurance Co. v. B.G.K. Security Services, Inc.*[219] returned to the issue of the admissibility of extrinsic evidence to deny coverage. That case arose from a fire in Chicago that caused death and injuries to multiple persons. In ruling on the duty to defend, the trial court refused to consider an agreement between B.G.K. and another party.[220] The appellate court ruled that the agreement would determine an underlying fact and likewise refused to consider it.[221]

Several important considerations for analyzing a duty to defend arise from the cases discussed above. In analyzing a claim for a duty to defend, the claims personnel should make every effort to obtain documents that might impact coverage. The following are the very basics. Not all of them will necessarily be admissible in an action to deny coverage, but under certain circumstances they might be, and as such, they should be obtained:

1. The complaint, any answers, any affirmative defenses, and any counterclaims or third party claims from the underlying claim;
2. Any construction contracts, including the full contract entered into by the general contractor and by the relevant subcontractor;
3. Project records showing the scope of the subcontractor's work and the dates and locations of that work; and
4. Any other records that might provide grounds for denial of coverage.

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With those records in hand, the claims professional and the attorneys will be in a better position to evaluate coverage and respond to or make any tenders of defense.

In addition, in order to prepare a defense, the claims professional must indentify and protect any evidence in the control of the insurer or the insured that might impact either the claim or the defense. Finally, wherever there is a potential for bad faith, the claims professional must make sure that the investigation is thorough and complete, in order to potentially defend a claim for bad faith in the event of an adverse verdict.

III. Reaching the Decision: How Not to Lose Coverage Defenses Through Estoppel or Bad Faith

A. Estoppel for Failing to Defend

It is becoming increasingly common for parties seeking coverage to tack "estoppel" and "vexatious delay" counts on to any complaint seeking coverage or responding to a coverage denial. Illinois courts have been reluctant to create strong and fast rules as to when an insurer has been estopped from denying coverage. As Judge Learned Hand wrote in another context, "It is quite impossible to establish any rule from the decided cases; we must step from tuft to tuft across the morass."[222] The result has been that judges in Cook County's chancery court have been reluctant to dismiss any claims of estoppel, which potentially could lead to lengthy and costly discovery battles.

The walk across that morass should start with the Illinois Supreme Court's 1999 decision in *Employers Mutual Insurance of Wausau v. Ehlco Liquidating Trust.*[223] That case involved two disputes over insurance coverage for environmental property damage.[224] The dispute first involved an Arkansas site. On March 18, 1982, the United States Environmental Protection Agency ("EPA") advised the insured that it might be responsible for contamination on that site. On that same day, the insured tendered the defense of one claim to Employers Mutual Insurance of Wausau (Wausau). On March 29, 1982, Wausau denied the tender and refused to defend. On August 2, 1982, and on March 8, 1983, the insured again requested a defense.[225] On March 17, 1988, the EPA filed suit against the insured. Shortly thereafter, the insured agreed to certain damages.[226]

The second dispute involved a Wyoming site. In 1981, the State of Wyoming sued Union Pacific for environmental damage. In December 1991, Union Pacific sued the insured under an indemnification agreement for that site. In January 1992, the insured tendered the matter to Wausau. That company acknowledged the tender but took no other action.[227] In June 1992, the insured advised Wausau of a settlement offer by Union Pacific. Wausau offered to pay 9% of the settlement and 9% of the defense cots. The insured rejected the offer and settled the matter directly.[228]

In June 1993, with both underlying suits concluded, Wausau filed suit in the Circuit Court of Cook County seeking a declaration that it had no duty to defend or indemnify the insured for the two sites. The insured filed a counterclaim seeking a declaration that Wausau was obligated to defend and indemnify. The circuit court found that Wausau was estopped from asserting defenses to coverage.[229]

Initially, the appellate court found that there was a question of fact as to whether Wausau ever had notice of the lawsuit in the Arkansas claim, and as such remanded the matter.[230] The court then went on to discuss the application of estoppel to both sites. According to the doctrine of estoppel, an insurer that breaches the duty to defend is estopped from raising defenses to coverage.[231] An insurer may not simply refuse to defend. Instead, stating well-settled law, the court ruled that an insurer seeking to deny coverage for late notice should either defend the insured or litigate the matter by means of a declaratory action.[232] What the insurer cannot do is "simply abandon its insured."[233] If the court finds that the insurer "wrongfully denied coverage, the insurer is estopped from raising policy defenses to coverage."[234] The court pointed out that the doctrine of estoppel applies only when there has been a breach of the duty to defend.[235] The court listed particular circumstances where a denial of the duty to defend might be proper, including where the insurer was not given the opportunity to defend; where there was no insurance policy in existence; and where examining the policy and the complaint reveals "there clearly was no coverage or potential for coverage."[236] The court ruled that a late notice defense does not create an exception to that rule that requires an insurer either to defend or to seek a declaration as to coverage.[237] The Supreme Court remanded the matter to determine if there had been a beach of the duty to defend.

That decision left many questions unsettled and there remains some confusion to date. In particular, the questions arise as to how quickly the insurer must act in order to preserve coverage defenses, as well as in what circumstances an insurer can deny the duty to defend without filing a complaint for declaratory relief.

In 2001, in *Korte Construction Co. v. American States Insurance*,[238] the Illinois Appellate Court Fifth District began the process of sorting out the answers to some of the matters of *Ehlco Liquidating Trust.* In *Korte Construction*, the underlying complaint was filed December 8, 1997.[239] More than a year later, on December 31, 1998, Korte Construction Co. ("Korte") sought a declaratory judgment that American States Insurance ("American States") was required to defend and indemnify it for the pending action.[240] Korte alleged that it was an additional insured under a policy that American States issued to another party.[241] American States responded to that complaint by asserting the affirmative defense that its coverage was excess only and that the accident did not arise from the work of its insured.[242] The court ruled that the insurer must take some action within a reasonable time of the demand for defense.[243] The court found that the one-year delay was too long, and as such found that the insurer was estopped from denying coverage.[244] The court, however, noted that if the purported insured files suit for declaratory judgment, the insurer need not also file suit. The court left open the issue of whether the method used by the insurer, if it had been timely, would have been a sufficient means to contest coverage (that is, whether the proper method could be an answer, affirmative, or counter-claim).[245] Finally, it is important to note that the court did not give a reason for finding that the one-year delay was too long, and did not provide any real guidance to insurers to determine what the appropriate time might be to get the declaratory action on file.

In 2002, in *West American Insurance Company v. J.R. Construction Co.*,[246] the First District fleshed out a bit about what may be considered in determining whether the duty to defend had been breached. In that case, J.R. Construction Co. tendered the defense of a personal injury suit to West American on October 23, 1997.[247] On November 14, 1997, West American acknowledged in writing that J.R. Construction Co. was listed as an additional insured under the subject policy. West American, however, claimed that its coverage was excess only.[248] For approximately the next two years, West American did nothing while waiting for another insurer to assume the defense. On August 25, 1999, West American filed a declaratory judgment action, claiming that there was no written contract obligating West American to provide coverage and, further, that the accident did not arise out of the work of its insured.[249]

Initially, the court evaluated the duty to defend, finding that there was additional insured status based in part on a certificate of insurance that was issued and in part on letters and internal memos from West American on the issue.[250] In reaching that determination, the court found that the 21.5 months from the time of notice until the time of the filing of the declaratory judgment was unreasonable.[251] As such, West American was estopped from raising coverage exclusions in order to deny coverage.[252] Thus, apparently the rule is that in evaluating the duty to defend to determine if the insurer is estopped, the policy does not include any exclusions. It is not clear why certain parts of the policy are included in that determination, but exclusions are not. Why should a court consider an endorsement, but not an exclusion? The policy is made up of grants of coverage, definitions, endorsements, and exclusions. All work together to produce a document granting coverage to certain losses. Nonetheless, Illinois courts have chosen to read only part of that document in making the determination.

Why should a court consider an endorsement, but not an exclusion? The policy is made up of grants of coverage, definitions, endorsements, and exclusions. All work together to produce a document granting coverage to certain losses.

In 2003, in *Illinois EMCASCO Insurance Co. v. Northwestern National Casualty Co.*,[253] the First District returned to the issue of the duty to defend. That case also involved a tender by a construction company to the insurer for a subcontractor, alleging that the construction company was an additional insured under the sub-contractor's policy.[254] Northwestern National Casualty Co. ("Northwestern National") denied the tender on the basis that its coverage applied to imputed negligence only.[255] Illinois EMCASCO Insurance Co. (Illinois EMCASCO), the carrier for the contractor, ac-

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cepted the defense and filed suit against Northwestern National, alleging that Northwestern National had breached its contract by refusing to defend.[256]

Initially, the court found that there is a duty to defend "any complaint that leaves open the possibility of coverage." Because the underlying complaint did not preclude coverage, Northwestern National was obligated to defend.[257] The court remanded the case for "further proceedings." The court, however, also found that by refusing to defend, the insurer was estopped from raising any defenses to coverage, particularly the defense that coverage was provided only where liability was imputed.[258] The court did not state the time from the date of tender until Illinois EMCASCO filed suit was too long. Instead, the court stated that simply because there was a refusal, the insurer was estopped.[259] Needless to say, if followed, the decision would be problematic for any insurer. Seemingly, the only way to avoid estoppel would be for an immediate declaratory action, along with the denial letter.

In 2006, the Illinois Appellate Court Second District, in *State Automobile Mutual Insurance Co. v. Kingsport Development, LLC*,[260] backed away from the strict rule of *Illinois EMCASCO Insurance Co.* In *Kingsport Development*, the court was faced with a situation where the delay between the notice and the complaint for declaratory relief was seven months long.[261] The question for the court was whether the complaint for declaratory judgment was filed within a reasonable time.[262] The court ruled:

> We conclude that State Auto's seven-month delay in seeking a declaratory judgment was not unreasonable, especially in light of the fact that the Halek action was still ongoing at the time Kingsport and State Auto filed their appellate briefs in this case. See *Westchester Fire Insurance Co.*, [citation deleted] (declaratory judgment action, which was filed 6 months after insurer received notice of the underlying suit and 15 months before that suit was settled, was timely); see also *Employers Reinsurance Corp.*, [citation deleted] (15-month delay in filing declaratory judgment action not unreasonable where insurer previously denied coverage and filed action only three months after insureds actually sought coverage, and underlying action remained unresolved).[263]

No Illinois case has found estoppel or bad faith on anything close to the facts presented in the *Kingsport Development* case. In *Employers Mutual Insurance of Wausau,* the time from notice to the filing of the declaratory judgment was approximately five years for one claim and over one year for the other. In *Insurance Company of the State of Pennsylvania v. Protective Insurance Company*,[264] the time from proper notice to the filing of the declaratory judgment action was nearly two years. In *Shell Oil Company v. AC&S, Inc*.,[265] estoppel was found as to indemnity due to the fact that even after the trial court hearing the declaratory judgment found a duty to defend, the insurer still refused to defend. In *Korte Construction Company v. American States Insurance Co.*,[266] the delay from the filing of the underlying case to the filing of the declaratory judgment was over one year.

At times, of course, the purported insured files the complaint for declaratory relief prior to the time that the insurer files. There is some authority that if the party seeking coverage files suit seeking declaratory judgment before the insurer files, the insurer must still take some action to deny the claim. In *County of Massac v. United States Fidelity and Guaranty Co.*,[267] the Fifth District held that simply filing a motion to dismiss was not enough to deny the claim and thus the insurance company was estopped from asserting its defenses. As a result, an insurer facing a declaratory action should file a pleading denying coverage.

As noted above, the law regarding whether a complaint for declaratory relief has been timely filed remains confusing. Courts do seem to make up the rules as they go along. In Cook County, the courts tend to lean towards ruling that estoppel claims state a cause of action even if the time frame is as little as six months. As a result, it would be good practice for insurers to attempt, where possible, to file declaratory actions within three to four months after receiving notice. It can be difficult to file that quickly, particularly where coverage is being sought for additional insureds, but nonetheless doing so would create a better chance of avoiding estoppel.

B. The Reservation of Rights Letter: What Must It Contain?

Considering that courts go into great detail about waiver and estoppel, there has been comparatively little discussion by Illinois courts as to what the reservation of rights letter must contain. Under Illinois law, the reservation of rights letter must make specific reference to the policy defenses being asserted and to any potential conflict of interest.[268] The letter must be clear and unequivocal in its reservation of rights, and *Royal Insurance Co. v. Process Design Associates, Inc.*[269] includes a nice description of what not to do with a reservation of rights letter. That case involved a dispute over the

duty to defend an engineering firm.[270] The defense of that firm was tendered to Royal Insurance Co. ("Royal"), which responded with a letter stating that should the complaint be amended to include allegations of professional negligence or should a third party complaint be filed "'there *may* be a question as to whether or not [Royal] would continue with the defense.'"[271] Royal advised the company to put its professional liability carrier on notice.[272] The letter did not state that there was any potential conflict. Three years later, after discovery proceeded, Royal again wrote to the insured, and in that letter stated that the conduct of the insured fell within the policy's exclusions.[273] More than a year later, and approximately four-and-a-half years after the first letter from it, Royal filed a complaint seeking to deny coverage.[274]

The appellate court ruled that the reservation of rights must be specific and must adequately inform the insured of the rights the insurer intends to reserve so that the insured can intelligently choose between retaining its own counsel or accepting counsel offered by the insurer.[275] According to the court, Royal's letter did not clearly and unequivocally advise the insured of the intention to reserve rights. Moreover, it advised of contingencies that never occurred, and despite the fact that those contingencies did not occur, the insurer still sought to deny coverage.[276] According to the court, the letter served only as a warning. As such, it did not serve as a reservation of rights.[277]

The standard applied in *Royal Insurance Co.* is a bit abstract. Stating, "if this happens, we may do this," apparently is not sufficient to reserve rights. The standard almost seems to focus as much on the grammar as on the underlying content. Although the statement, "if this happens, we *will* pull the defense," would seem to meet the standard, the statement, "if this happens, we *may* pull the defense," would not.

In 2008, the Illinois Appellate Court cast additional light on the issue. In *Stonebridge Development Co., Inc. v. Essex Insurance Co.*,[278] the court reiterated that the reservation of rights must "adequately" inform the insured that it is proceeding under a reservation of rights.[279] Obviously, if there is a potential conflict of interest with regard to the defense, that conflict must be stated in the reservation of rights letter.[280]

The court in *Stonebridge Development Co., Inc.* found that the contents of the reservation of rights letter might be considered in determining whether the insurer had a conflict of interest.[281] That case involved a claim for defective construction.[282] The insurer defended under a reservation of rights, asserting that there was a question as to whether the underlying complaint alleged property damage arising out of an occurrence.[283] It further asserted that any claims for breach of contract would not be covered.[284] The underlying complaint asserted two different theories of liability. According to the insured, the reservation of rights letter distinguished between those two theories, and thus a conflict existed. The court rejected that argument, finding that the reservation of rights letter focused on whether there was property damage from an occurrence, and not on whether the claim was stated under one count as opposed to another.[285]

The lesson from those cases is that insurers should err on the side of being more specific rather than less. The reservation of rights should set forth every defense known in detail, and should be definite in stating the insurer may deny coverage on those policy defenses.

C. Was the Conduct Vexatious and Unreasonable?

Finally, § 155 of the Illinois Code of Insurance provides harsh penalties for conduct by insurers deemed to be vexatious and unreasonable.[286] That section provides the following penalty for conduct deemed to be vexatious and unreasonable:

> [A]n amount not to exceed any one of the following amounts:
>
> (a) 60% of the amount which the court or jury finds such party is entitled to recover against the company, exclusive of all costs;
>
> (b) $60,000;
>
> (c) the excess of the amount which the court or jury finds such party is entitled to recover, exclusive of costs, over the amount, if any, which the company offered to pay in settlement of the claim prior to the action.[287]

Courts looking at the section have examined whether the insurer deliberately delayed refusal to provide coverage and whether any refusal to provide coverage was due to a bona fide dispute. *McGee v. State Farm Fire & Casualty Co.*[288] provides a nice example of the issues presented in litigating the issue. That case involved a claim over a home damaged by fire.[289] Suit was filed, and eventually, pursuant to the policy, two appraisers and an umpire were selected to evaluate the damages.[290] They eventually agreed to an award that more than doubled what the insurer initially had offered to pay.[291]

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The insurer sought to pay the full amount and have the case dismissed.[292] Despite the offer to pay, Todd McGee filed an amended complaint under Section 155, claiming that the insurer had acted in a manner that was vexatious and unreasonable. That amended complaint listed 23 alleged facts supporting the claim.[293] In response, the insurer claimed that, because it discharged the liability through payment, it could not be liable under §155 for proceeding in bad faith. In addition, it blamed any delays on the plaintiff.[294]

According the court, the purpose of §155 was to provide a remedy when an insurer wrongfully withholds payment.[295] The "key question in a §155 claim is whether an insurer's conduct is vexatious and unreasonable."[296] Although the insurer is not liable merely for failing to settle a claim, the insurer is liable if it failed to establish a bona fide defense.[297] In evaluating the matter, factors include whether the insured was forced to sue, the insurer's attitude, and whether the insured was deprived of the use of property.[298]

In order to determine whether a claim was presented, the court in *McGee* looked at the allegations only.[299] The court found significant the following:

1. The insurer refused to provide its insured a copy of the policy, and misled the insured about the contents of the policy;
2. The insured relied upon the insurer in hiring an investigator, and a subsequent dispute with that investigator delayed resolving the claim;
3. The insurer investigated inadequately and refused to negotiate in good faith;
4. The insurer demanded that the claim be submitted to appraisers but then delayed approving selection of an umpire;
5. The insurer continued to delay even after the appraisal process.[300]

The court found those facts sufficient to support a §155 bad faith claim.[301] Importantly, the court noted that payment alone cannot defeat a §155 claim.[302] Nor could a §155 claim be defeated by simply demanding that all procedures be followed.[303] When an insurer demands that all procedures be followed and refuses to evaluate, investigate, or even discuss a claim, then there may be a violation of §155.[304]

In February 2010, the First District in *Uhlich Children's Advantage Network v. National Union Fire Company of Pittsburgh*[305] discussed the standards for a §155 claim. That case involved an insurer's denial of a claim based on allegations that the loss did not occur during the policy period and that proper notice was not provided. The court reiterated that, where there is a bona fide dispute over coverage, there can be no §155 claim. In that case, there was an issue of whether the insurer received notice in writing in compliance with the policy. Therefore, the court found that §155 sanctions were not appropriate.

In order to prevent a §155 claim, the insurer must do the basics correctly. All contacts with the insured should be documented. If the insured requests a copy of the policy, it should be provided. Any reasons for denial or delays should be well documented. In short, the way to avoid a bad faith claim for vexatious and unreasonable delay is to deny claims properly, and not vexatiously or unreasonably.

IV. Conclusion

Claims should be won on the merits. The best way to get to the merits of a claim is by making sure that initial claims handling is done properly. Insurers need policies and procedures in place so that they can prevail on notice claims. Insurers need to understand their obligation to investigate claims, and also should be aware of the potential use of extrinsic evidence to deny claims. Finally, the response to any claim or tender should be timely and complete so that defenses can be asserted. Doing so will best allow an insurer to prevail on all the defenses available.

(Endnotes)

[1] *State Security Ins. Co. v. Burgos*, 145 Ill. 2d 423, 583 N.E.2d 547 (1991).

[2] Although there is a distinction in Illinois law between an insurance agent or broker, unless that distinction is relevant, the seller of insurance will be referred to as "producer."

[3] *Burgos*, 145 Ill. 2d at 433.

[4] *Id*. 145 Ill. 2d at 430.

[5] *Id*. at 431 (following *Barrington Consol. High School v. American Ins. Co.*, 58 Ill. 2d 278, 319 N.E.2d 25 (1974)).

[6] *Id*.

[7] *Id*.

[8] *Burgos*, 145 Ill. 2d at 427-28.

[9] *Id*.

[10] *Id*.

[11] *Id*. at 427-28.

[12] *Id*.

[13] *Burgos*, 145 Ill. 2d at 427-28.

[14] *Id*.

[15] *Id*.

[16] *Id*.

[17] *Id*. at 428.

[18] *Burgos*, 145 Ill. 2d at 428.

[19] *Id*.

[20] *Id*.

[21] *Id*. at 435.

[22] *Id*. at 435-36.

[23] *Burgos*, 145 Ill. 2d at 436.

[24] *Id*. at 431.

[25] *Id*.

[26] *Id*.

[27] *Id*. at 432.

[28] *Burgos*, 145 Ill. 2d at 432.

[29] *Id*. at 433.

[30] *Id*.

[31] *West Am. Ins. Co. v. Yorkville Nat'l Bank*, 388 Ill. App. 3d 769, 902 N.E.2d 1275 (3d Dist. 2009), petition for leave to appeal allowed 232 Ill. 2d 597, 910 N.E.2d 1133 (May 28, 2009).

[32] *Dumenric v. Union Oil Co. of Cal.*, 238 Ill. App. 3d 208, 606 N.E.2d 230 (1st Dist. 1992).

[33] *Dumenric*, 238 Ill. App. 3d at 209.

[34] *Id*. at 211.

[35] *Id*.

[36] *Id*. at 212.

[37] *Id*.

[38] *Dumenric*, 238 Ill. App. 3d at 214.

[39] *Id*. at 215.

[40] *Cincinnati Cos. v. West Am. Ins. Co.*, 183 Ill. 2d 317, 701 N.E.2d 499 (1998).

[41] *Cincinnati Cos.*, 183 Ill. 2d at 318-19 (emphasis in original).

[42] *Id*. at 328.

[43] *Id*.

[44] *Id*. at 319-20.

[45] *Id*.

[46] *Cincinnati Cos.*, 183 Ill. 2d at 319.

[47] *Id*. at 322-23.

[48] *Id*. at 328.

[49] *Id*. at 329.

[50] *West Am. Ins. Co. v. Yorkville Nat'l Bank*, 388 Ill. App. 3d 769, 902 N.E.2d 1275 (3d Dist. 2009), petition for leave to appeal allowed 232 Ill. 2d 597, 910 N.E.2d 1133 (May 28, 2009).

[51] *Yorkville Nat'l Bank*, 388 Ill. App. 3d at 769.

[52] *Id*. at 770-71.

[53] *Id*. at 771.

[54] *Id*.

[55] *Id*.

[56] *Yorkville Nat'l Bank*, 388 Ill. App. 3d at 771.

[57] *Id*. at 771-72.

[58] *Id*. at 772.

[59] *Id*.

(Continued on next page)

[60] *Id*. at 772-73.

[61] *Yorkville Nat'l Bank*, Ill. App. 3d at 774.

[62] *Id*.

[63] *Id*. at 777.

[64] *Id*.

[65] *Barrington Consol. High School v. American Ins. Co*., 58 Ill. 2d 278 (1974).

[66] *Id*.

[67] *Id*.

[68] *Id*.

[69] *Id*.

[70] *Id*.

[71] *Barrington Consol. High School*, 58 Ill. 2d at 282.

[72] *Id*. at 282-83.

[73] *Id*. at 283.

[74] *Sowinksi v. Ramey*, 36 Ill. App. 3d 690, 344 N.E.2d 635 (1st Dist. 1976).

[75] *Sowinksi*, 36 Ill. App. 3d at 691.

[76] *Id*.

[77] *Id*. at 691-92.

[78] *Id*.

[79] *Id*.

[80] *Id*. at 691-92.

[81] *Id*.

[82] *Id*.

[83] *Id*. at 694-95.

[84] *Illinois Valley Mineral Corp. v. Royal-Globe Ins. Co.*, 70 Ill. App. 3d 296, 388 N.E.2d 253 (3d Dist. 1979).

[85] *Illinois Valley Mineral Corp*., 70 Ill. App. 3d at 298.

[86] *Id*.

[87] *Id*.

[88] *Id*. at 300.

[89] *Id*.

[90] *Id*.

[91] *Id*.

[92] *Equity Gen. Ins. Co. v. Patis*, 119 Ill. App. 3d 232, 456 N.E.2d 348 (1st Dist. 1983).

[93] *Patis*, 119 Ill. App. 3d at 233.

[94] *Id*.

[95] *Id*. at 234.

[96] *Id*. at 235.

[97] *Country Mut. Ins. Co. v. Livorsi Marine, Inc*., 222 Ill. 2d 303, 856 N.E.2d 338 (2006).

[98] *Patis*, 119 Ill. App. 3d at 236.

[99] *Id*. at 237.

[100] *Id*.

[101] *Brotherhood Mut. Ins. Co. v. Roseth*, 177 Ill. App. 3d 443, 532 N.E.2d 354 (1st Dist. 1988).

[102] *Roseth*, 177 Ill. App. 3d at 446.

[103] *Id*.

[104] *Id*.

[105] *Id*. at 448-49.

[106] *Id*.

[107] *Id*. at 449.

[108] *River v. Commercial Life Ins. Co*., 160 F.3d 1164, 1170 (7th Cir. 1999).

[109] *River*, 160 F.3d at 1166.

[110] *Id*.

[111] *Id*. at 1166-67.

[112] *Id*. at 1167.

[113] *Id*.

[114] *Id*. at 1167.

[115] *Id*.

[116] *Id*. at 1170.

[117] *Id*.

[118] *Northbrook Property & Cas. Ins. Co. v. Applied Sys., Inc*., 313 Ill. App. 3d 457, 729 N.E.2d 915 (1st Dist 2000).

[119] *Applied Sys., Inc*., 313 Ill. App. 3d at 459.

[120] *Id*.

[121] *Id.* at 462.

[122] *Id.*

[123] *Id.* at 465-66.

[124] *Id.* at 466.

[125] *Id.* at 467.

[126] *Montgomery Ward and Co., Inc. v. Home Ins. Co.*, 324 Ill. App. 3d 441, 753 N.E.2d 999 (1st Dist. 2001).

[127] *Montgomery Ward and Co., Inc.*, 324 Ill. App. 3d at 449.

[128] *Country Mut. Ins. Co. v. Livorsi Marine, Inc.*, 222 Ill. 2d 303, 856 N.E.2d 338 (2006).

[129] *Livorsi Marine, Inc.*, 222 Ill. 2d at 317.

[130] *Id.* at 305-06.

[131] *Id.* at 306.

[132] *Id.*

[133] *Id.* at 311-12.

[134] *Id.* at 316.

[135] *Id.* at 317.

[136] *Id.* at 320.

[137] *Id.*

[138] *Id.* at 321 ("Thus we express no opinion as to whether the notice in this case was reasonable.").

[139] *IMC Global v. Continental Ins. Co.*, 378 Ill. App. 3d 797, 883 N.E.2d 68 (1st Dist. 2007).

[140] *IMC Global*, 378 Ill. App. 3d at 808.

[141] *Id.*

[142] *Id.*

[143] *West Am. Ins. Co. v. Yorkville Nat'l Bank*, 388 Ill. App. 3d 769, 777, 902 N.E.2d 1275 (3d Dist. 2009), petition for leave to appeal allowed 232 Ill. 2d 597, 910 N.E.2d 1133 (May 28, 2009).

[144] *Yorkville Nat'l Bank*, 388 Ill. App. 3d at 777.

[145] *INA Ins. Co. v. City of Chicago*, 62 Ill. App. 3d 80, 379 N.E.2d 34 (1st Dist. 1978).

[146] The author of this Monograph wishes to acknowledge the work of William T. Barker, and his article *Using Extrinsic Evidence to Defeat the Duty to Defend in Illinois*, which was presented at the Illinois Association of Defense Trial Counsel's Fall Seminar in 2002. The author also has had a number of conversations with Mr. Barker over the years regarding this topic and appreciates his work and insights. In addition, William McVisk's work in the First Quarter 2002 IDC QUARTERLY Monograph, entitled *Insurance Law: Defining the Contours of the Duty to Defend* was a starting point for the discussion, and his work is gratefully acknowledged.

[147] *O'Neill v. Gallant Ins. Co.*, 329 Ill. App. 3d 1166, 769 N.E.2d 898 (5th Dist. 2002).

[148] In the interest of full disclosure, the author of this article was employed in the corporate legal department of Gallant Insurance Co. at the time that the O'Neill claim was analyzed, but took no official role in any part of the analysis or settlement discussions. As the department was small, however, he was aware of some of the discussions. Nothing in this article is based upon any personal recollection of those discussions, but rather is based upon the court's opinion only.

[149] *O'Neill*, 329 Ill. App. 3d at 1168-69.

[150] *Id.*

[151] *Id.* at. 1174.

[152] *Id.*

[153] *Id.* at 1176.

[154] *Id.* at 1174.

[155] *North River Ins. v. Grinnell Mut. Ins.*, 369 Ill. App. 3d 563, 860 N.E.2d 460 (1st Dist. 2006).

[156] *North River Ins.*, 369 Ill. App. 3d at 570.

[157] *Boyd v. Travelers Ins. Co.*, 166 Ill. 2d 188, 192-93, 652 N.E.2d 267 (1995).

[158] *Boyd*, 166 Ill. 2d at 193.

[159] *Dardeen v. Kuehling*, 213 Ill.2d 329, 821 N.E.2d 227 (2004).

[160] *Dardeen*, 213 Ill. 2d at 331-32.

[161] *Id.* at 336.

[162] *Id.*

[163] *Id.*

[164] *Id.* at 337.

[165] *Employers Mut. Ins. of Wausau v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 708 N.E.2d 1122 (1999).

[166] *Employers Mut. Ins. of Wausau*, 186 Ill. 2d at 153 (citations omitted).

[167] *National Union Fire Ins. Co. v. R. Olson Constr. Contractors, Inc.*, 329 Ill. App. 3d 228, 769 N.E.2d 977 (2d Dist. 2002).

[168] *National Union Fire Ins. Co.*, 329 Ill. App. 3d at 230.

(Continued on next page)

[169] *Id.* at 230-31.

[170] *Id.* at 231.

[171] *Id.* at 235.

[172] *Id.* at 238.

[173] *American Economy Ins. Co. v. Holabird & Root*, 382 Ill. App. 3d 1017, 886 N.E.2d 1166 (1st Dist. 2008)

[174] *Holabird & Root*, 382 Ill. App. 3d at 1031 (citation omitted).

[175] *American Economy Ins. Co. v. DePaul Univ.*, 383 Ill. App. 3d 172, 890 N.E.2d 582 (1st Dist. 2008)

[176] *DePaul Univ.*, 383 Ill. App. 3d at 173.

[177] *Id.* at 181.

[178] *Id.*

[179] *National Fire Ins. of Hartford v. Walsh Constr. Co.*, 392 Ill. App. 3d 312, 322, 652 N.E.2d 285 (1st Dist. 2009).

[180] *Walsh Constr. Co.*, 392 Ill. App. 3d at 322.

[181] *Associated Indem. Co. v. Insurance Co. of N. Am.*. 68 Ill. App. 3d 807, 386 N.E.2d 529 (1st Dist. 1979).

[182] *Associated Indem. Co.*, 68 Ill. App. 3d at 811.

[183] *Id.* at 818.

[184] *Id.* at 816.

[185] *Id.* at 816-17.

[186] *Id.* at 817 n.5.

[187] *LaRotunda v. Royal Globe Ins. Co*, 87 Ill. App. 3d 446, 408 N.E.2d 928 (1st Dist. 1980).

[188] *LaRotunda*, 87 Ill. App. 3d at 448.

[189] *Id.*

[190] *Id.* at 448-49.

[191] *Id.* at 452.

[192] *Id.*

[193] *Fidelity & Cas. Co. of N.Y. v. Envirodyne Engineers, Inc.*, 122 Ill. App. 3d 301, 461 N.E.2d 471 (1st Dist. 1983).

[194] *Id.* at 302.

[195] *Id.* at 303.

[196] *Id.* at 305.

[197] *Id.*

[198] *Millers Mut. Ins. Ass'n of Ill. v. Ainsworth Seed Co.*, 194 Ill. App. 3d 888, 552 N.E.2d 254 (4th Dist. 1989).

[199] *Millers Mutual Ins. Ass'n of Ill.*, 194 Ill. App. 3d at 890.

[200] *Id.* at 891.

[201] *Oakley Transp., Inc. v. Zurich Ins. Co.*, 271 Ill. App. 3d 716, 648 N.E.2d 1099 (1st Dist. 1995).

[202] *Oakley Transp., Inc.*, 274 Ill. App. 3d at 719.

[203] *Id.* at 720.

[204] *Transcontinental Ins. Co. v National Union Fire Insurance Company of Pittsburgh*, 278 Ill. App. 3d 357, 662 N.E.2d 500 (1st Dist. 1996).

[205] *Transcontinental Ins. Co.*, 278 Ill. App. 3d at 358.

[206] *Id.* at 358-59.

[207] *Id.* at 359.

[208] *Id.*

[209] *Id.* at 360.

[210] *Transcontinental Ins. Co.*, 278 Ill. App. 3d at 361-62.

[211] *Id.* at 362-63.

[212] *Shrivers Ins. Agency v. Utica Mut. Ins. Co.*, 323 Ill. App. 3d 243, 750 N.E.2d 1253 (2d Dist. 2001).

[213] *Shrivers Ins. Agency*, 323 Ill. App. 3d at 246.

[214] *Id.*

[215] *Id.* at 248.

[216] *Id.* at 251.

[217] *Cincinnati Ins. Co. v. River City Constr. Co.*, 325 Ill. App. 3d 267, 273, 757 N.E.2d 676 (3d Dist. 2001) (overturned as to equitable subrogation only by *Home Ins. Co. v. Cincinnati Ins. Co.*, 213 Ill. 2d 307, 821 N.E.2d 269 (2004)).

[218] *River City Constr. Co.*, 325 Ill. App. 3d at 273.

[219] *Clarendon Am. Ins. Co. v. B.G.K. Sec. Servs., Inc.*, 387 Ill. App. 3d 697, 900 N.E.2d 385 (1st Dist. 2008).

[220] *Clarendon Am. Ins. Co.*, 387 Ill. App. 3d at 702.

[221] Id. at 704.

[222] *Hutchinson v. Chase & Gilbert Inc.*, 45 F.2d 139, 142 (2d, Cir. 1930).

[223] *Employers Mut. Ins. of Wausau v. Ehlco Liquidating Trust*, 186 Ill. 2d 127, 708 N.E.2d 1122 (Ill. 1999).

[224] *Ehlco Liquidating Trust*, 186 Ill. 2d at 130.

[225] *Id*. at 132-33.

[226] *Id*. at 133-34.

[227] *Id*. at 134.

[228] *Id*.

[229] *Id*. at 135.

[230] *Id*. at 145-46.

[231] *Id*. at 147-48.

[232] *Id*. at 154.

[233] *Id*.

[234] *Id*. at 151.

[235] *Id*.

[236] *Id*.

[237] *Id*.

[238] *Korte Constr. Co. v. American States Ins. Co*., 322 Ill. App. 3d 451, 750 N.E.2d. 764 (5th Dist. 2001).

[239] *Korte Constr. Co.*, 322 Ill. App. 3d at 453.

[240] *Id*.

[241] *Id*.

[242] *Id*. at 454.

[243] *Id*. at 458.

[244] *Id*.

[245] *Id*.

[246] *West Am. Ins. Co. v. J.R. Constr. Co.*, 334 Ill. App. 3d 75, 777 N.E.2d 610 (1st Dist. 2002).

[247] *Id*. at 78.

[248] *Id*.

[249] *Id*. at 79.

[250] *Id*. at 81.

[251] *Id*. at 87.

[252] *Id*. at 86.

[253] *Illinois EMCASCO Ins. Co. v. Northwestern Nat'l Cas. Co*., 337 Ill. App. 3d 356, 785 N.E.2d 905 (1st Dist. 2003).

[254] *Illinois EMCASCO Ins. Co*., 337 Ill. App. 3d at 357.

[255] *Id*.

[256] *Id*.

[257] *Id*.

[258] *Id*. at 362.

[259] *Id*.

[260] *State Automobile Mut. Ins. Co. v. Kingsport Dev., LLC*, 364 Ill. App. 3d 946, 846 N.E.2d 974 (2d Dist. 2006).

[261] *Kingsport Dev., LLC*, 364 Ill. App. 3d at 960.

[262] *Id*.

[263] *Id*. at 961.

[264] *Insurance Co. of the State of Pa. v. Protective Ins. Co*., 227 Ill. App. 3d 360, 592 N.E.2d 117 (1st Dist. 1992).

[265] *Shell Oil Co. v. AC&S, Inc*., 271 Ill. App. 3d 898, 649 N.E.2d 946 (5th Dist. 1995).

[266] *Korte Construction Co. v. American States Ins. Co.*, 322 Ill. App. 3d 451, 750 N.E.2d 764 (5th Dist. 2001).

[267] *County of Massac v. United States Fidelity and Guar. Co*., 113 Ill. App. 3d 35, 446 N.E.2d 584 (5th Dist. 1983).

[268] *Cowan v. Insurance Co. of N. Am*., 22 Ill. App. 3d 883, 896, 318 N.E.2d 315 (5th Dist. 1974).

[269] *Royal Ins. Co. v. Process Design Assocs., Inc*., 221 Ill. App. 3d 966, 974, 582 N.E.2d. 1234 (1st Dist. 1991).

[270] *Royal Ins. Co*., 221 Ill. App. 3d at 968.

[271] *Id*. at 974.

[272] *Id*. at 969.

[273] *Id*. at 970-71.

[274] *Id*. at 971.

[275] *Id*. at 973 (following *Cowan v. Insurance Co. of N. Am*., 22 Ill. App. 3d 883, 896, 318 N.E.2d 315 (5th Dist. 1974)).

[276] *Royal Ins. Co*., 221 Ill. App. 3d at 974.

[277] *Id*. at 975.

[278] *Stonebridge Dev. Co., Inc. v. Essex Ins. Co.*, 382 Ill. App. 3d 731, 888 N.E.2d 633 (2d Dist. 2008)

[279] *Stonebridge Dev. Co., Inc.*, 382 Ill. App. 3d at 741; *see* also *Royal Ins. Co*., 221 Ill. App. 3d at 966.

[280] *Stonebridge Dev. Co., Inc.*, 382 Ill. App. 3d at 741.; see also *American Family Mut. Ins. Co. v. W.H. McNaughton Builders, Inc*., 363 Ill. App. 3d 505, 510, 843 N.E.2d 492 (2d Dist. 2006).

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[281] *Stonebridge Dev. Co., Inc.*, 382 Ill. App. 3d at 745.

[282] *Id.* at 732-33.

[283] *Id.* at 735-36.

[284] *Id.*

[285] *Id.* at 748.

[286] 215 ILCS 5/155.

[287] *Id.*

[288] *McGee v. State Farm Fire & Cas. Co.*, 315 Ill. App. 3d 673, 734 N.E.2d 144 (2d Dist. 2000).

[289] *McGee*, 315 Ill. App. 3d at 676.

[290] *Id.* at 677.

[291] *Id.*

[292] *Id.*

[293] *Id.* at 677-79.

[294] *Id.* at 679.

[295] *Id.* at 680-81.

[296] *Id.* at 681.

[297] *Id.*

[298] *Id.*

[299] *Id.* at 681.

[300] *Id.* at 681-82.

[301] *Id.* at 682.

[302] *Id.*

[303] *Id.* at 682.

[304] *Id.* at 683.

[305] *Uhlich Children's Advantage Network v. National Union Fire Co. of Pitt.*, No. 1-08-3400, 2010 WL 395645 (Ill. App. Ct. 1st Dist. Feb. 3, 2010).