

CLIENT ADVISORY

Key Terminology for Claims-Made Policies for Professional and Management Liability

OCCURRENCE VERSUS CLAIMS MADE COVERAGE. Insurance written on an occurrence form provides coverage for events or wrongful acts solely occurring during the policy period. The claim from the wrongful act can be brought in the future after the policy expires and still have coverage respond. For example, if you buy an auto policy that is valid for one year, then it will cover an accident that happens during that one-year period, even if a lawsuit isn't filed until after the policy has already expired. On the other hand, coverage is triggered for a claims-made insurance policy only when a claim is first reported during the policy period, even if the injury actually occurred prior to the inception date of the insurance policy. Conversely, if the injury occurs during the policy period and a claim isn't reported until after the policy has expired, then the policy will not provide coverage. Management liability and professional liability policies are typically on claims-made forms. The common exceptions are media liability and health care professional liability, which tend to be on occurrence forms.

WHAT IS A "RETROACTIVE DATE"? Claims-made policies also often contain a retroactive date that specifies the earliest point in time for which the insurance will provide coverage. The coverage applies to actual or alleged wrongful acts from the retroactive date forward. Only injuries or wrongful acts occurring after the retroactive date will be covered by a claims-made policy.

WHAT IS A "CONTINUITY DATE"? This is synonymously called the "prior and pending litigation date." Similar to a retroactive date, this feature sets a date in time for prior or active litigation but not wrongful acts. This clause will state that any litigation of any type that initiated prior to the continuity date will not be covered, even if the allegations were not part of a potentially covered claim. Many claims can evolve from one type to another. For example, a pollution event could harm the value of a corporation and evolve into a Directors & Officers Liability claim, or a Privacy Litigation claim could evolve into a Directors and Officers Liability claim. This date is typically set as the date the named insured first bought a type of insurance policy. When moving coverage from one insurer to another, it is critical to maintain your continuity date.

WHAT IS A "CLAIM"? Often a claims-made policy will define the term "claim" quite broadly to include much more than just a lawsuit. Many policies define "claim" to include written demands for damages as well as proceedings such as arbitration, administrative (such as those brought by the SEC or EEOC), regulatory, mediation and civil proceedings. The language of each particular policy will govern what constitutes a claim. If you receive a demand or threat of any kind, however, and are unsure what to do, then contact your insurance agent or your insurance company promptly.

DOES THE INSURANCE HAVE A CLAIM REPORTING REQUIREMENT? Claims-made policies require that claims must be reported to the insurance company before the insurer will respond to the claim. Obviously the insurer's participation in the claim process often cannot begin until the claim is reported. Claims should be reported promptly to preserve your rights under the policy. The insurer will often reserve their rights to cover any defense expenses incurred prior to their receipt of the claim. They will need to consent to any expenses if you wish to have those expenses insured. Different policies set different time periods for reporting claims. For example, claims normally must be reported as soon as practicable within the policy period. Other policies offer a limited grace period after the policy expiration for up to 30 or 60 days. In some instances this grace period is only provided if coverage is discontinued. If coverage is continuous – the policy was renewed with the same insurer or a new insurer – the claim will be made on the next policy assuming you have backdated both the retroactive date and the continuity date to match the preceding policy. You should consult the specific language of your policy to verify your reporting requirements. Your insurance broker should also be able to offer assistance.

To learn more about how AmWINS can help your clients who may be impacted a third party action over claim, reach out to your AmWINS contact or send an email message to marketing@amwins.com.

The logo for AmWINS Group, Inc. features the word "AmWINS" in a large, bold, serif font with a star above the "A". Below it, "Group, Inc." is written in a smaller, sans-serif font.

AmWINS Group, Inc. is a leading wholesale distributor of specialty insurance products and services. AmWINS has expertise across a diversified mix of property, casualty and group benefits products. AmWINS also offers value-added services to support some of these products, including product development, underwriting, premium and claims administration and actuarial services. With over 1,800 employees located in 16 countries, AmWINS handles over \$5 billion in premium annually through our four divisions: Brokerage, Underwriting, Group Benefits and International.

CLIENT ADVISORY

Key Terminology for Claims-Made Policies for Professional and Management Liability

Failure to report a claim within the period set by the policy can seriously prejudice your rights under the policy, including an outright coverage denial by the insurer.

DO YOU HAVE THE RIGHT TO REPORT A CIRCUMSTANCE THAT IS NOT YET A “CLAIM”? Many policies now provide you with the ability to report a circumstance that could give rise to a claim prior to receiving an actual claim. This provision enables you to report potential claims or circumstances under the policy for protection in the event such circumstances eventually evolve into claims.

We recommend reporting known circumstances anytime you are considering changing insurers so you are less likely to have complications with a new insurer. It is also recommended to send notice of potential circumstances prior to your policy expiration so you can preserve the limits of your next policy for new and unknown claims.

WHAT IS A DUTY TO DEFEND POLICY? A duty to defend policy allows the insured to tender the defense of a claim to the insurance company. The insurance company will select counsel and control the defense of the claim. Typically a duty to defend policy form obligates the insurance company to provide a defense if coverage is applicable to any of the allegations in the claim.

A NON-DUTY TO DEFEND policy allows the insured to select its own counsel and defense costs may be advanced or reimbursed by the insurance company. If there are matters that the insurer deems uninsurable under the terms of the policy, they will have the ability to allocate their reimbursement based upon covered and uncovered loss on an ongoing basis.

WHAT IS A HAMMER CLAUSE? The “hammer clause” is also called the consent to settle clause. Many insurers have a provision that says that if the plaintiff offers to settle for a certain amount, the maximum the insurer will pay is that offered amount plus expenses paid up to the date of the settlement offer. It is their way to encourage the named insured to make a business decision to resolve the claim and move on to other business. The insured can continue to fight the claim for whatever reason, but not with the insurer’s money. Many carriers now offer “softened” consent to settlement provisions of 50/50, 75/25 or 80/20. Such softened clauses allow the carrier to contribute to settlements and/or defense costs at the specified percentage (i.e. 50/50 = 50% allocated to carrier, 50% at insured’s expense). Some carriers will consider deleting the provision in its entirety.

SUMMARY For a claims-made policy to cover an otherwise covered claim (per the definitions and exclusions in your policy), the following conditions will apply:

- 1) The injury, damage or alleged wrongful act must occur after the retroactive date;
- 2) The claim for that injury, damage or wrongful act must be made against the insured during the policy period; and
- 3) The claim must be reported to the insurer within the time specified.

It is advisable to report all claims and potential claims during the policy period to reduce coverage limitations based upon missing the claims reporting deadline. The most common reason for denial of coverage is late or improper reporting.