AMWINS

Claims Made vs. Claims Made and Reported Policies – Why It Matters

Many professional and executive liability insurance policies are written on a "Claims Made and Reported" basis. This means that the claim must be made against the insured organization **and** reported to the insurer during the policy period, or within a specified number of days, post-policy expiration.

As a result of this requirement, late reporting of claims is one of the most common reasons for claim denials. Why? Because insurance buyers are often unaware that the time allowed to notice a claim is not unlimited, but rather clearly specified in the policy form.

Less common today are policies that are "Claims Made" without the "and Reported" requirement. In other words, there is no hard-stop as to when the claim must be reported. However, the ability to report and secure coverage on a "Claims Made" policy is not unlimited.

CONTACT

To learn more about how Amwins can help you place coverage for your clients, reach out to your local Amwins broker.

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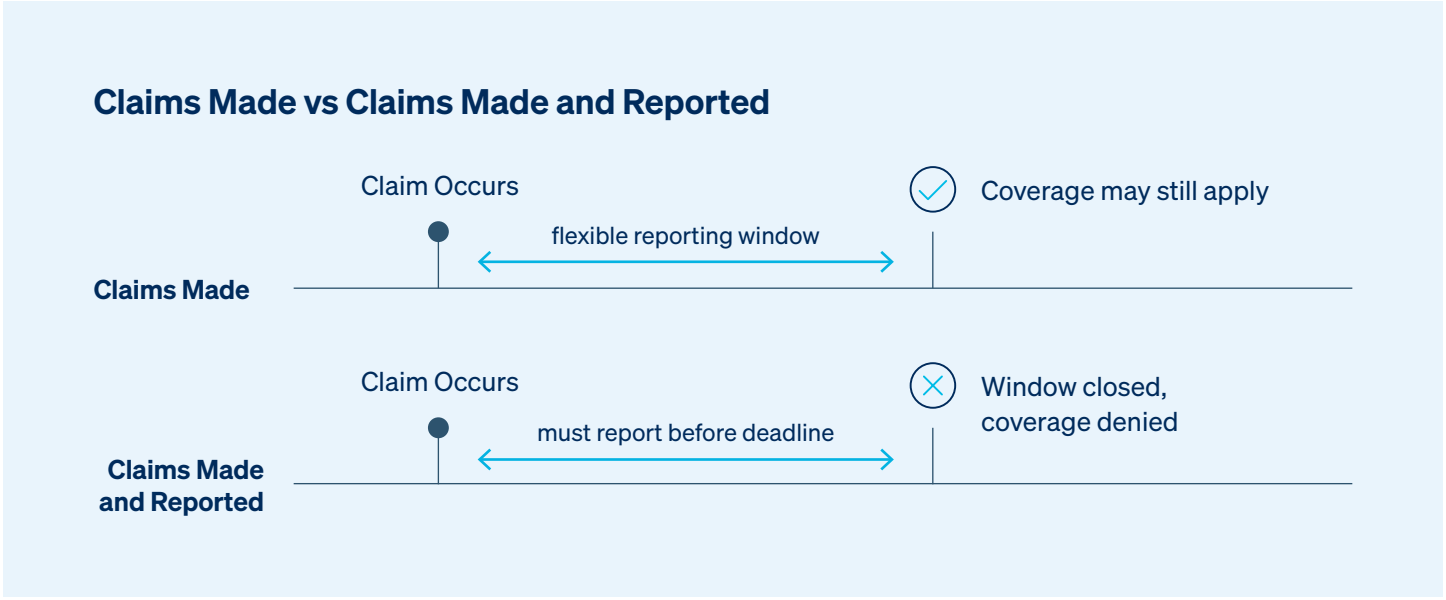


Claims Made policies

Coverage under a claims made policy is triggered when the claim is made against an insured during the policy period. Reporting is typically required "as soon as practicable," but no later than a specified number of days after policy expiration. Under certain circumstances you may also purchase an extended reporting period after the end of the policy.

You should never assume that the time to report a claim is unlimited, especially if such a delay in reporting is beyond what is practicable and results in prejudice to the insurer in its ability to reasonably adjust the claim.

The contention that "claims made" policies don't allow unlimited reporting is well-supported. Many jurisdictions apply the notice-prejudice rule, which requires insurers to show actual prejudice from late notice to deny coverage. In other venues, late is simply late.

Claims Made and Reported policies

Coverage under a claims made and reported policy is triggered if the claim is both made and reported within the policy period or a defined grace period (e.g., 60 to 90 days post-expiration). This creates a hard deadline for reporting.

Some older forms may have more limited language that requires the claim be reported within a certain number of days after the claim is first made, versus post expiration. This nuance in language can increase the chance of a late notice claim denial.

It is highly recommended to include language that specifies a claim is deemed made upon the knowledge of certain positions with the Named Insured (e.g., GC, CEO or CFO), versus any Insured Person. This helps to avoid a late notice if an administrator is on vacation and/or a claim gets misplaced. State-of-the-art language should also specify that unless the insurer is prejudiced, late notice alone will not preclude coverage.

Most courts do not apply the notice-prejudice rule to claims made and reported policies, viewing the reporting deadline as part of the coverage grant itself; however, a continuous renewal with the same insurer does not remove that reporting requirement. Courts often treat the reporting requirement in claims made and reported policies as a condition precedent to coverage, meaning late notice—even without prejudice—can void coverage.

Key terminology and best practices

An insurance policy is not tested until a claim is made against it. Most policies are straightforward regarding the acts or events that are covered. The policy language will govern what constitutes a claim.

Claims made policies often define the term "claim" quite broadly. Including more than just lawsuits, many policies include coverage for written demands for damages or for non-monetary relief, as well as proceedings such as arbitration, administration (e.g., brought by the SEC or EEOC), regulatory, mediation and civil proceedings. Making sure a client is aware of the definition of a claim (what triggers coverage) is key to ensuring timely notice.

Claims made policies also include key terms that further define when coverage is triggered, including:

Retroactive date: The earliest point in time for which the insurance may provide coverage.

Continuity date: Also called the "prior and pending litigation date," this is the date in time that any litigation of any type initiated prior will not be covered, even if the allegations were not part of a potentially covered claim. The continuity date is typically set as the date the named insured first purchased a type of insurance policy. When moving coverage from one insurer to another, it is critical to maintain the continuity date

Other considerations for both policies include:

Duty to defend: These policies enable the insured to tender the defense of a claim to the insurance company. The insurance company selects counsel and controls of the defense of the claim. Typically, a duty to defend policy form obligates the insurance company to provide a defense for all causes of actions in a claim (if at least one is covered). Ideally, the policy should also contain language specifying that the insurer will not allocate loss between covered and uncovered matters or persons for defense costs (otherwise called 100% allocation language).

Non-duty to defend: These policies enable the insured to select their own counsel. Generally, receipts for defense must be submitted for reimbursement to the insurer to be paid on an ongoing basis. This often involves more administration but does grant the insured more control over the claims process. It should be noted, however, that if there are matters the insurer deems uninsurable under the terms of the policy, they will have the ability to allocate reimbursement based upon covered and uncovered loss on an ongoing basis (versus the 100% allocation under a duty to defend policy).

Consent to settle: Also called the hammer clause, this provision states that if the insurer recommends acceptance of a settlement offer and the insured refuses (wants to fight the claim), the maximum the insurer will pay is the offered amount plus expenses paid up to the date of the settlement offer. The insured may continue to fight the claim for any reason but will do so without the support of the insurer. Most carriers now offer a "softened" consent to settle provision, whereby further defense costs or any increased settlement amount will be subject to coinsurance, which can vary between 10 and 50 percent.

Claims reporting requirements

Insurance policies spell out the proper way to submit a claim to the insurer; however, claims should be reported promptly as the insurer's participation in the claim process often cannot begin until the claim is reported and accepted by the insurer.

Defense costs incurred prior to the insurer's approval are customarily not considered part of the covered loss. It's also critical to note that providing notice to an agent or broker does not constitute notice to the insurer.

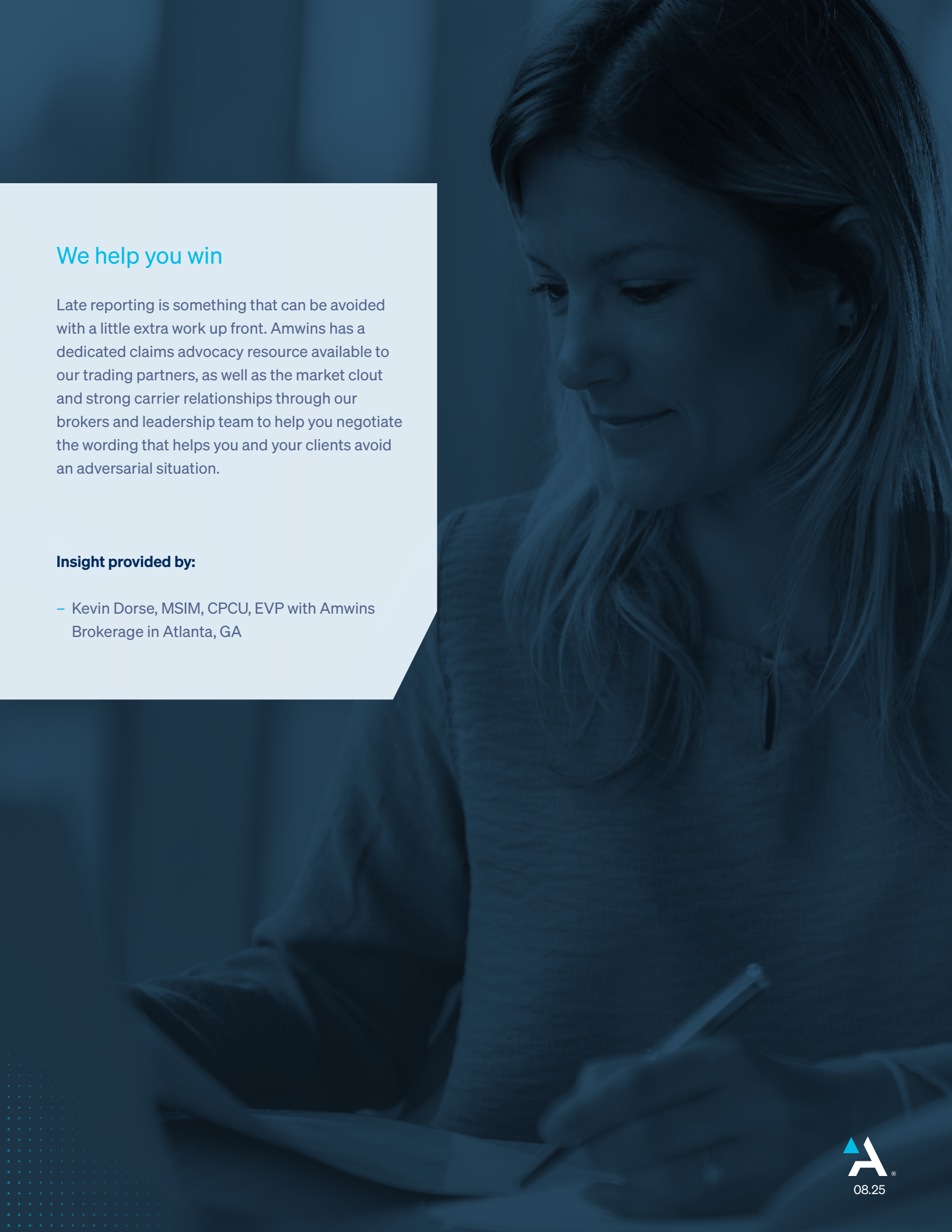
To avoid missing reporting deadlines, the first notice of loss can be made directly by the insured but, time permitting, we recommend that notice be made in conjunction with an agent to help ensure that the correct policies are noticed and information is properly presented.

Another important nuance of claim reporting is the option to provide notice of a circumstance that might reasonably be expected to develop into a claim. The advantage of doing so is that any future claim arising from that circumstance is tied back to the policy period (and limits) under which the notice was accepted — rather than the policy in force when the claim is actually made. For a notice of circumstance to be valid (accepted by the insurer), most policies require a certain level of specificity, often outlined in the General Conditions section. This typically includes:

1. The identity of potential claimants
2. The identity of potential defendants
3. The anticipated alleged wrongful acts
4. The potential damages

That said, there is an important cautionary nuance. Some policies state that a circumstance must be reported once known, while others state it may be reported at the insured's discretion. Where the word "must" is used, insurers may later argue that a failure to report a known circumstance bars coverage if it later ripens into a claim. This subtle wording difference can be a landmine for insureds, and it underscores why careful review of reporting obligations is critical.

As already stressed, the failure to report a claim within the period set by the policy will likely cause an outright coverage denial by the carrier, regardless of whether the late notice has prejudiced the insurer's ability to successfully defend the claim. You can **learn more about what can cause a claim to be reported late** and **how to mitigate the risk of late notice claim denials** here.



We help you win

Late reporting is something that can be avoided with a little extra work up front. Amwins has a dedicated claims advocacy resource available to our trading partners, as well as the market clout and strong carrier relationships through our brokers and leadership team to help you negotiate the wording that helps you and your clients avoid an adversarial situation.

Insight provided by:

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