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When a Tenant Complaint Is a Claim and When It Isn't

Regulatory complaints are a routine part of real estate operations. Tenant-related filings often reach well into the hundreds every year. These matters can seem purely administrative, with many insureds assuming they fall outside the scope of coverage. However, that may not always be the case. To illustrate the point, let's look at an example of how a complaint can escalate quickly, creating significant challenges for insureds.

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A case study

A property management company received a copy of a tenant's complaint alleging regulatory violations. The complaint had been sent directly to HUD (the U.S. Department of Housing and Urban Development), the federal agency that receives these types of complaints.

The tenant did not demand any payment for damages or name the property management company as a party; they simply asked the agency to investigate. And because the company viewed this as an administrative inquiry rather than a claim, it did not notify its insurer.

Upon receipt of the complaint, HUD launched an investigation that spanned several months. When attempts at conciliation failed, the matter was escalated and ultimately referred for enforcement. This resulted in the tenant filing civil litigation seeking significant monetary damages from the company.

It was only then, months after the initial complaint was filed, that the company notified its insurer.

When is a complaint a claim?

When policies are written, they include what the carrier defines as a "claim." Depending on the nature of the risk the policy is designed to cover, the definition of "claim" might include additional verbiage specific to that type of risk. For example, a Professional E&O policy might also include as a "claim" a Professional Disciplinary Proceeding against any Insured.

Generally, a "claim" will be defined to include something like the following, wherein claim means any:

1. Written demand against any insured for monetary damages or non-monetary or injunctive relief;
2. Civil proceeding against any insured seeking monetary damages or non-monetary or injunctive relief, commenced by the service of a complaint or similar pleading;
3. Arbitration, mediation or other alternative dispute resolution proceeding against any insured seeking monetary damages or non-monetary or injunctive relief, commenced by the receipt of a written demand, or service of a complaint or similar pleading; or
4. Written request directed at any insured to toll or waive a statute of limitations applicable to a claim referenced in items 1-3 immediately above.

The policy will also be made either on a **claims-made or a claims-made and reported basis**. With claims-made policies, there is no hard stop as to when the claim must be reported. When a policy is based on claims made and reported, 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.

Using our example above, let's assume that the policy was a claims made and reported policy and included "a written demand against any insured for monetary damages or non-monetary or injunctive relief" in its definition of "claim". In this scenario, the insurer could argue that the original regulatory complaint to HUD counted as a "claim". If the insured did not report the matter until the following policy period when it received a lawsuit, the insurer could deny coverage for late notice because the insured should have reported the matter when the regulatory complaint was filed with HUD.

While the property management company in our example believed it had done the right thing by reporting the complaint only once a formal lawsuit was filed, they did not. The insurer argued that the insured should have reported the HUD complaint to the insurer. Unfortunately, this mistake is not uncommon and, in many cases, failure to report the HUD Complaint could provide the insurer with a basis to deny coverage for late reporting.

A shift in interpretation

While the denial in our example reflected a strict interpretation of the policy language, the crux of the issue was the policy's inclusion of the broadly worded phrase "written demand for . . . non-monetary . . . relief" in its definition of "claim." In practice, regulatory complaints of this kind are not made against the insured. They are often requests for investigation by a third-party authority and are resolved informally without any finding of wrongdoing.

The good news is that historically, most carriers have not treated these early-stage complaints as claims. They recognize that property management companies receive numerous complaints each year and typically have a periodic bordereau reporting structure (e.g., quarterly or annually) for insureds. By requiring insureds to report such complaints on a schedule rather than individually, they can relieve some of the pressure on the insured as well as their own claims departments.

You may want to make your own judgment call if something is a claim, but it is much safer to put that judgment in the hands of the insurance company, which is ultimately responsible for judging if coverage will apply.

What's at stake

A strict interpretation of policy language like the one illustrated above can leave an insured facing a major lawsuit without coverage. Beyond the immediate financial exposure, it could also create ripple effects for a broker team and their clients.

For retailers, it's important to understand how small shifts in policy wording can dramatically change risk allocation. A seemingly innocuous phrase like "written demand . . . for non-monetary . . . relief" in the definition of "claim" can be the difference between full coverage and none at all.

For insureds, it's a reminder that administrative matters can carry significant insurance implications and misunderstanding how a policy operates can leave them exposed to high-stakes litigation.

How to protect against this

To avoid similar disputes, consider the following best practices.

For retailers and brokers

- Review the definition of "claim." If it includes the word "complaint," or a phrase like "written demand for . . . non-monetary . . . relief," clarify whether that includes agency complaints made to regulators. If so, consider negotiating changes.
- Get it in writing. Document carrier positions on how regulatory complaints are treated. If they are not considered claims, keep that confirmation.
- Educate your insureds. Explain the importance of early notice and the potential risks of late reporting under claims made and reported policies.

For insureds

- Report early. When unsure, submit a notice of circumstance to preserve coverage rights.
- Centralize and track complaints. Maintain a log of agency complaints, notices to insurers and responses.
- Train staff. Make sure anyone who receives regulatory complaints knows to escalate them to risk management immediately.

Amwins can help

Regulatory complaints may feel like routine paperwork, but they can carry significant insurance implications. And because policy definitions vary, what one carrier treats as background noise, another may treat as a claim. You may want to make your own judgment call if something is a claim, but it is much safer to put that judgment in the hands of the insurance company, which is ultimately responsible for judging if coverage will apply.

Working with a partner like Amwins can help. Our real estate specialists understand how important it is to clarify expectations up front and encourage clients to err on the side of early reporting. A simple notice now can prevent a costly coverage dispute later.

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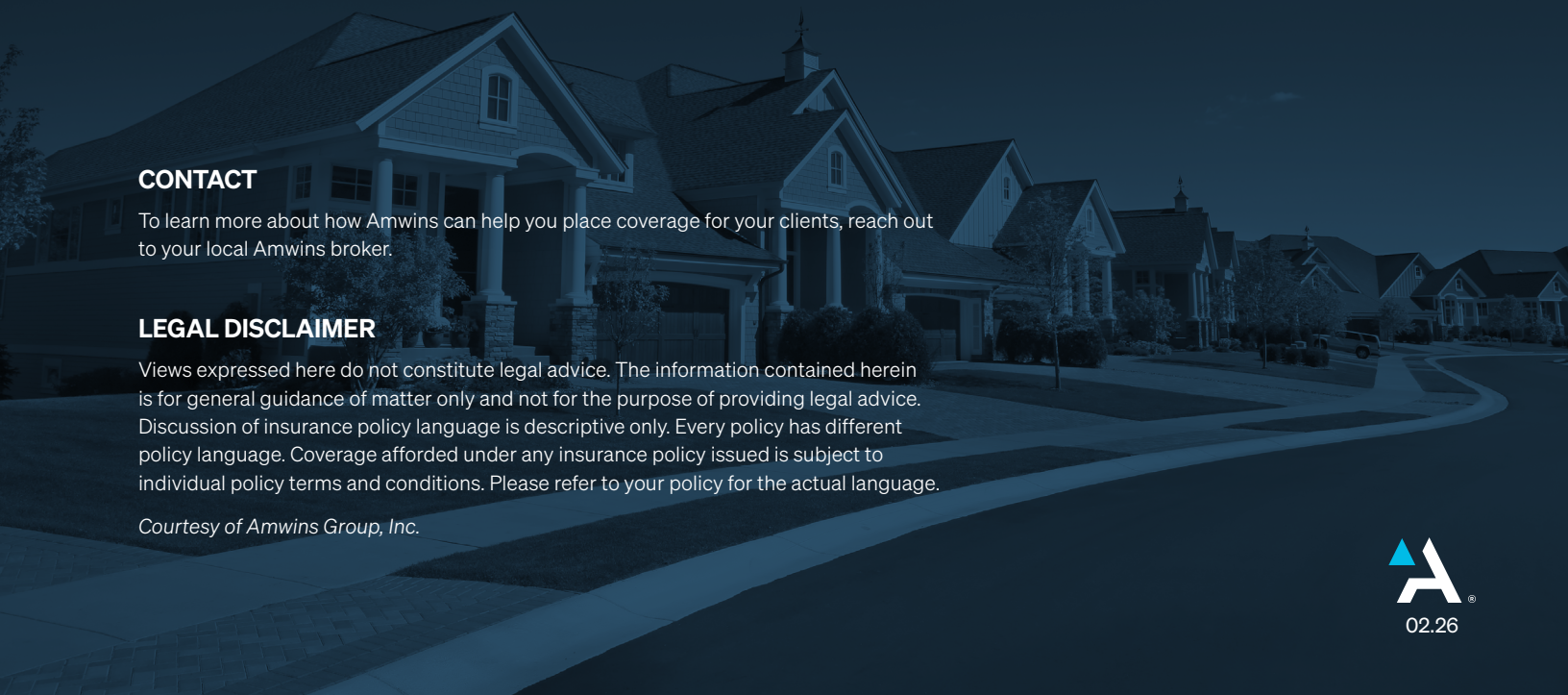

CONTACT

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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