

***UNDERSTANDING THE “LATE NOTICE” COVERAGE DEFENSE UNDER
CLAIMS-MADE AND OCCURRENCE POLICIES***

**By: Marc J. Pearlman &
David W. Kane
Kerns, Pitrof, Frost &
Pearlman, LLC
333 W. Wacker Drive
Chicago, IL 60606
(312) 261-4550**

March 6, 2003

INTRODUCTION

Whenever an attorney is retained to handle an insurance coverage claim, it is critical to determine whether the insured has complied with the “notice” requirement contained in the insurance policy at issue. This analysis is of great importance since an insurer is likely to assert coverage is not owed under the policy if the insured failed to give timely notice of the claim or suit. An insurer’s likelihood of success on such a “late notice” defense will often hinge on whether it must prove “prejudice” as a result of the insured’s delay. As discussed in more detail below, the insurer’s obligation to prove prejudice is greatly influenced by the type of insurance policy (“claims-made” vs. “occurrence”) and, to a lesser extent, the applicable prejudice test adopted in each jurisdiction. This article attempts to provide practitioners with an outline of the issues that will most likely effect whether an insured’s delay will result in a loss of coverage. The topics addressed in this article include: 1) how the notice requirements under “claims-made” and “occurrence” policies differ; 2) how the type of coverage at issue impacts the “late notice” coverage analysis; 3) which party has the burden of proving prejudice; and 4) what constitutes prejudice.

I. NOTICE REQUIREMENTS UNDER INSURANCE POLICIES

In order to better appreciate how notice provisions operate, it is helpful to have a basic understanding of the historical development of insurance coverage. The two most common types of liability policies sold today provide coverage on either a “claims-made” or “occurrence” basis. However, this was not always the case. Initially, almost all insurance policies were sold on an occurrence basis, which provides unlimited prospective coverage. Occurrence policies were originally developed when the primary peril insured against was loss at sea because of collision, fire, war and other easily identifiable events.¹ As our industrial society became more complex and the perils insured more diverse, inherent problems with occurrence coverage became apparent. Unlike losses at sea, often it was not clear when the injury-causing event occurred. Consequently, determining which of many possible occurrence policies was required to respond was difficult. This usually resulted in time consuming and costly litigation. Moreover, more perils caused latent injuries and injuries that developed over a period of time. Thus, when the injury was finally discovered, or by the time liability attached, the insurer was often no longer in existence.² Of course, this was problematic for both insureds and injured third parties. Further, because of an occurrence policy’s unlimited prospective coverage or “tail”, insurers found it increasingly difficult to set adequate reserves and determine fair premiums. This resulted in instability in the insurance market and increased premiums to insureds.

To combat these problems, the insurance industry developed claims-made policies. The goal of these policies was twofold: 1) make the timing of the injury causing event irrelevant, thereby eliminating disputes regarding which policy attaches; and 2) eliminate the “tail”, thereby reducing uncertainty and augmenting stability and fair pricing. This is possible because an insurer who knows that claims will not arise under the policy after its expiration can underwrite a risk and calculate premiums with greater

certainty.³ The insurer is then free to establish its reserves without having to consider the possibilities of inflation beyond the policy period or rising jury awards.⁴

Both claims-made and occurrence policies contain provisions that require the insured to give the insurer notice whenever it learns of a claim that might trigger coverage under the policy. However, the purpose of these notice requirements in the context of a claims-made policy and an occurrence policy are quite different. In order to understand this difference, it is necessary to have a complete understanding of how the two types of coverage operate.

A. Coverage Under A Claims-Made Policy

Under a claims-made insurance policy, coverage is based upon when the actual claim is made against the insured, as opposed to when the insured committed the negligent acts that gave rise to the claim. Although some claims-made policies only require that notice of claims be reported “as soon as practicable” this is not the norm. Typically, claims-made policies provide that a claim is not “deemed made” until such time as the insured actually reports it to the carrier. This type of policy is often referred to as a “claims-made and reported” policy, since coverage is only provided for claims that are both made against the insured and reported to the insurer, during the term of the insurance policy. The very essence of such claims-made and reported policies is that notice must be given during the policy period.⁵ This article will focus on this later type of policy since coverage under a claims-made and reported policy is far more likely to result in late notice problems for insureds.⁶

Under such claims-made policies, it does not matter when the insured committed the acts or omissions that caused the injury. Rather, the critical inquiry is when the date the injured party made the claim against the insured. As an example, assume an engineer designed and built a bridge in 1995. In July of 2000, the bridge collapsed due to construction defects in the insured’s design. The owner of the bridge made a claim against the engineer the following day. If the engineer was insured under a claims-made policy, coverage would potentially be triggered in the 2000 policy year (and not the 1995 policy year), since this was the year the claim was made against the insured.

B. Coverage Under An Occurrence Policy

In contrast, under an occurrence policy, coverage is provided for negligent acts or omissions that occur during the policy period, regardless of the date of discovery or the date the claim against the insured is made.⁷ Using the above example, if the engineer had been insured under an occurrence policy, the 1995 policy year would have been triggered since this was when the acts or omissions causing injury (i.e. the negligent design/construction) took place. As such, under an occurrence policy, an insurer could potentially owe indemnity coverage to an insured for a policy it might have sold the insured 20 or 30 years prior to the making of the claim (e.g. asbestos and tobacco litigation).

II. CONSEQUENCES OF LATE NOTICE UNDER CLAIMS-MADE VERSUS OCCURENCE POLICIES

Based upon the above, it is easy to understand why the notice provisions under the two types of coverages serve different purposes. Under an occurrence policy, the notice provision is inserted to prevent insureds from prejudicing the insurers' ability/right to investigate the claims that are brought against their insureds. In a claims-made policy, the notice requirement identifies what claims are eligible for coverage during the term of the policy since coverage is only afforded for claims that are both made and reported.⁸ Due to these differences, courts treat late notice issues drastically different depending on the type of policy at issue.

A. Late Notice Under A Claims-Made and Reported Policy

As discussed above, in order to obtain coverage under a claims-made policy, the triggering event typically must both occur and be reported to the insurer during the term of the policy. Accordingly, when an insured becomes aware of a claim it must notify the carrier. As a general rule, the insured's failure to give such notice during the policy period will relieve the insurer of its coverage obligations under the policy.⁹

As such, an insured that learns of a claim at the end of the policy period has to make sure to report it to the carrier before the policy expires. A failure to do so, even by a few days after expiration, may result in a loss of coverage under the policy.¹⁰ Insureds who face such late notice dilemmas will often argue that a forfeiture of coverage is far too harsh, especially where the delay did not cause any prejudice to the insurer. This argument is commonly referred to as the "notice-prejudice rule" (i.e. an insurer can only disclaim coverage based upon the insured's late notice of a claim if it can demonstrate that it was materially prejudiced by the late notice).

Except for a few exceptions, almost every jurisdiction has flatly rejected this argument (the notice-prejudice rule) in the context of claims-made policies.¹¹ Accordingly, insurers providing liability coverage under a claims-made policy need not demonstrate that they were prejudiced in order to deny coverage based upon an insured's failure to give notice of a claim during the policy period. The reasoning behind these decisions is twofold.

First, because the notice requirement in a claims-made and reported policy (i.e. informing the insurer of a claim during the policy period) defines and/or sets the parameters of coverage, it is considered a part of the insuring agreement of the policy. Unlike an occurrence policy, these notice provisions actually serve to identify what claims are potentially covered under the policy.¹² As such, a notice provision under a claims-made policy is considered a condition precedent to coverage and not just some technical reporting requirement.¹³ Since notice is a condition precedent to coverage, it should not be surprising that the insured, and not the insurer, should suffer the consequence of failing to satisfy such a condition.

Second, although the occasional preclusion of coverage may seem unfair in some circumstances, courts recognize that the purchase of claims made coverage was a bargained for exchange. Although the insured receives a narrower scope of coverage under a claims-made policy, it also is typically charged a much lower premium than it would have been under an occurrence policy.¹⁴ When implemented, the notice-prejudice rule drastically alters one of the fundamental aspects of a claims-made policy (i.e. the insurer's benefit of a clear cut-off date for coverage).¹⁵ Since giving notice under a claims made policy actually triggers the insurer's coverage obligation (i.e. the claim is not deemed made until notice is given), any extension of time to give notice necessarily enlarges the scope of coverage for the insured. Applying the notice-prejudice rule to claims made policies would effectively convert such policies into occurrence policies; something the insured did not pay for when contracting with the insurer.¹⁶

As alluded to above, there are a few jurisdictions which have extended the "notice-prejudice" rule to claims-made policies.¹⁷ However, in each instance, the jurisdiction in question had some type of state statute that precluded a contrary result. Since exceptions to the "no prejudice" rule do exist, we strongly recommend that lawyers always check the law of the jurisdiction in question before assuming that the insurer need not prove prejudice.

B. Late Notice Under An Occurrence Policy

Occurrence policies provide coverage for injury caused by negligent acts or omissions that occur during the policy period, regardless of the discovery date or the date the claim or suit is brought against the insured. The notice provision in occurrence policies typically require that the insured must provide the insurer with written notice of any occurrence "as soon as practicable" or "promptly." Insurers have traditionally argued that, like claims-made policies, timely notice should be considered a condition precedent to coverage under occurrence policies. In support of this argument, insurers often relied on the "no action" clause of the policy, which generally provide that an insured is not entitled to coverage unless it satisfied all the terms (i.e. notice) of the policy first.¹⁸ As a condition precedent to coverage, insurers successfully argued that a showing of prejudice was not required.

However, over a period of years, most courts have steadily changed their views on the traditional "no prejudice" rule with respect to occurrence policies. As of today, the vast majority of states have adopted the "notice prejudice" rule discussed above.¹⁹ Under this rule, an insurer has the burden of proving that its rights have been prejudiced by the insured's delay in giving notice in order to successfully deny coverage under the policy.

One of the reasons courts have changed their position on this issue is the role the notice provision plays in an occurrence policy. It is widely recognized that the intended purpose of the notice provision in an occurrence policy is to enable the insurer to investigate the facts relating to liability and to adequately respond to claims.²⁰ Accordingly, unlike in a claims-made policy, the "notice-prejudice" rule under an

occurrence policy does not broaden the scope of coverage under the policy. Rather, “notice prejudice” for an occurrence policy simply lengthens the amount of time between when the covered occurrence took place and the insurer’s receipt of the notice from the insured.

III. PREJUDICE TESTS UNDER OCCURRENCE POLICIES

Although the notice-prejudice rule is employed by the vast majority of courts, there are a total of three tests that courts will employ: 1) No Prejudice Required; 2) Rebuttable Presumption of Prejudice; and 3) Notice-Prejudice.

A. Insurer Need Not Prove Prejudice

A small minority of jurisdictions hold that a notice provision in an occurrence policy is a condition precedent to coverage. Under this analysis, an insured’s unexcused notice delay creates an irrebuttable “presumption of prejudice” for the insurer. Courts applying this approach hold that an insured’s failure to provide timely notice of a claim will act to relieve the insurer from its coverage obligations under the policy. Thus, insurers in these jurisdictions are not required to show prejudice.²¹

B. Rebuttable Presumption of Prejudice

A few courts have held that an insured’s late notice of a claim creates a presumption of prejudice on behalf of the insurer. However, this presumption can be overcome if the insured can present evidence demonstrating that the insurer has not suffered any actual prejudice as a result of the delay.²²

C. Notice-Prejudice Rule

Finally, as discussed above, the majority of courts now apply the “notice-prejudice rule” for occurrence policies. Under this rule, an insurer is only relieved of its coverage obligations if it can prove that it was prejudiced by the delay.

IV. WHAT IS PREJUDICE?

The notice provision in an occurrence policy is generally meant to give the insurer an opportunity to investigate the claim/loss against the insured. As such, if the insurer has the burden of proving it was prejudiced (i.e. under the notice-prejudice rule) by the late notice, it will typically have to establish that the delay impaired its ability to properly investigate the claim. As a practical matter, insurers face a difficult uphill battle in this regard and rarely succeed. Generally, courts are unlikely to find prejudice unless the insurer can show a substantial prejudice that directly impaired the insurer’s ability to protect its interests (e.g. witnesses are now missing or deceased; a settlement opportunity is no longer available; the insurer can no longer bring a third-party action; trial has already begun, etc...).²³ Furthermore, the determination of prejudice is a question of fact.

As such, an insurer seeking to relieve itself of its coverage obligations based upon late notice will likely have to incur the expenses of trial.

CONCLUSION

The first step in analyzing the effect of a potential late notice issue is to consider the type of insurance policy at issue and the language used in the policy. This will give the practitioner a general idea of whether notice is a condition precedent to coverage and whether the insurer will be required to prove prejudice as a result of the delay. However, it is critical that the specific jurisdiction's notice rules be reviewed to determine if it has adopted any of the minority approaches discussed above.

¹ *Zuckerman v. National Union Fire Ins. Co.*, 495 A.2d 395, 398 (N.J. 1985).

² *Id.* at 399.

³ *Pacific Employers Ins. Co. v. Superior Court*, 270 Cal. Rptr. 779, 785 (Cal. Ct. App. 1990).

⁴ *Id.*

⁵ *Continental Casualty Co. v. Maxwell*, 799 S.W.2d 882, 887 (Mo. Ct. App. 1990).

⁶ For the remainder of this article, whenever "claims-made" coverage should be treated as being synonymous with "claims-made and reported" coverage.

⁷ *Samuel N. Zarpas, Inc. v. Morrow*, 215 F.Supp. 887, 888 (D. N.J. App. 1963); *Bill Binko Chrysler-Plymouth, Inc. v. Compass Ins. Co.*, 385 So.2d 692, 693 (Fla. Dist. Ct. App. 1980); *Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 919 (Ariz. Ct. App. 1994); *See also* 7A, J. Appleman, *Insurance Law and Practice* §4504.01, at 313 (Berdal ed.1979).

⁸ *McCullough v. Fidelity & Deposit Co.*, 2 F.3d 110, 113 (5th Cir. 1993); *Continental Casualty Co. v. Cuda*, 715 N.E.2d 663, 669 (Ill. App. Ct. 1999).

⁹ *See Continental Casualty Co. v. Cuda*, 715 N.E.2d at 669 (Ill. App. Ct. 1999); *Lexington Ins. Co. v. Rugg & Knopp, Inc.*, 165 F.3d 1087, 1090 (7th Cir. 1999); *Calocerinos & Spina Consulting Engineers v. Prudential Reinsurance Co.*, 856 F.Supp. 775, 779 (W.D.N.Y. 1994); *Civic Assocs. v. Security Ins. Co.*, 749 F.Supp. 1076, 1082 (D. Kan. 1990); *Zuckerman*, 495 A.2d at 405-06 (N.J. 1985); *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28, 29 (Mass. 1990).

¹⁰ Although not discussed here, it should be noted that many claims-made policies contain an extended reporting period or "tail coverage" if the insurer terminates the policy or elects not to renew. However, these clauses generally do not apply if the insured renews its policy. Additionally, some states have adopted statutes mandating extended reporting period provisions (usually 30 days) for any claims that are not discovered by the insured until the end of the policy period. Accordingly, a detailed review of the jurisdiction in question should always be undertaken in order to rule out any statutory requirements that could affect the "late notice" analysis.

¹¹ *See Sletten v. St. Paul Fire & Marine Ins. Co.*, 780 P.2d 428, 430 (Ariz. Ct. App. 1989); *Esmailzadeh v. Johnson & Speakman*, 869 F.2d 422, 424-25 (8th Cir. 1989); *Zuckerman*, 495 A.2d at 405-

06; *Pizzini v. American International Specialty Lines Ins. Co.*, 210 F.Supp.2d 658, 669-70 (E.D. Penn. 2002); *Thoracic Cardiovascular Assocs., Ltd.*, 891 P.2d 916 at 921-22; *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So.2d 512, 515-16 (Fla. 1983).

¹² See *McCullough v. Fidelity & Deposit Co.*, 2 F.3d at 112 (applying Texas Law).

¹³ *Thoracic Cardiovascular Assocs., Ltd.*, 891 P.2d at 920.

¹⁴ *Employers Reinsurance Corp. v. Sarris*, 746 F.Supp. 560, 564-65 (E.D. Penn. 1990) (citing *City of Harrisburg v. International Surplus Lines Ins. Co.*, 596 F.Supp. 954 (M.D. Pa. 1984)).

¹⁵ *Textron, Inc. v. Liberty Mut. Ins. Co.*, 639 A.2d 1358, 1365-66 (R.I. 1994).

¹⁶ *Campbell & Co. v. Utica Mut. Ins. Co.*, 820 S.W.2d 284, 288 (Ark. Ct. App. 1991); *Gulf Ins. Co.*, 433 So.2d at 515-16; *Pacific Employers Ins. Co.*, 270 Cal.Rptr. at 784; *Calocerinos & Spina Consulting Engineers*, 856 F.Supp. at 779-80; *Textron, Inc.*, 639 A.2d at 1366.

¹⁷ See *Lexington Ins. Co.*, 165 F.3d 1087 at 1092 (applying Wisconsin law)(rejecting argument that the notice-prejudice rule does not apply to claims-made policies since Wisconsin statute expressly incorporates a notice-prejudice rule for all liability policies); *Sherlock v. Perry*, 605 F.Supp. 1001, 1005 (E.D. Mich. 1985)(pursuant to an express provision in the Michigan Insurance Code, liability insurers cannot deny coverage based upon an insured's failure to timely report a claim unless it can show it was prejudiced by the delay); and *Williams v. Lemaire*, 655 So.2d 765, 767-69 (La. Ct. App. 1995), *writ denied*, 660 So.2d 481 (La. 1995)(under Louisiana's direct action statute, third parties have the right to bring an action against a tort-feasor's insurance carrier, and therefore, those rights cannot be taken away due to the tort-feasor's failure to comply with a condition of the policy).

¹⁸ Stanley C. Nardoni, *Illinois Adopts the "Modern" Prejudice Rule for Insurers' Late-Notice Defense*, 87 Ill. B.J. 86 (Feb. 1999).

¹⁹ See *Reliance Ins. Co. v. St. Paul Insurance Cos.*, 239 N.W.2d 922, 925 (Minn. 1976); *Clemmer v. Hartford Ins. Co.*, 587 P.2d 1098, 1106 (Cal. 1978); *Cooper v. Government Employees Ins. Co.*, 237 A.2d 870, 874 (N.J. 1968); *Motor State Ins. Co. v. Benton*, 192 N.W.2d 385, 387 (Mich. Ct. App. 1971); *Cooperative Fire Ins. Ass'n v. White Caps, Inc.*, 694 A.2d 34, 36 (Vt. 1997); *Holt v. Utica Mut. Ins. Co.*, 759 P.2d 623, 630 (Ariz. 1988); *Lumbermens Mut. Casualty Co. v. Oliver*, 335 A.2d 666, 668-69 (N.H. 1975).

²⁰ Ostrager & Newman, *Handbook on Insurance Coverage Disputes* §4.02[a] (9th ed. 1998); *Zuckerman*, 495 A.2d at 406.; *Chas. T. Main, Inc.*, 551 N.E.2d at 29.

²¹ See *Midwest Employers Casualty Co. v. East Ala. Health Care, Inc.*, 695 So.2d 1169, 1172 (Ala. 1997); *Illinois Ins. Guar. Fund v. Lockhart*, 504 N.E.2d 857, 860 (Ill. App. Ct. 1987); *State Farm Fire & Casualty Co. v. Nikitow*, 924 P.2d 1084, 1087 (Colo. Ct. App. 1995); *Hartford Ins. Group v. Liberty Mut. Ins. Co.*, 311 A.2d 506, 507 (D.C. 1973); *KHD Deutz of America Corp. v. Utica Mut. Ins. Co.*, 469 S.E.2d 336, 338-39 (Ga. Ct. App. 1996); *S.B. Corp. v. Hartford Accident & Indem. Co.*, 880 F.Supp. 751, 756-57 (D. Nev. 1995); *American Home Assurance Co. v. International Ins. Co.*, 684 N.E.2d 14, 16 (N.Y. 1997); *Whaley v. Underwood*, 922 S.W.2d 110, 112-113 (Tenn. Ct. App. 1995).

²² See *Miller v. Dilts*, 463 N.E.2d 257, 265-66 (Ind. 1984); *Aetna Casualty & Surety Co. v. Murphy*, 538 A.2d 219, 223 (Conn. 1988); *Henschel v. Hawkeye-Security Ins. Co.*, 178 N.W.2d 409, 415 (Iowa 1970); *Bankers Ins. Co. v. Macias*, 475 So.2d 1216, 1218 (Fla. 1985).

²³ See *West Bay Exploration v. AIG Specialty Agencies*, 915 F.2d 1030, 1036-37 (6th Cir. 1990)(applying Michigan law); *Augat, Inc. v. Liberty Mut. Ins. Co.*, 571 N.E.2d 357, 361 (Mass. 1991); *Met-Coil Sys. Corp. v. Columbia Casualty Co.*, 524 N.W.2d 650, 658-59 (Iowa 1994).