

# NO INDEMNITY OBLIGATION WHERE POLICYHOLDER FAILED TO COMPLY WITH REPORTING REQUIREMENTS

In *Wallace v. General Star Indemnity Company*, Case No. 1:06-cv-106 (E.D. Tenn., June 1, 2007) (Applying Tennessee law), the District Court for the Eastern District of Tennessee held that a professional liability insurance carrier did not owe an obligation to indemnify a policyholder under a claims-made policy for a judgment where the policyholder did not submit a written report of a patient's malpractice claim before the coverage period expired.

The insurer issued a professional liability policy for a policy period starting on September 1, 2003 and expiring on September 1, 2004. The underlying plaintiff filed a complaint against the policyholder on August 30, 2004 and the policyholder was served with the complaint on September 1, 2004. On September 3, 2004, the policyholder sent a facsimile containing the summons and complaint to the professional liability insurance carrier. The professional liability policy required that the professional services giving rise to the claims be rendered "on or after the retroactive date ... and before the end of the policy period ... and such claim is reported to us within ten (10) days of receipt by the named insured of a written notice of a claim and ... the named insured's written report of a claim is received by us prior to the expiration of the policy period." (Emphasis added).

The policyholder argued that the claims made provision which required the policyholder to submit in writing a report of a claim before the coverage period expired was at odds with the paragraph requiring that the policyholder report the claim within ten (10) days after the insured received written notice. However, the district court held that there was no ambiguity because the policy used the connector "and",

which connotes that both provisions must be satisfied before the insurer is required to offer coverage.

The district court reasoned that it was not inconsistent to require the policyholder to report a malpractice claim both within the coverage period and within ten days of receiving notice of the claim.

The district court also held that there was no ambiguity in the "Notice of Claim" provision of the professional liability policy. The "Notice of Claim" provision required the policyholder to deliver to the insurer "within ten (10) days of the date of receipt of the claim, every demand, notice summons, notice of intent to sue, summons, complaint and/or other documents the insured ... receives relating to the claim." The policyholder argued that the "Notice of Claim" section was inconsistent because it provided two different deadlines one within the policy period and one within ten (10) days. The district court found that there was no inconsistency in requiring the policyholder to submit a written report of a malpractice claim within the coverage period and then requiring the policyholder to forward any documents relating to the claim within ten days after receiving them.

The policyholder also argued that under the Tennessee Supreme Court ruling in *Alcazar v. Hayes*, 982 S.W.2d 845 (Tenn. 1998), the

policyholder's breach of the notice condition could not result in the forfeiture of insurance coverage unless the insurer was prejudiced by the delay (the "notice-prejudice rule"). However, the district court held that the Tennessee Supreme Court would not apply the notice-prejudice rule to claims-made policies because the application of this rule would "defeat the purpose of 'claims-made' policies, and in effect, change such a policy into an 'occurrence' policy." The court found that the professional liability policy at issue contained aspects of both a claims-made policy and an occurrence policy because the insured was required to report a malpractice claim before the coverage period expired, and the services which gave rise to the claim must have occurred before the coverage period expired. The district court reasoned that the claims made portion of the professional liability policy was a substantive requirement in the policy that measured the coverage provided under the policy and thus, it was not a technicality" like the notice requirement in an occurrence policy.

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