COVERAGE ESSENTIALS:
Policy Analysis – Reading, Interpreting and Understanding Insurance Contracts

A Risk Management Primer

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STUDENT GUIDE – POLICY ANALYSIS – READING, INTERPRETING AND UNDERSTANDING INSURANCE CONTRACTS

I. INSURANCE IS SUBJECT TO THE LAW OF CONTRACTS

Insureds, agents, and insurance carriers each have a specific role in the insurance transaction. Each also brings its own views, goals, and purposes to the transaction. Because of these differences, the intentions and responsibilities of all parties must be captured in writing so that each party knows what to expect from the other and what is expected of them – thus we have the insurance contract.

Insurance contracts are most often referred to as the insurance policy. The term policy sounds less threatening than "contract," but the parties must never forget that the insurance policy is a legal contract subject to all the general laws of contract. Insurance contracts (or policies) are also subject to several additional and unique legal theories because of the nature of their use and purpose.

The following paragraphs highlight general contract law and discuss the unique laws and legal theories surrounding insurance contracts. However, this handbook cannot and should not be construed as legal advice.

Defining **"Contract"**

A *contract* is a formal, private agreement between two or more parties intent on accomplishing a specific task, purpose or goal. Contractual agreements can encompass the performance of an act or acts, or an agreement to refrain from a particular act or acts. The Second Restatement of Contracts defines a contract as "a promise or set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty."

Specific duties and responsibilities are created and defined by a contract. In general, there are two types of contracts: 1) express contracts and 2) implied

contracts. With an express contract, the existence of the contract creates a duty, conversely, with an implied contract, the existence of a duty creates the contract.

Express Contracts

An *express contract* is one that has been reduced to writing. If designed properly, each contracting party's rights and duties are addressed in the final document. Express contracts leave little question of the intent to contract, but questions may remain regarding the intent or application of the contract. Each requirement of express contracts is discussed in this handbook, as are the unique facets of insurance contracts.

Implied Contracts

Implied contracts are oral or "understood" contracts or agreements created by the actions, words, or the apparent intentions of the parties and are generally based on the surrounding circumstances. Such contracts may or may not have the same legal bearing as an express contract.

For an implied contract to have the same weight as an express contract there must be an assumed and presumed "meeting of the minds." In essence, an implied contract enforces what a "reasonable person" sees as fair based on the actions, inactions, statements, or non-statements of the parties.

Two types of implied contracts are 1) implied-in-fact and 2) implied-in-law. The first is based on the conduct of the parties leading up to the dispute; the second is used by courts to prevent one person's unjust enrichment at another's expense. A discussion of each follows.

Implied-in-fact contracts are created by words and/or deeds of the "contracting" parties, even when the exact intentions or expectations of each are not in writing – they are created by the facts surrounding the dispute. For example, a manufacturer contacts a supplier, with which the manufacturer has had a business relationship for many years, and says, "I'm in a bind; please send me 3,000 widgets – fast."

The supplier sends the 3,000 widgets and an invoice for $30,000 due in 30 days. The manufacturer refuses to pay because the historical price has been $5.00 per piece, but this order was $10.00 per piece. The manufacturer assumed the price would be

the same, but never asked. The supplier explains that the cost of raw materials had increased, and the rush job required overtime and other expenses. Does the manufacturer owe the $30,000? Without any other information (e.g., prior agreements, etc.) and based on the facts surrounding this transaction, yes – there is an implied-in-fact contract. An incorrect assumption by the manufacturer does not relieve it of its duty to pay what is owed.

Implied-in-law contracts, also called "quasi-contracts," are legal fictions created by courts to avoid unjust enrichment by one party to the detriment of another. Courts create these contracts after the fact to preserve "fairness" and reasonable expectations between the parties.

Again, the existence of a duty creates the contract; where there is no duty (no unjust enrichment), there is no contract.

Deciding the existence of an implied-in-law contract hinges on duty and fairness. To illustrate: While working in my office one afternoon, the doorbell rang. A lawn care contractor handed me a bill for whatever the substance was he just sprayed on my yard. I refused to pay because I had not asked for his services. Turns out he had gone to the wrong house and didn't confirm it before he began spraying. Since I had not ordered or requested the services, nor knew anything about them until after he had finished, no duty had been created and no quasi, implied-in-law contract existed.

But changing the facts could change the duty owed in the mind of a reasonable person. Suppose I looked out just as the contractor began spraying my yard, and knowing what he was doing, I let him continue, even though I had not ordered the treatment. Would I have been unjustly enriched at his expense? Would a duty on my part have been created? The answer to both is yes; thus, a quasi-contract is created, and I have a duty to pay.

Insurance as a Contract

Insurance is the transfer of risk from the insured (the party with an exposure to loss) to the insurance carrier. Additionally, insurance involves risk sharing or pooling among the members of a group (the insureds). Such a complicated arrangement involving multiple parties requires some formality to allow it to work

properly. Without a formalized agreement/contract, managing such a program would be impossible.

Insurance contracts, or policies, are subject to the general law of contracts. However, insurance contracts also require special consideration and treatment because they are unique in their purpose, creation, and design.

Before we explore general and specific insurance contract law, there is one unique feature of insurance contracts to understand, and few insurance carrier employees may fully grasp this. *The insurance contract is only the minimum the insurance carrier must do*. Insurance carriers can always do *more* than is required by the contract; but they cannot do *less*. The policy is the minimum standard. This is true of all insurance contracts or policies.

II. THE GENERAL LAW OF CONTRACTS

Contracts are private, legally enforceable documents between or among two or more parties. Courts do not intend to govern contracts because of their private nature, and because courts prefer to avoid interfering with a person's (natural or legal) right to contract. However, contracts must adhere to five requirements to be considered legal and thus enforceable:

- There must be an offer and acceptance;
- Consideration is required;
- The object or objective must be legal;
- Competent parties are required; and
- The contract must be in a legal form.

Offer and Acceptance

Enforceable contracts require *an offer and full acceptance* of the offer. Contracts are offered by one party and accepted, *in whole*, by another party. Nonacceptance of any part of a contract is considered a counteroffer that must be accepted by the

initial offering party for a contract to exist. Several offers and counteroffers may occur before a final contract is approved by all parties.

In the insurance contract, an offer is made by the insured (the insurance buyer) in the form of the application. This is why all the information in the application is important and must be addressed by the insured (not the agent).

Acceptance is granted by the insurance carrier when coverage is bound as per the terms of the insurance contract. All policy forms and endorsements referenced and attached are all part of the contract.

Consideration

Consideration in the context of a contract means something of value. All parties to a contract must put up or pledge consideration. In insurance contracts, the insured pays the premiums and promises to meet all contract conditions; the insurance carrier promises to pay claims.

The premium and promise are the insured's consideration. A promise is the insurance carrier's consideration. Insurance contracts seem to involve an unequal exchange of consideration; this is one of the unique facets of an insurance contract that is addressed later in this handbook.

Legal Object and/or Objective

Contracts can be written, but they cannot be enforced when they involve illegal objects or activities. No court is going to enforce a contract that requires someone to commit an illegal act or whose object is illegal. Contracts are only enforceable when the subject/object of the contract or the actions required by the contract are legal.

Competent Parties

Only competent parties can be held to the requirements of a contract. Two tests must be satisfied for an individual to be considered competent: 1) the individual must have sufficient mental capacity to understand the contract (this includes intoxication) and 2) the individual must be of legal age (varies by state). Each state

and the federal government have individual rules for judging and declaring an individual incompetent under these two tests.

Any party to a contract who is considered or judged *incompetent* by one of these two tests can repudiate the contract. To *repudiate* means to reject the contract as unauthorized or having no binding force. Essentially, the incompetent party is not forced to abide by the contract.

Legal Form

Beyond the requirement that the subject of the contract or the activity required in a contract be legal, the contract itself must be legal. There are contracts whose activities are perfectly legal, but the construction of or the requirements of the contract are not. These are often referred to as contracts against or contrary to public policy; in extreme circumstances, these contracts are called *unconscionable*.

Contracts must also be constructed according to a certain standard, however broad, so that all the information necessary to judge the contract is contained in or specifically referred to by the contract. To be enforceable, both parties must know all the provisions that affect the contract. Without this knowledge by all parties, "communication" has not been established and the offer/acceptance is based on incomplete information. Therefore, the contract may not be enforceable.

Another requirement of contracts is that they cannot be used to remove or transfer away an individual's or organization's legal responsibility. For instance, an employer cannot contract away the statutory requirement to provide workers' compensation benefits for their employees. The employer can contract for the *financing* of the benefits required (the purpose of a workers' compensation policy), just not the *responsibility*. These can be referred to as *exculpatory* agreements. (***Note:*** Don't confuse this example with the use of a professional employer organization (PEO). In a PEO arrangement, the workers are the PEO's and the former employer contracts them back.)

III. UNIQUE LEGAL CHARACTERISTICS OF INSURANCE CONTRACTS

Insurance contracts must comply with the general rules of contracts and a set of rules unique to insurance policy forms. The unequal relationship between the contracting parties, the legal and financial necessity of insurance, and each party's dependence on the other necessitate seven additional insurance-specific rules of contract, as follow:

- Personal contract;
- Unilateral contract;
- Contractor of adhesion;
- Aleatory contract;
- Indemnity contract;
- Condition contract; and
- Contract of utmost good faith.

Personal Contract

Insurance contracts (with the exception of surety bond forms) are two-party agreements between the insurance carrier and the insured. There are no other parties to the contract; even the agent is not a party to the agreement (and as such has no duties in the contract). This is why the named insured must be correct and why policies cannot be transferred to another party without the insurance carrier's approval.

The insurance carrier underwrites the specific insured, and they accept the risk presented by that insured – no others. Because insurance policies are personal contracts between the insurance carrier and the insured, the idea that any other party could or should assert their will over that contractual relationship borders on obscene. But such interference occurs every day, especially in the construction industry.

Unilateral Contract

"Uni" means "one way." Only one party to the insurance transaction *must* do something: the insured. The insured pays the premium and the insurance carrier

waits until something happens before they have to do anything. If no loss occurs during the policy period, the insurance carrier owes no duty to perform. A promise by the insurance carrier is given in exchange for an act by the insured.

Consideration is a requirement under the general law of contracts. To meet this requirement, both parties must put up something of value. Conceptually, unilateral contracts seem to violate the requirement of consideration because only one party (the insured) is initially, and potentially singularly, required to put up anything of value. But this is not the correct view; what is the value of the promise made by the insurance carrier? The promise's value is potentially the entire face amount of the insurance policy; thus, the promise has value (provided the insurance carrier lives up to the contract).

Contract of Adhesion

"Adhesion" connotes the idea of sticky or "stuck with," and to some extent, this idea is correct. The insurance carrier and the insured are not bargaining from an equal footing; the insurance carrier controls a much stronger position because it wrote the policy. The carrier chooses which insureds and which coverages it is willing to accept. Essentially, the insured is "stuck with" the insurance contract agreed to by the insurance carrier (remember, in the insurance transaction the insurance carrier accepts the insured and its risk).

Because insureds have little ability to negotiate policy language, they are stuck with what they get. It is true they can ask for broadening endorsements or the removal of an exclusion by endorsement, but even those forms and endorsements (contracts) are written by or for the insurance carrier. Although being "stuck" with the wording might sound like a negative, it is actually a positive for the insured.

Coverage extended by an insurance contract is interpreted in its broadest sense and exclusions are narrowly applied because of the concept of adhesion. Courts conclude that because the insurance carrier controls the policy language, the party that did not participate in writing the policy language – i.e., the insured – should get the benefit of the broadest coverage interpretation and the narrowest application of exclusions. If coverage can be reasonably asserted or a reasonable ambiguity is

found, courts give the benefit to the party with the weaker negotiation position – again, the insured (in most cases).

However, if the insured does have a part in crafting policy language, the concept of adhesion is altered. When insureds are allowed to attach manuscript policy language, the insured is in a stronger negotiating position and the rules of interpretation differ. If a loss or claim triggers the co-written policy language, the outcome falls back to the application of general contract law.

Aleatory Contract

Aleatory means "dependent on chance, luck or an uncertain event." With insurance contracts, the performance of the insurance carrier is contingent or dependent on the occurrence of an insured event, which may never materialize. Aleatory is the other side of unilateral – if a specific event occurs, the insurance carrier will fulfill its promise. If nothing occurs, the insurance carrier owes no duty.

For example, a homeowners' insurance contract promises to pay if there is damage caused by a fire. If the policy year runs and a fire never occurs, the insurance carrier is not contractually bound to pay anything.

Indemnity Contract

Insurance operates on the principle of indemnity. *Indemnity* (or indemnification) means to return the insured, as closely as possible, to the same financial condition that existed prior to the loss or would have existed had no loss occurred without unjust enrichment or improved position.

To accomplish and preserve indemnification, the insurance contract limits when and what the insured or the injured party is paid following a loss. These limitations and requirements include: 1) insurable interest, 2) an unimproved position, 3) the inability to collect from multiple insurance policies, and 4) subrogation rights.

Insurable Interest: Property and casualty insurance requires insurable interest to exist at the time of loss (life insurance requires insurable interest only when the policy is acquired). If damage to or destruction of property could cause financial harm or loss to the insured, they are considered to have an insurable interest.

Ownership, a bailment, a contract, and/or a loan or mortgage can create insurable interest.

Property owners obviously have insurable interest in the property they own. Damage to or destruction of the property deprives them of its value and use generally resulting in some level of financial harm.

Bailments make the bailee (the person who takes possession of the property) responsible for any damage to the bailor's property while it is in the bailee's possession – as if it were his own property (but payment is only for the benefit of the owner/bailor). For example, a dry cleaner loses or damages a customer's clothes. The dry cleaner (the bailee) is financially responsible to the customer (the bailor) for the loss.

Contracts, such as a lease agreement, can transfer financial responsibility for damage to property to a tenant where they would not have been prior to the execution of the contract. Lease agreements often make the lessee (the person who takes possession of the building via contract) financially responsible for any damage to the building. Such contractual responsibility creates insurable interest where it previously did not exist.

Any person or entity that loans money for the purchase of property has an indirect insurable interest in the property's continued viability until the loan has been repaid. A mortgagee has financial interest in the real property on which it loaned money because the property (the house or building) is the collateral until the loan is repaid. If the structure is destroyed, and the buyer (mortgagor) stops paying, the mortgagee could be harmed financially. The same concept applies to loss payees that extend loans for personal property (such as cars and equipment). Once the loan is repaid, the mortgagee and loss payee have no further interest in the property.

Unimproved Position: Indemnification is preserved when the insured is returned, as closely as possible, to the same financial condition that existed before the loss. But indemnification is violated if the insured is placed in a *better* financial position than existed prior to the loss. Being, or the possibility of being, financially improved by a loss creates a moral hazard. To assure that the insured is not improved

financially, the insurance policy limits the amount of payment by valuing insured property on either an actual cash value basis or replacement cost basis.

Actual cash value (ACV) is the cost to replace damaged property with new property of like kind and quality minus the value of its physical depreciation. Essentially, the "used up" value of the property is subtracted from the loss payment. Calculation of ACV often differs by jurisdiction. The most common calculation methodologies are:

- Replacement cost at the time of the loss minus PHYSICAL depreciation;
    - Use of the Broad Evidence Rule (all facts regarding the value of the property are considered; or
    - Market value – what a willing buyer will pay a willing seller.

Replacement cost does not consider or apply the "used up" value; it is the cost to replace with like kind and quality at the time of the loss without deduction for depreciation. Why doesn't this arrangement violate the principle of indemnity? Isn't the insured better off than before the loss? After all, they are getting new property for used property.

In practice, replacement cost is the *truest* form of indemnification. Consider this illustration: The insured's production equipment is destroyed by fire. Without the machinery, the insured cannot operate; money from the insurance carrier doesn't necessarily do any good – the insured needs the equipment to stay in business. The same is true with a building: the insured needs a building, not the money.

Replacement cost is the best mechanism for returning the building and contents to the insured with the only out-of-pocket expense being the deductible chosen by the insured (provided the correct limits are chosen by the insured). This is the most appropriate demonstration of the goal and purpose of indemnification – the insured gets a building for a building; a machine for a machine; etc.

To further assure that indemnification principles are not violated and are, in fact, upheld when replacement cost is the chosen valuation method, the amount of insurance purchased must equal the cost new of the insured property *on the day of the loss*. Consider this example: A piece of production machinery cost $100,000 when purchased new 5 years ago; its current depreciated value is $50,000. But to

buy the same piece *today* cost $150,000. When insuring on a replacement cost basis, the *only* amount that matters is what it cost on the date of the loss; thus, the insured purchases $150,000 coverage on the machinery. The same process is applied to all real and personal property insured on a replacement cost basis. Insuring the property for what it would cost to purchase *today* and paying the premium to cover that amount assures that replacement cost does not violate indemnification.

Multiple Insurance Policy Provisions: Two provisions in property and casualty insurance policies address the existence of more than one insurance policy that may respond to a specific loss. In property insurance, the limitation exists to assure that the insured is not enriched by a loss or by collecting or being able to collect from multiple policies. In liability coverage, these provisions assure that there is a predetermined method for dividing the total loss among multiple carriers. The first of the two provisions is the "other insurance" provision, which applies to property and liability policies. The second is an exclusion (with an exception) that applies only to property policies.

- **"Other Insurance" Provisions**: Commercial property and commercial general liability policies both address the possible existence of other insurance policies covering the same property or loss. Essentially, form wording for both coverage types states that the most the insured or injured party can or will be paid is the amount of damage or loss. Each policy in effect and applying at the time of the loss responds and pays. How each policy pays is based on the provisions contained in each subject policy.
    - *Pro-Rata Sharing:* Property policies state that if both (or all) policy forms apply the same coverage plan, terms, conditions, and provisions, the policies share the loss on a pro-rata basis. Pro-rata sharing means that each carrier pays the percentage of loss in proportion to the amount of coverage they provide compared to the entire amount of coverage. So, if the insured has two policies with a total limit of $100,000, and carrier "A" provides $75,000 of that limit, it will pay 75% of the loss (up to its policy limits).

- *Contribution by Equal Shares:* Liability coverage forms prescribe a different method of sharing when policies share policy language, terms, conditions, and provisions – contribution by equal shares. Such sharing means that each carrier will pay equal amounts of the loss until one or all of their limits are exhausted. Consider the insured with two commercial general liability policies: Carrier "A" provides $1 million of coverage and Carrier "B" (*not* an umbrella/excess carrier) extends $2 million for a total primary limit of $3 million. If there is a $2.5 million loss, Carrier "A" and "B" would both share the loss until carrier "A's" limits are exhausted, then "B" would pick up any excess. In this example, both carriers pay $1 million, but Carrier "B" pays an additional $500,000. However, on a *pro-rata basis*, Carrier "A" would have paid one-third of the loss (a little over $830,000) and Carrier "B" would have paid two-thirds. So, contribution by equal shares costs "A" more but "B" less – a more equitable split.
- *Excess of Loss Sharing:* Both property and liability policies specify that if the "other" policy(ies) applies different language, terms, conditions, and provisions, one policy will be primary and the other excess until all limits are exhausted. The policy that states it will apply as excess doesn't pay until the "primary" policy has exhausted its limits. For example, Carrier "A's" policy and Carrier "B's" policy are written applying different language, terms, conditions, and provisions. Carrier "A's" policy states that it is excess over any other policy when these differences exist. Carrier "A" provides $45,000 coverage and Carrier "B" extends $35,000 protection. A $45,000 loss occurs; because different forms are used, Carrier "B" pays first, and Carrier "A" does not respond until "B's" policy limits ($35,000) are exhausted. In this loss example, Carrier "A" only pays $10,000 because "B" paid the first $35,000. But what happens if *both* policies say they are excess? In that situation, the method of sharing reverts back to pro-rata sharing or

contribution by equal shares, depending on the policy type, as described above.

- **Specific Exclusion**: Property policies expressly exclude from the list of covered property any property that is specifically insured by another policy (such as an inland marine form). However, property forms that do exclude property specifically listed and insured on another policy do, generally, agree to pay any loss in excess of the limits paid by the other, more specific, form; but only the excess amount – regardless of whether or not the insured can collect from the primary policy. Such exclusion and exception combine to assure that the insured is indemnified for his loss (subject to the limits purchased).

Rules regarding recovery from multiple sources in cases of legal liability (injury to a third party) differ from the rules applicable to property losses as detailed above. When there is legal liability on the part of the insured, the injured party is allowed to recover from multiple sources because of the *collateral source rule*. The collateral source rule holds that in cases of legal liability, the injured party (not the insured) can collect from multiple sources (e.g., the CGL, health insurance, etc.) because allowing the at-fault party (the insured) to escape some level of liability because another source of funds exists would, in effect, relieve him of part of his legal responsibility to the injured party.

Subrogation: Individuals or entities harmed by a third party have the right to recover the financial cost of that harm from the at-fault party. If, however, the injured party chooses to seek reimbursement from his own insurance carrier rather than going through the process of trying to collect from the at fault party, the right of the injured party to recover from the at-faulty party is transferred to the insurance carrier. In essence, a third party has financially harmed the insurance carrier. The insurance carrier's right to recover from the at-fault party flows from the injured insured's right to recover from that party.

Without subrogation provisions, the injured party might be able to collect from *both* the at-fault party and the insurance carrier. Subrogation ensures that such double recovery is avoided, and the principle of indemnification is preserved.

Notice that the insurance carrier's subrogation rights flow from the right of their insured (the injured party) to recover from the at-fault party. If the injured party has waived its right to recover from the at-fault party, the insurance carrier has no right to recover. Such waiver is often done in writing via contract. Once the right of the injured party to recover is waived in writing, there is no way it can recover any loss from the at-fault party – thus indemnification rules cannot be violated. And because the injured party cannot recover from the at-fault party, neither can the insurance carrier.

Rights of subrogation can only be waived in and under specific circumstances. Liability policies state that the insured must do nothing "*after a loss*" to impede the insurance carrier's right to recover from the at-fault party. This presumably indicates that the insured can waive its rights of recovery prior to a loss; indeed, this is often done as part of contractual risk transfer or by endorsement. The commercial property policy allows insureds to waive their and thus the carrier's right to recover before the loss, if done in writing, and also after the loss, but only if:

- The at-fault party is also an insured in the policy,
- The at-fault party is a business owned or controlled by the insured or that owns or controls the insured; or
- The at-fault party is the insured's tenant.

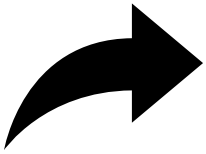
(***Note****:* This only applies to commercial property coverage.)

Endorsements can also be added to all property and most general liability policies waiving the insurance carrier's right to recover from the at-fault party. These "waiver of subrogation" endorsements are often subject to underwriter approval.

The term "subrogation" may not actually be found in the policy. Various terms are used to describe the carrier's subrogation rights; three examples are:

- "Transfer of Rights of Recovery Against Others to Us" (found in commercial property, commercial general liability (CGL), business auto (BAP), businessowners (BOP), inland marine, and umbrella)
- "Subrogation" (found in the homeowners' policy)
- "Our Right to Recover Payment" (found in the personal auto policy)

Conditional Contract



Before any insurance contract responds as promised, certain conditions must be met; they are known as either *conditions precedent* or *conditions subsequent*. "Precedent" and "subsequent" require a certain point in time – that point in the insurance transaction is the loss or occurrence and the incident's report to the insurance carrier.

Conditions precedent must be fulfilled to initially activate the insurance contract and trigger a review for the payment of a loss. In insurance, the conditions precedent are: 1) the premium must be paid, 2) a covered loss must occur, and 3) the claim must be properly reported (this includes method and timing).

Conditions subsequent are acts or duties that must be accomplished after the loss and its report in order to receive the benefits promised by the policy. The "duties after a loss" section of any insurance policy demonstrates examples of the conditions subsequent.

If either the conditions precedent or conditions subsequent are not met, a claim may not be paid. Insurance benefits are paid only when the insured satisfies the conditions placed on it. See also "Rule 11" for reading an insurance contract.

Contract of Utmost Good Faith

Both parties to the insurance contract rely almost totally on the honesty of the other party. The insurance carrier relies on the honesty of the insured in providing information; the insured relies on the honesty of the insurance carrier and its promise to pay when a covered loss occurs.

Dependence on honesty and utmost good faith begins with the offer to purchase insurance. Remember, the offer is made by the insured in the form of an application. The insurance carrier has little choice but to trust the information the insured provides in the application; thus, the insured is required to be honest. Most insurance applications require the insured to "represent" that the information they are providing is true, but only to the *best of their knowledge*.

A representation allows room for unintentional mistakes. Conversely, a *warranty* application holds that all the information provided is guaranteed to be true and correct; any incorrect information can adversely affect coverage, and wrong information generally negates coverage. Use of warranty applications is now limited almost exclusively to ocean marine insurance applications.

A middle ground exists between representation and warranty applications – the *representation with dependence*. Applications (and their resulting policies) utilizing representation with dependence are most often found in executive and professional liability coverage. The application is generally made a part of the policy for these lines of coverage.

Although not as stringent as a warranty, the representation with dependence does require a much higher level of certainty when providing the information requested in the application. Anytime an application is to be attached to and become part of the policy, polling letters are recommended.

A *polling letter* is a letter sent to and questioning all staff members who would or should have knowledge of any acts or omissions that could give rise to a claim requesting specific information about such acts or omissions. In large companies, the CEO, CFO, COO, or even the risk manager charged with filling out the application may not and likely do not know of every circumstance or threat that has occurred; and because the underwriter places more emphasis on the application, it is important to ask everyone involved or who might have special knowledge not widely known.

Since the majority of insurance applications treat the information provided by the insured as a representation, the remainder of this section focuses on the concept of representation and its violation. The terms misrepresentation, concealment, material fact, and void are all defined and explained in the following paragraphs as they relate to the concept of representation. Also explored are the concepts of waiver and estoppel.

Misrepresentation and Concealment: *Misrepresentation* is a dressed-up term for a lie. This is knowingly providing false information on an insurance application or to the agent in order to entice the underwriter to accept the offer for coverage. *Concealment* is a misrepresentation (or lie) by omission to prevent information

detrimental to the insured from being known. Misrepresentation and concealment of a material fact can void coverage. This is why agents should never fill out the application for or on behalf of the insured. All the questions must be asked, and the insured must answer; the information provided in the application is the insured's representations of the facts.

Two key concepts were introduced in the preceding paragraph: material fact and void. A *material fact* is information or data supplied by the insured and relied on by the underwriter to make an underwriting decision. *Void* means "as if the policy never existed." Essentially, if the underwriter accepted coverage, to its detriment, on the basis of a misrepresentation or concealment of a material fact and a loss occurs, it's as if the policy never existed, and no coverage is provided for the loss.

Material Fact: What makes a fact material? Not all information provided by the insured qualifies as material. A fact is material if one of the following applies.

- The underwriter would not have accepted the risk offered if the underwriter/carrier had been aware of all the correct information.
- The underwriter would have charged a different (higher) premium.
- The underwriter would have applied different terms and conditions in the coverage provided.

Applications do not and cannot address every conceivable risk presented by insureds. Sometimes it is incumbent upon the insured to provide information that would be considered material. The, "You didn't ask me if I made fireworks in my basement so I didn't tell you," argument will not carry much weight with the carrier or the court. Even though insureds may not know or understand insurance, reasonably intelligent people intrinsically know when something is important in regard to insurance and insurability.

Waiver and Estoppel: Insurance carriers must also practice utmost good faith in all transactions with their insureds, not just in their promise to pay claims. Two concepts apply to insurance carriers preserving the idea of utmost good faith in the insurance carrier/insured relationship: 1) waiver and 2) estoppel.

A *waiver* is the intentional forfeiture of a known right. Once given up, the insurance carrier cannot attempt to enforce the previously held right at some future point –

the right is lost forever. For example, the underwriter discovers a material misrepresentation but agrees to provide coverage anyway. Any rights previously owned by the insurance carrier to assert misrepresentation and void coverage are waived now and in the future.

Estoppel completes the concept of waiver and is defined as: "To stop, block, or not allow a party to take a new position detrimental to the insured that contradicts previous actions or conditions upon which an expectation was created." When a right is waived, the party waiving its right (the insurance carrier) is estopped from being able to assert that right in the future.

True waivers are generally given in writing (although some are given verbally). However, some waivers are created by the silence, actions, or inaction of the party that previously held the right.

Consider, as an example, the insurance carrier that has allowed insureds to deliver payment to the agent, even though company guidelines do not allow for this arrangement. After years of this practice, an insured drops his payment at his agent's office; the agent calls the carrier only to learn that this practice is no longer allowed, and the insured's policy will be cancelled at midnight unless the money can be delivered to the insurance carrier's office (two states away).

Although the carrier originally had the right to require payment directly to its office, its previous action, the failure to enforce this right, serves to waive the right. Because of this waiver by action (or inaction), the carrier is estopped from enforcing its previously held rights. To reassert this right, the carrier must give reasonable warning, and should be forced (under waiver and estoppel) to accept payment through the agent for a reasonable amount of time.

If a change in position on a previously held yet waived right is unfairly detrimental to the insured who relied on the position, the insurance carrier is estopped from asserting that right for a reasonable period. This is known as equitable estoppel or *estoppel in pais*.

IV. THE INSURANCE CONTRACT AND THE "DOCTRINE OF REASONABLE EXPECTATION"

Insurance contracts are subject to state and federal statutes related to contract, the Statute of Frauds, and common law (including the concept of *stare decisis* or precedent). But because insurance contracts (policies) apply the concept of "adhesion" – stating that any ambiguity is found in favor of the insured – the Doctrine of Reasonable Expectation also applies to the insurance contract.

The Doctrine of Reasonable Expectation takes the concept of adhesion one step further by mandating that an insurance contract be interpreted the way a reasonable buyer would interpret it, even to the point of finding coverage where it may not expressly exist. The doctrine requires that:

- The insurance contract is to be interpreted the way a reasonably intelligent person, who has not been trained in law, would interpret it; and
- Where a provision has more than one reasonable interpretation, the findings must favor the objectively weaker party – the insured.

Legal documents such as insurance contracts are designed to accomplish specific goals and assign specific duties. The insurance policy defines the coverages provided, plus it describes the duties and responsibilities of each party to the contract. Because of the legal design of the insurance policy and its need to fulfill the expectations of the insured, the Doctrine of Reasonable Expectation applies when:

- A term is not defined within the policy. When the insurance carrier wants to control the meaning of a term, it is defined in the policy. When not defined, the term is given its dictionary or common use meaning.
- The plain meaning of the contract is not readily apparent to a reasonably intelligent person.
- Policy terms and provisions are susceptible to more than one reasonable interpretation.

- There is no plain meaning apparent when the terms of a particular section are viewed in the context of the policy as a whole.

In essence, the Doctrine of Reasonable Expectation requires that the insured be granted protection if a reasonable case can be made that coverage exists, regardless of the insurance carrier's intent in the policy language. If a reasonable person would expect there to be coverage when he reads all the applicable sections of the insurance policy, then coverage exists under this doctrine. Insurance and legal professionals who read policy language every day, and presumably understand it, must not forget that most insureds do not "get" insurance, and their expectations may differ from the policy's intended reality.

However, this doctrine does not open the policy to every conceivable interpretation. The interpretation must be reasonable in the context of the entire contract. Courts will deny interpretations deemed unreasonable.

Add the law of agency to the Doctrine of Reasonable Expectation and the insured's confusion intensifies. With the agent-carrier relationship, the agent represents the insurance carrier; and the law of agency states that the actions of the agent are imputed to its principal (the insurance carrier). If the agent creates an expectation in the mind of the insured, more problems may be created - and more claims may be paid than intended. This is why a certain percentage of errors and omissions claims are insurance carriers suing their agents – the agent created an incorrect expectation in the mind of the insured.

Consider the case in which an agent told his insureds, "If you can touch it, it's covered." An overly broad statement such as this without any other qualifiers creates an expectation in the insured's mind with which the insurance carrier may have to comply.

V. CONSTRUCTION OF THE INSURANCE CONTRACT

Every insurance policy contains at least four parts: 1) declarations, 2) insuring agreement, 3) conditions, and 4) exclusions. An easy way to remember these four parts is the mnemonic "DICE." Most policies also contain one or more policy endorsements to customize the policy to the particular insured or to meet certain underwriting guidelines (among other reasons).

- **Declarations:** The declarations relate all the pertinent information about the insured. It includes the insured's name, address, coverage types, coverage limits, policy effective dates, premiums, the insurance carrier providing the coverage, and often the agent representing the carrier.
- **Insuring Agreement:** Generally found on the first page of the policy itself, the insuring agreement gives the outer perimeters of coverage. This is the broadest coverage available in the policy; if the loss is not considered or covered by the insuring agreement, there is no reason to go any further. The insuring agreement is altered by the policy exclusions and conditions.
- **Conditions**: The duties of the insured are spelled out in this section.
- **Exclusions:** This section details what is not covered by the policy.

VI. THE RULES OF READING ANY INSURANCE POLICY

Rarely does any insurance practitioner, even the "hard core" ones, undertake to read an entire insurance policy, including endorsements. Generally, the agent consults the form only when a specific answer is being sought or a problem is being researched. In situations like these, usually only individual parts of the form and its applicable endorsements need to be reviewed to develop an answer or opinion.

Whether reading an entire policy or only sections, some specific "rules" can be applied when reading the policy form to make finding the needed and most correct answer easier and quicker. These are not shortcuts to reading the policy, as there are no shortcuts to reading any legal document; instead, these are pointers towards correct policy interpretation and application.

VII. WHO QUALIFIES AS AN INSURED?

Ascertain who qualifies as an insured. If the person or entity suffering or causing the loss, injury, or damage is not an insured, there is no need to go any further – there is no coverage. Remember, there are four potential levels of insureds: 1)

named insured(s), 2) extended insureds (same amount of protection as the named insured), 3) automatic insureds, and 4) additional (by endorsement) insureds.

a. **Named Insureds:** These are the "You" on the policy. These persons (natural or legal) are given the broadest protection in the policy. The named insured HAS to be right! Both to extend the coverage to intended entities and to NOT extend coverage to unintended parties/entities.
b. **Extended Insureds:** Varies based on entity type
    1) **Individual**: You and Spouse for liability arising from the conduct of the business.
    2) **Partnership**: You, Partners, and Spouses for liability arising from the conduct of the business.
    3) **Joint Venture**: You, Members, and Spouses (if applicable) for liability arising from the conduct of the business.
    4) **Limited Liability Company**: You and members for the conduct of the business; Managers for duties as manager.
    5) **Other Organization:** You, executive officers, and directors with respect to their duties. Stockholders for their vicarious liability as stockholders.
    6) **Trusts:** You and Trustees(for their duties as such)

Protection for "Extended Insureds" is equivalent to the protection extended to the "You."

- **Automatic Insureds:** Protection is provided because of their relationship with and to the named insured. These individuals/entities are related to and/or contribute directly to the activities of the insured's business or operation and are often subject to exclusions not applicable to "You's" and "extended insureds."
- **Additional Insureds:** Provide benefit to OR receive benefit from the named insured but are not "related" to the named insured. Coverage is always extended by endorsement to additional insureds. Additional Insureds are often extended the **least** amount of or very limited protection.

Not every policy contains all four "levels" or types of insureds. Read the form to confirm which types or "levels" of insureds are present.

Correctly Name Insureds Remembering the Differences in Entity Types

- Corporation: Exactly as listed with the Secretary of State
- Professional Association: Exactly as listed
- LLC/LLP: As listed with the Secretary of State
- Partnerships: Depends on whether a partnership agreement exists and if so if it is named in the agreement. Exactly as named. If not named, the last names of the partners.
- Sole Proprietors: Full legal name of the owner.
- Joint Ventures: As found on the JV agreement
- Associations: Exactly as listed with the state regulatory body.
- Trust: The name found on the trust agreement.

Annotate the policy form. Annotation is necessary; do this by highlighting the areas modified by an attached endorsement and list which endorsement(s) change(s) that section. When reading and trying to interpret that part, apply the endorsement wording directly. Additionally, where other parts of the form or endorsement alter the wording of the form (such as an additional coverage directly altering an exclusion), note that in both places.

Confirm all forms and endorsements are attached. Compare the forms and endorsements listed on the declarations page with the forms and endorsements actually attached to confirm that the entire policy is available. This includes confirming that the edition dates match (the breadth of coverage can change between edition dates).

VIII. READ THE INSURING AGREEMENT FIRST

Read the "Insuring Agreement" first. This is the broadest coverage will ever be, so start here. If the loss is not contemplated in the insuring agreement, there is no reason to go any further. Generally, there are limitations found in the insuring agreement:

***General Liability**: We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages.*

There are four limitations to this wording: 1) the actions leading to injury must in some way involve an insured in the policy; 2) The insured must be legally obligated to pay (4 parts to this: Duty, Breach, Injury, Proximate Legal Cause); 3) the damages must arise out of "Bodily Injury" or "Property Damage" (no other causes are listed such as breach of contract, malfeasance, wrongful act, etc.); and 4) Must be paid in money (uses the term "sums") – and not to do something.

***Commercial Property**: We will pay for direct physical loss of or damage to **Covered Property** on the **premises described** in the Declarations caused by or resulting from any Covered Cause of Loss.*

First, notice that this does not refer to a particular insured, just the property. This is where the concept of "insurable interest" applies. Now, note There are four limitations in this agreement: 1) There must be a direct physical loss; 2) the loss must be to covered property (which is defined in the policy); 3) the property must be at the premises named on the declarations page (property underwriters like to know where stuff is and that it isn't going to move); and 4) the loss must be caused by a "Covered Cause of Loss" (made up of one of three cause of loss forms and any number of endorsements). If any of these is missing, there is no coverage.

IX. READ THE EXCLUSIONS

Read the exclusions. After reading the insuring agreement, move to the exclusions. In most liability and special form ("all risk") property policies, coverage is created when not excluded. Treat named peril property policies and the "personal and advertising injury" section of the commercial general liability policy differently. Read the list of covered perils (that which causes a loss) first, then the exclusions. Specialty forms such as D&O, EPLI and professional forms often contain a long list of exclusions limiting the definition of what is covered by the policy (i.e., a "wrongful act").

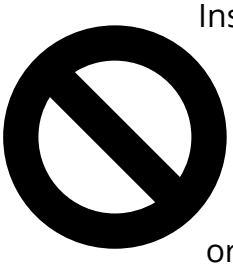
X. READ THE EXCEPTIONS TO THE EXCLUSIONS

Read the exceptions to the exclusions. Exceptions to exclusions give coverage back in specific amounts. It's easier for the carrier to give coverage back by exception than to try to use a long list of exclusions and it allows the insurer to control the breadth and sometimes the limits of coverage provided. This technique is used in property and liability forms.

When the policy refers to another section, read that section immediately. This can point to other provisions affecting a specific coverage or condition. Doing this gives a clearer picture of the language. Refer back to annotation.

Read and understand the definitions of specifically defined terms. When the insurance carrier desires to control the meaning of certain words and phrases, it does so by specifically defining them in the policy. Such definitions can limit or explain the breadth of protection. Words not defined in the contract are given either their common, everyday meaning as found in the dictionary or its technical meaning if a term of art within the context (a "term of art" is how a specific industry defines a term (this is common in professional liability policies). Be aware of legal translations that can be problematic (i.e., "Arising out of…" vs. "Caused by…"). Sometimes a legal translation of an undefined term results from a court finding that changes the historical understanding or application of a term or phrase.

XI. UNDERSTAND WHY EXCLUSIONS EXIST



Insurance was created as a mechanism to protect insureds against the financial consequences of an unforeseen, potentially catastrophic individual loss. The number of covered perils has expanded and contracted over time to match the changes in exposure's severity, frequency, and ultimate costs. But the original concept of protecting the insured's financial condition has not changed. However, insureds are not protected against every possible source of financial loss.

Traditional insurance policies contain a list or description of excluded perils. This is true whether the coverage is provided by a property or liability form, and regardless of whether the insured is a commercial or personal lines client. Exclusions always exist, and there is a reason for each one.

Three Categories of Exclusions

To fully understand the six reasons for exclusions first requires knowledge of the three broad exclusionary categories: 1) excluded "perils," 2) excluded "hazards," and 3) excluded "property." A *peril*, as defined previously, is the actual cause of the damage resulting in financial loss (e.g., a fire); a *hazard* is anything that increases the likelihood that a financial loss or peril will occur (e.g., frayed wires (the hazard) may cause a fire (the peril)); and *property* can be tangible or intangible.

- Excluded "perils": A "peril" is "that which causes the loss." And there are three "classes" of perils: 1) Natural (flood and earthquake); 2) Human (theft by an employee; and 3) Economic (loss of business income).
- Excluded "hazards": A "hazard" is something that increases the chance that a loss or peril will occur. There are five types of hazards: 1) Physical hazards; 2) Moral hazards; 3) Morale hazards; 4) Legal hazards; and 5) Informational hazards. The first three, Physical, Moral and Morale, are the most commonly known in the insurance world.

Excluded perils and excluded hazards are not equal in their ultimate effect on the insured. *Excluded perils* can often, but not always, be remedied by either an

exception to the exclusion, an endorsement, or the purchase of a separate policy. Conversely, *excluded hazards* are almost always absolute and without remedy.

In the Insurance Services Office's (ISO's) **Cause of Loss – Special Form** (CP 10 30), for instance, "Earth Movement" is an *excluded peril* but "War and Military Action" is an *excluded hazard*. Insureds can purchase earthquake coverage; but even difference in condition (DIC) forms exclude war, leaving the insured no recourse. Earth movement or earthquake is the peril, the actual cause of the loss, whereas war or military action simply increases the chance that something bad is going to happen. The war itself doesn't cause a loss; it's just a hazard that increases the chance of a loss.

Some exclusions walk the line between excluded peril and excluded hazard. The "Ordinance or Law" exclusion is a prime example. Ordinance or law is a peril because the enforcement of building codes actually does cause a financial loss; but it's also a hazard because the condition of being "out of code" increases the amount of loss and the possibility that a peril will occur. Because it is both, the exclusion can be remedied or removed by endorsement.

"Excluded property" is somewhat self-explanatory. There are two types of property: 1) tangible (things you can touch); and 2) intangible (intellectual property). Excluded tangible property can usually (but not always) be remedied by endorsement or a separate policy. Under the commercial property form, for example, there is no coverage for money. Likewise, under the commercial general liability form, there is no coverage for the property of others in the insured's care, custody, or control (with some exceptions). Both are property-related exclusions.

Intangible property generally needs specialty coverage such as Copyright Infringement, Patent Infringement (or even Patent Abatement).

Why the Exclusion?

From the three broad exclusionary categories flow the six most common reasons for exclusions. Nearly all policy exclusions arise from one of the following:

1. The peril or property is better covered elsewhere.
2. The loss or damage is collectively catastrophic in nature.
3. The loss or damage is not accidental or unforeseen.
4. The insurance carrier is willing to provide coverage, they just want more information and more premium.
5. The insurance carrier wants to control the amount of coverage granted.
6. The loss results from a "speculative" or business risk.

The Peril or Property is Better Covered Elsewhere: Some exclusions exist because a more appropriate coverage form is available to provide the needed protection. For example, loss of money is excluded in the commercial property form because this exposure is better covered under a crime policy; likewise, coverage for the use of an auto is excluded under the commercial general liability policy because the auto policy is the more appropriate place for coverage.

Property and liability forms both contain exclusions existing simply because the particular form was not created for that specific exposure. Agents must cover exposures using the appropriate coverage forms.

Another reason for the use of separate policies to provide coverage is the threat of *adverse selection*. Some perils and hazards are such that only those in danger of suffering such loss are willing to pay for the coverage. If only a small number of insureds buy the coverage, the insurance carrier would not have the necessary funds to pay the potential losses, which in turn would require higher premiums and would result in fewer insureds (thus begins the adverse selection death spiral). Some of these excluded losses also fall under the catastrophic loss exclusion.

The Loss or Damage is Collectively Catastrophic in Nature: Insurance was not designed to respond to community disasters (fundamental risk), only to individual "disasters" (particular risk). Certain perils and hazards have the potential to result in

widespread damage the industry is not prepared to handle. Nor is the consuming public willing to pay the additional premium to finance coverage for catastrophic losses in their policies.

Two adverse selection exclusions common within the commercial property form also fall under the collectively "catastrophic," fundamental risk loss category. Flood and earthquake damage can be insured by purchasing other coverage, but damage by these perils is considered collectively catastrophic. So, coverage is *not* provided in most standard, unendorsed property form.

The Loss or Damage is *Not* Accidental or Unforeseen by the Insured: An "insurable loss" is one that is accidental, unforeseen, definite in time and place, and measurable. Coverage is excluded by nearly every property and liability form when insureds inflict intentional damage or injury. Also falling outside the definition of "insurable loss" are losses that are likely to or will happen, damage specifically controllable by the insured, and known events.

- **Exclusions for losses that are likely or will happen:** Wear and tear to property is going to happen, as does general deterioration. The insurance carrier is simply not going to insure something guaranteed to happen (the policy would then be a warranty rather than insurance).
- **The insured can control the loss:** This eliminates coverage for intentional acts, damage over long periods of time, and failure to care for the property (not maintaining heat to keep water pipes from freezing). An example from the CGL is the violation of SPAM laws.
- **Exclusion for known or previously occurring events:** This eliminates coverage for losses that the insured knew about prior to the policy period or began prior to coverage being enacted.

Insurance Carrier Wants More Information and Premium: Endorsements are available to remove or narrow the breadth of some policy exclusions, allowing the insured to customize coverage to fit its needs. Insurance policies are, to some extent, written with the "average" insured in mind; not doing this would increase premiums for all insureds – even when some have no need for the additional

coverage. Other-than-average insureds with special exposures or needs have the option to endorse certain exclusions.

Before granting the extension of coverage by endorsement, insurance carriers often want more information about the insured plus some additional premium. This allows some level of policy customization for unique insureds while maintaining an appropriate premium for the risk, but without discriminating unfairly against insureds who do not need the same breadth of coverage. (***Note:*** There are no "average" insureds, so nearly every insured will require at least one coverage-altering endorsement.)

Insurance Carrier Wants to Control the Amount of Coverage Granted: As an example, the commercial property policy specifically excludes loss caused by collapse; but then it gives back a limited amount of financial protection against loss caused by collapse under the "Additional Coverage" section. Excluding coverage only to give it back elsewhere (or even in the same section) seems to perpetuate the public's perception that insurance is a racket. But this method of exclusion/give back is not as counterintuitive as it first appears.

Excluding coverage and giving some back allows the insurance carrier to dictate the exact amount of coverage it is willing to offer. The carrier controls the breadth of coverage. Compare that with trying to give the coverage outright then limiting it with exclusions—there is no way that all possible situations could be imagined, ultimately leading to more confusion and increased court involvement.

Taking coverage away and giving it back in predetermined amounts is far more effective than trying to limit coverage. This tactic is used in both property and liability coverage forms.

Speculative or Business Risk Exclusions: *Pure risk* has only two possibilities: something bad or nothing. There is no possibility of gain; the insured either enjoys a "zero-sum year" or suffers financial loss. Pure risk, also known as absolute risk, is insurable. Its counterpart is "speculative risk."

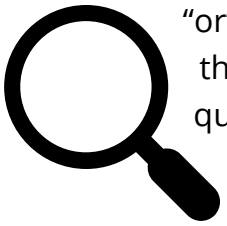
Speculative risk (or "business risk") involves the chance of loss, of no change, or of gain. Insurance is not designed to protect the insured from a bad investment or a bad business decision.

Does Coverage Exist?

Applying these policy-review rules and understanding the reasons for exclusions enables quicker coverage determinations subject, of course, to the specific situation and surrounding laws. Following is a loss/claims flowchart to guide the user through the policy by applying these rules to determine the availability and amounts of coverage.

XII. PAY ATTENTION TO CONJUNCTIONS

Pay attention to the conjunctions "and"/ "or" used in a list. "And" is inclusive; "or" is exclusive. In a list of several qualifiers, the use of "and" means that *all* qualifications must be satisfied. "Or" means that if *any* of the qualifications apply, coverage is granted or excluded (or whatever the list is intended to provide). Other conjunctive terms/phrases include But…, Yet (not yet…), Even if… and Provided that….



XIII. PAY ATTENTION TO KEY WORDS AND PHRASES

Pay attention to key words and phrases. There are certain key words that must be underlined or highlighted when reading the policy. These words and phrases create, delete, or alter coverage and limits (this may not be an all-inclusive list):

a) "Not" as in" does not apply to …" or "does not include…." This changes or limits whatever grant, or denial of coverage preceded it.
b) "Greater than …," "lesser than …," "Greater of …," "lesser of …," "no more than," "the most …," "all," or any other quantifying phrase. "The insured receives the 'lesser of' …" is a quantifying phrase indicating that of the upcoming values, the insured will get the least or lowest amount.
c) "Unless" "except," "only if …" or "subject to …" each connote a change in condition, an added requirement, or an alternative.
d) "However" discounts everything before it. This is a qualifying term that creates some parameter around a coverage or condition.
e) "Includes," as the name suggests, is an inclusive term that broadens the provision to which it applies.

f) “Must” and "regardless." There is no alternative, and surrounding circumstances are of no consideration in meeting the requirement. “The insured must….”

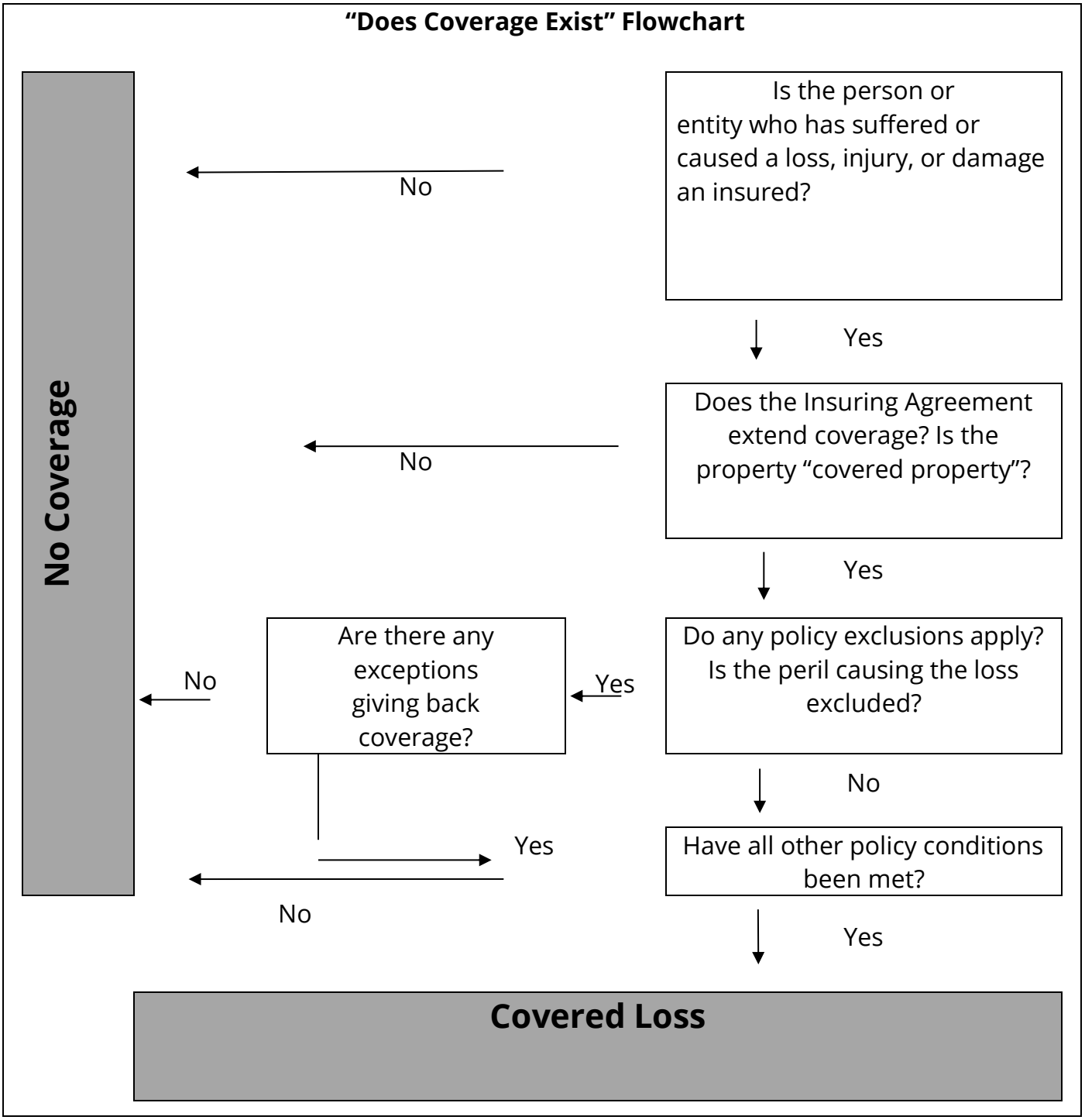
g) “Fist” is an order of sequence term. Some policy provisions list the order of events or actions. Particular attention must be given to the order of events prescribed by these sequencing terms.

XIV. CONFIRM ALL POLICY CONDITIONS HAVE BEEN MET

Understand and make sure all the policy conditions have been met. Failure to meet the policy’s conditions can result in the denial of coverage. Remember the legal concept previously discussed of conditional contract. Conditions often found in policies may include:

- Duties in the Event of Loss or Damage
- Recovered Property
- Vacancy
- Coinsurance
- Consent to Settle
- Duties in the Event of Occurrence, Offense, Claim or Suit
- Legal Action Against Us

Confirm the coverage limits are adequate for the loss. This is not only a limit problem, but incorrect limits could be a “condition” problem (e.g., coinsurance provisions).


"Does Coverage Exist" Flowchart
No Coverage
Is the person or entity who has suffered or caused a loss, injury, or damage an insured?
No
Yes
Does the Insuring Agreement extend coverage? Is the property "covered property"?
No
Yes
Do any policy exclusions apply? Is the peril causing the loss excluded?
Yes
Are there any exceptions giving back coverage?
No
Yes
No
Have all other policy conditions been met?
Yes
No
Covered Loss