

SURVEY OF RECENT DEVELOPMENTS IN INSURANCE LAW

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INTRODUCTION

During this survey period,¹ the courts published far fewer automobile insurance opinions than in past years and significantly more commercial liability opinions. There were fewer than expected cases dealing with claims against insurers for breach of duty of good faith. Nevertheless, for the first time in Indiana, a federal court, predicting what Indiana courts would do, allowed for the possibility of an award of damages for emotional distress and recovery of attorney fees in a bad faith lawsuit.

In general, the courts continued to value the freedom of the parties to establish their rights in contracts even in the insurance setting, with only one exception. If an ambiguity exists in the contract, either with respect to contract terms or as a result of the insurer's conduct, the courts will work hard to extend coverage to the insured. Despite Indiana's strict enforcement of the contract terms as written, courts endeavor to protect innocent victims by seeking to find a means by which coverage can be extended to them. This Article addresses the past year's cases and analyzes their effect on the practice of insurance law.

I. COMMERCIAL AND PROPERTY INSURANCE CASES

A. Intentional Acts Exclusion

During this survey period, several cases examined the intentional acts exclusion contained in insurance policies covering general commercial liability and agribusiness. Interestingly, all of the "intentional act" exclusion cases involved the issue of whether an insured could recover for losses caused by the firing of a gun on the insured's property. Of course, each case focused on whether the shooting was intentional and, thus, excluded under the policy. In one case, the court found the shooting intentional and denied coverage.² In the second case, the court found the shooting was not intentional, thereby allowing for coverage.³ In the third case, the court did not rule on whether the shooting was intentional, but rather held that the insured was collaterally estopped from re-litigating his intent after he was convicted for the shooting in his criminal

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1. The survey period for this Article is approximately October 1, 1999 to September 30, 2000.

2. *See Sans v. Monticello Ins. Co.*, 718 N.E.2d 814, 820-21 (Ind. Ct. App. 1999).

3. *See Stout v. Underhill*, 734 N.E.2d 717, 721 (Ind. Ct. App. 2000).

trial.⁴

In *Sans v. Monticello Insurance Co.*,⁵ the liability insurer for the Tic Tock Lounge sought a declaratory judgment stating that it owed no coverage to the lounge and its bartender for an unruly patron's lawsuit under the assault and battery exclusion.⁶ The patron's lawsuit against both the lounge and the bartender sought recourse for personal injuries, contending that the bartender carelessly and negligently shot him following an altercation.⁷

On the night of the shooting, the bartender, who also served as security in the bar, placed a pistol on top of the bar in the customers' plain view in an effort to keep the peace. At some point during the evening, a patron came into the bar and began drinking heavily. The patron became intoxicated and grew increasingly belligerent. In response to the patron's obvious intoxication, the bartender refused to serve him more alcohol. After the patron attempted to grab someone else's drink, the bartender and the patron exchanged words and began to wrestle, until the bartender pushed the patron out of the bar. The patron returned and the fighting continued until the bartender expelled him a second time. During the altercation, the bartender grabbed the gun and pointed it at the patron trying to frighten him into submission. The bartender knew the gun was loaded when he cocked it and placed a bullet in the chamber of the pistol. When the patron entered the bar for the third time, the bartender approached the door, raised the pistol and fired into the unarmed patron's forehead from about two to three feet away.⁸

The appellate court had previously refused to rule, as a matter of law, that the shooting was intentional to support summary judgment for the insurer on the application of the "intentional acts" exclusion.⁹ At trial, the lower court weighed the evidence and concluded that the shooting was intentional, thereby excluding coverage.¹⁰

In determining whether the shooting was intentional, the court of appeals considered the bartender's expansive experience and familiarity with firearms. The court further determined that at the time of the shooting, the bartender was not under the influence of drugs or alcohol, he was not distracted or bumped, he

4. See *Meridian Ins. Co. v. Zepeda*, 734 N.E.2d 1126, 1130 (Ind. Ct. App. 2000).

5. See *Sans*, 718 N.E.2d at 814.

6. See *id.* The intentional acts exclusion in the policy, which was entitled the "assault and battery exclusion," read in pertinent part:

It is agreed that the insurance does not apply to bodily injury or property damage arising out of assault & battery or out of any act or omission in connection with the prevention or suppression of such acts, whether caused by or at the instigation or direction of the insured, his employees, patrons or any other person.

Id. at 817 n.7.

7. See *id.* at 817.

8. See *id.*

9. See *Sans v. Monticello Ins. Co.*, 676 N.E.2d 1099 (Ind. Ct. App. 1997).

10. See *Sans*, 718 N.E.2d at 818.

did not drop the gun, and the gun did not malfunction.¹¹ All of these facts led the court to enter judgment in favor of the insurance company and against the bartender.¹²

The second “intentional acts” case involved a shooting of a trespasser on the insured’s land. In *Stout v. Underhill*,¹³ the insured owned 300 acres of land on which yellow root grew naturally. The insured caught a trespasser digging yellow root on his property and ordered the trespasser to walk to the road under gunpoint until the game warden arrived. Two weeks later, the trespasser was again caught by the insured digging yellow root. On this occasion, as the insured walked with the trespasser to the road, the trespasser ran. The insured fired three shots from approximately 120 feet in the trespasser’s direction. At trial, the insured insisted that he was not trying to shoot the trespasser, while the trespasser claimed it was intentional.¹⁴

At trial, the insurer stressed the facts of the case to rebut the insured’s assertion that the shooting was unintentional. The insurer argued that the insured either intended to injure the trespasser or at least demonstrated an expectation by the insured that injuries were certain to occur.¹⁵ However, the trial court concluded that the exclusion did not apply, as the insured neither intended nor expected the injuries to occur.¹⁶

On appeal, the court refused to reweigh the evidence and affirmed.¹⁷ In so doing, the court made an interesting comment about the effect of its decision:

We share [the insurer’s] concern that our holding may allow an insured to shoot someone and then simply say, “I didn’t mean to hit him,” in order to obtain coverage. Currently, and under our holding in this case, the “I didn’t mean to” defense is a credibility issue left to resolution by the fact finder at trial. Without question, firearms are dangerous weapons and aiming and firing a gun in the general vicinity of another person (or, as in this case, within ten feet of a person) is a dangerous act. However, we disagree with [the insurer’s] assertion that “[a]cquisition [sic] to this conduct is tantamount to the court rewriting the policy to delete the [intentional act] exclusion and has the effect of destroying the

11. *See id.* at 820.

12. *See id.* at 821.

13. 734 N.E.2d 717 (Ind. Ct. App. 2000).

14. *See id.* at 718-19.

15. Under the policy exclusion, coverage was not offered for injuries or damages “intended or expected” by the insured. *Id.* at 719. It is important to observe that different standards apply to each. “Intentional” refers to “the volitional performance of an act with an intent to cause injury, although not necessarily the precise injury or severity of damage that in fact occurs.” *Allstate Ins. Co. v. Herman*, 551 N.E.2d 844, 845 (Ind. 1990). The term “expected” means the insured was “consciously aware that the injury was practically certain to result.” *Bolin v. State Farm Fire & Cas. Co.*, 557 N.E.2d 1084, 1086 (Ind. Ct. App. 1980).

16. *See Stout*, 734 N.E.2d at 721.

17. *See id.*

public policy of this State to not permit insurance for intentional wrongs.¹⁸

The court also invited the insurer to seek transfer for resolution by the Indiana Supreme Court.¹⁹

In the third case, *Meridian Insurance Co. v. Zepeda*,²⁰ the court did not have to consider the facts of the shooting in determining that the insured was bound by the jury's finding that the shooting was intentional.²¹ Simon Zepeda, who shot Ernest King with a .22 caliber rifle, was convicted of aggravated battery. A week before Zepeda's conviction, King filed a personal injury action against Zepeda claiming that he negligently discharged the rifle causing King's injuries.²²

Zepeda's insurer defended him under a reservation of rights and filed a declaratory judgment action alleging that because Zepeda had been convicted of the shooting, the policy excluded coverage under the "intentional acts" exclusion. The insurer argued that both Zepeda and King were collaterally estopped from litigating whether Zepeda's conduct in the shooting was intentional because the criminal jury in Zepeda's case necessarily found the shooting intentional in order to convict Zepeda for aggravated battery.²³

The court, analyzing principles of collateral estoppel, found Zepeda's conviction to be a finding that the shooting was intentional.²⁴ However, this finding was only binding on Zepeda, not King, so only Zepeda was collaterally estopped from re-litigating whether the shooting was intentional.²⁵ Because King was not a party to the criminal case and did not have a full and fair opportunity to litigate the issue of Zepeda's intent, he was not estopped from litigating Zepeda's intent in the personal injury action.²⁶ The court recognized that its holding could create "potentially inconsistent determinations of fact," but it did not want to deprive King of his day in court.²⁷

These three shooting cases expand upon a long line of decisions addressing the "intentional acts" exclusion.²⁸ They are significant in demonstrating that insurance companies will have a much harder time enforcing the "intentional acts" exclusion. By allowing an insured to simply say "I didn't mean to cause the injury," courts will almost always find an issue of fact to prevent summary

18. *Id.*

19. *See id.*

20. 734 N.E.2d 1126 (Ind. Ct. App. 2000).

21. *See id.* at 1128.

22. *See id.*

23. *See id.* at 1128-29.

24. *See id.* at 1130.

25. *See id.* at 1131-32.

26. *See id.*

27. *Id.* at 1132.

28. Many of these cases are cited in the *Stout* decision where the court sought guidance in the definitions of the terms and facts for comparison. *See Stout v. Underhill*, 734 N.E.2d 717, 719 (Ind. Ct. App. 2000).

judgment. Thus, more of these cases will be resolved via trial. Insurers must also be prepared to show, by overwhelming evidence, that the insured's conduct refutes the assertion that the injuries were unintentional.

*B. Emotional Distress Damages and Attorney Fees Available
in Bad Faith Cases*

In a case of first impression in Indiana, the United States District Court for the Northern District of Indiana predicted that Indiana courts would allow plaintiffs to recover damages for emotional distress, attorney fees and consequential damages in bad faith insurance cases.²⁹ In *Patel*, the Patels brought suit against their insurance companies seeking coverage for losses they sustained when their restaurant and motel burned down. The authorities found the fire to be a result of arson. After investigating the circumstances surrounding the fire, the insurance companies denied coverage to the Patels based upon their belief that the Patels started the fire themselves.³⁰

While the Patels' lawsuit was pending, the Fort Wayne Police Department found the individual who started the fire that destroyed the Patels' property. Upon learning of the confession, one of the insurers paid the loss claim, plus interest. However, the insurer refused to pay the consequential damages sought by the Patels as a result of the delay in the payment of their claim, such as lost rents from the motel and lost profit from the restaurant.³¹

In their bad faith lawsuit against the insurer, the Patels sought damages for emotional distress associated with the insurer's alleged bad faith denial of coverage as well as punitive damages and attorney fees.³² The district court was barraged with motions from both sides asking the court to determine as a matter of law whether the Patels were entitled to pursue damages for emotional distress, lost profits and attorney fees as part of their bad faith claim against the insurer.

The court acknowledged that no prior Indiana court had decided these issues.³³ Citing *Erie Insurance Co. v. Hickman*³⁴ and *Firstmark Standard Life Insurance Co. v. Goss*,³⁵ the court noted that Indiana courts previously presented with this issue resolved the cases on other grounds, thereby avoiding the emotional distress damages issue.³⁶

The court initially determined that it was not procedurally allowed to address whether the Patels were entitled to pursue consequential damages in their bad faith action.³⁷ The court was presented with the Patels' motion to reconsider its

29. *Patel v. United Fire & Cas. Co.*, 80 F. Supp. 2d 948 (N.D. Ind. 2000).

30. *See id.* at 951.

31. *See id.*

32. *See id.*

33. *See id.* at 952.

34. 622 N.E.2d 515 (Ind. 1993).

35. 699 N.E.2d 689 (Ind. Ct. App. 1998).

36. *See Patel*, 80 F. Supp. 2d at 952.

37. *See Patel v. United Fire & Cas. Co.*, 80 F. Supp. 2d 948, 953 (N.D. Ind. 2000).

prior order denying the Patels recovery for consequential damages. Because no new facts or law were presented in their motion, it was not proper for the court to reconsider its prior ruling. Faced with this ruling, the Patels urged the court to treat their motion to reconsider as a motion to certify to the Indiana Supreme Court the issue of whether they could recover consequential damages in either their breach of contract claim or their bad faith claim.³⁸ The court refused to certify the issue because certain requirements were not present.³⁹ Thus, the district court did not decide whether the Patels could recover consequential damages because it was not procedurally proper to do so.

In analyzing the Patels' ability to seek damages for emotional distress in their bad faith action, the court looked for guidance in *Erie*:

In tort, all damages directly traceable to the wrong and arising without an intervening agency are recoverable. By contrast, the measure of damages in a contract action is limited to those actually suffered as a result of the breach which are reasonably assumed to have been within the contemplation of the parties at the time the contract was formed. Nonetheless, in most instances, tort damages for the breach of the duty to exercise good faith will likely be coterminous with those recoverable in a breach of contract action.⁴⁰

The insurer argued that this language in *Erie* meant that tort damages in bad faith actions were limited to the same types of damages recoverable in contract actions. The Patels argued that *Erie* meant to allow for recovery of all damages directly traceable to the wrong, thereby expanding the types of damages recoverable in a bad faith tort action. Consequently, the Patels urged they should be allowed to recover emotional distress damages.⁴¹

The court impliedly adopted the Patels' reading of *Erie* and addressed whether the Patels could maintain an emotional distress cause of action under Indiana law. Specifically, the court determined that the modified impact rule enunciated in *Shuamber v. Henderson*⁴² applied to this emotional distress case.⁴³ Because it was undisputed that there was no impact, the Patels could not satisfy the modified impact rule. To be successful, the Patels had to fit their case into the intentional tort exception explained in *Cullison v. Medley*.⁴⁴ That is, the Patels' ability to recover emotional distress damages in their bad faith claim hinged on whether bad faith was an intentional tort under Indiana law.⁴⁵

The court acknowledged that there were no Indiana cases specifically addressing whether bad faith was an intentional tort: "Perhaps this is because the

38. *See id.*

39. *See id.* at 954.

40. *Id.* at 956 (citing *Erie Ins. Co. v. Hickman*, 622 N.E.2d 515, 519 (Ind. 1993)).

41. *See id.*

42. 579 N.E.2d 452, 455-56 (Ind. 1991).

43. *See Patel*, 80 F. Supp. 2d at 957-59.

44. 570 N.E.2d 27 (Ind. 1991).

45. *See Patel*, 80 F. Supp. 2d at 957-58.

tort of bad faith, as defined in Indiana, is a hybrid cause of action, sharing elements of both a negligence action and one for an intentional tort.”⁴⁶ Nevertheless, the court predicted that the “Indiana Supreme Court would consider the tort more closely aligned with the principles underlying an intentional tort than with those ascribed to negligence.”⁴⁷ In so doing, the court found that the Patels’ bad faith claim could satisfy the intentional tort exception to permit a claim for emotional distress damages.⁴⁸

Next the court considered whether the Patels may recover attorney fees if they were successful in their bad faith action. First, the court examined whether the common law allowed for an attorney fee award in bad faith cases. The court noted the existence of the long standing “American rule” generally requiring each party, absent agreement, statute or rule to the contrary, to pay its own fees.⁴⁹ Urging an exception to the “American rule,” the Patels cited to dicta in *Mikel v. American Ambassador Casualty Co.*,⁵⁰ suggesting that bad faith cases present an exception to the “American rule.” However, the court refused to adopt *Mikel*’s dicta and found that attorney’s fees would not be recoverable in bad faith cases as a matter of common law.⁵¹

Nonetheless, the court also looked to whether Indiana Code section 34-52-1-1(b)(3) provided for attorney’s fees if the Patels prevailed on their bad faith claim.⁵² This statute provides for an award of attorney’s fees to the prevailing party if there is a finding that the other party “litigated the action in bad faith.”⁵³ The court found that bad faith conduct which takes place prior to the filing of the lawsuit can be considered litigating in bad faith, thus making attorney fees recoverable.⁵⁴ The court, however, noted that while attorney fees are recoverable, the decision to award them lies within the discretion of the trial court.⁵⁵ Therefore, “not every finding of bad faith conduct will necessarily subject an insurer to liability for its insured’s attorney’s fees.”⁵⁶

It is important to note that this decision represents a federal district court predicting what the Indiana Supreme Court would do if faced with this question. Whether the Indiana Supreme Court will agree remains a matter to be addressed in the future. Nonetheless, the district court decision is logically sound. Because a claim for bad faith requires an element of “conscious wrongdoing,”⁵⁷ permitting

46. *Id.* at 958.

47. *Id.*

48. *See id.* at 958-60.

49. *See id.* at 960.

50. 644 N.E.2d 168 (Ind. Ct. App. 1994).

51. *See Patel*, 80 F. Supp. 2d at 961.

52. *See id.* at 961-63.

53. *See* IND. CODE § 34-52-1-1(b)(3) (2000).

54. *See Patel*, 80 F. Supp. 2d at 961-62 (citing *Mitchell v. Mitchell*, 695 N.E.2d 920, 922 (Ind. 1998)).

55. *See id.* at 963.

56. *Id.*

57. As stated by the court in *Colley v. Indiana Farmers Mutual Insurance Group*, 691

recovery of emotional distress damages is consistent with Indiana law allowing such damages for intentional conduct. However, such damages should not be recoverable if the insurance company merely breached the policy. Instead, the tort of bad faith must be proven.

C. Lack of Timely Notice of Claim Resulted in No Coverage

Two cases during this survey period examined situations in which the insured failed to give timely notice of a claim or lawsuit to the insurer, and the courts found no duty to defend or indemnify as a result of the untimely notice. The first case, *Askren Hub States Pest Control Services, Inc. v. Zurich Insurance Co.*,⁵⁸ analyzed the insured's notice obligations in the context of a general commercial liability policy, while the second case, *Paint Shuttle, Inc. v. Continental Casualty Co.*,⁵⁹ analyzed the notice requirement in the context of a legal malpractice policy. Both cases stand for the proposition that notice to the insurer is not timely if the delay prejudices the insurer, either presumably or actually, from conducting its own investigation and building its own defense. Obviously, this is a very fact-sensitive inquiry.

In *Askren*, a pest control company was sued for negligence arising out of a termite inspection.⁶⁰ The exterminator waited six months to notify its insurer of the claim against it. In the interim, the insured conducted multiple inspections, communicated with the customer, and made remedial repairs without notifying the insurer. As a result, the insurer argued that it was prejudiced by the delay in notice and sought to deny coverage, relying on the notice provisions in the policy.⁶¹

The court indicated that under Indiana law, a liability insurer's ability to prepare an adequate defense is presumptively prejudiced when there is an unreasonable delay in notification of a claim.⁶² In this case, the court found that the six month delay prejudiced the insurance company and coverage was denied.⁶³ The delay caused the insurer to be unable to conduct an investigation into whether Askren's initial termite inspection was erroneous and caused the homeowner's alleged damage.⁶⁴

N.E.2d 1259, 1261 (Ind. Ct. App. 1998), "[p]oor judgment or negligence do not amount to bad faith; the additional element of conscious wrongdoing must also be present."

58. 721 N.E.2d 270 (Ind. Ct. App. 1999).

59. 733 N.E.2d 513 (Ind. Ct. App. 2000).

60. See *Askren*, 721 N.E.2d at 273-74.

61. See *id.* at 277.

62. See *id.* at 278.

63. See *id.* at 280. The court's finding of prejudice was based on the fact that Askren did not preserve any of the portions of the home that had been infested by termites, and later replaced. See *id.* Askren failed to photograph the damaged portions of the home before making repairs and treated the home, which eliminated the termites from the residence. See *id.*

64. See *id.*

In *Paint Shuttle*, a law firm was sued for malpractice.⁶⁵ A partner in the law firm orally notified the firm's insurance agent of the suit several weeks after suit was filed. The law firm undertook to defend itself in the motion phase of the lawsuit, but eventually hired outside counsel to represent it at trial. Later, the client obtained a \$1.4 million judgment against the law firm. Over two years after the lawsuit was filed, and after judgment was already entered against it, the law firm finally notified its insurance company in writing that it had been sued for malpractice. This notice was sent at the same time the law firm filed a declaratory judgment action against the insurer to recover under the malpractice policy.⁶⁶

The malpractice policy was effective for the term of November 29, 1993 through November 29, 1994, a definitive policy period which included the date the lawsuit was filed, and included an undisclosed extended reporting period.⁶⁷ The policy was a "claims made" policy as opposed to an "occurrence" policy.⁶⁸

The notice provisions in the policy required the law firm to notify the agent and the insurance company in writing of any claim made against the firm "during the policy term or extended reporting period."⁶⁹

The court concluded that the law firm made a conscious decision to defend against the lawsuit without notifying the insurance company. As a result, the court found that the law firm failed to provide timely notice, and that the delay in notice resulted in prejudice to the insurer.⁷⁰

D. Insurer's Conduct May Waive One-Year Statute of Limitations Contained in the Policy

Two cases were decided during this survey period that addressed an issue that frequently surfaces concerning contractual time limitations on an insured's ability to sue an insurance company for breach of the policy. In *Auto-Owners Insurance Co. v. Cox*,⁷¹ and *Summers v. Auto-Owners Insurance Co.*,⁷² the court of appeals analyzed whether the insurer's conduct waived the twelve-month limitation on the insured's ability to sue. In both *Cox* and *Summers*, the policies

65. See 733 N.E.2d 513, 518 (Ind. Ct. App. 2000).

66. See *id.* at 518-20.

67. See *id.* at 517.

68. See *id.* at 522. The court explained the difference between "claims made" and "occurrence" policies. "A 'claims made' policy links coverage to the claim and notice rather than injury." *Id.* This type of policy is designed to protect the holder only against claims made during the policy term. An "occurrence" policy links "coverage to the date of the tort rather than of the suit." *Id.* Occurrence policies protect the holder from liability for any act done during the policy term. Because the policy in this case was a "claims made" policy, notice during the policy term was critical to the court's decision of the coverage issues. See *id.*

69. *Id.* at 519.

70. See *id.* at 521.

71. 731 N.E.2d 465 (Ind. Ct. App. 2000).

72. 719 N.E.2d 412 (Ind. Ct. App. 1999).

required the insured to file a lawsuit within one year of the date of loss.⁷³ In both cases the court of appeals recognized that the insurer, by its conduct, can waive the twelve-month limitations period.⁷⁴ In *Summers*, the court found that the insurer did not waive the twelve-month limitations period, but in *Cox*, the court found the insurer did waive the limitations period. The following is a discussion of the dispositive facts in each case.

In *Summers*, the insured suffered a loss from a theft⁷⁵ and informed the insurer of the loss approximately two weeks later. As part of its investigation, the insurer sent several forms to the insured, who returned them completed a month and a half later. Two months later, the insurer requested an examination under oath and various other documents from the insured. The insured's attorney agreed to the examination, but failed to cooperate in getting it scheduled until more than eight months after the theft. At the time of the examination under oath, the insured refused to authorize the release of his tax records to the insurer and refused to sign the transcript of his examination under oath. Nearly six months later, the insured's attorney contacted the insurance company claiming that there were discrepancies in the transcript of the examination under oath. At that time, the insurer notified the insured's attorney in writing that the twelve-month limitations provision in the policy applied to time-bar the insured's claim.⁷⁶

In *Cox*, the insured suffered roof damage during an ice storm on March 12, 1991.⁷⁷ She immediately notified her agent who sold her the homeowners' policy. Later that month, a repair crew was sent to work on her roof, but the repairs did not completely fix the damage. The insured continued to complain of roof problems, but the agent stalled in making the repairs. As time passed, the roof continued to sag. Almost eighteen months later, the insured reported the badly sagging roof to her agent again. The agent finally reported the loss to the insurer on September 23, 1992, listing storm damage as the cause of the damage. The insurer denied the claim citing the twelve-month limitations provision.⁷⁸

The court of appeals in *Cox* relied on the analysis in *Summers*. Comparing the facts, the *Cox* court explained that in *Summers* the insurer "did not waive the limitations period, but instead repeatedly sought to enforce the policy requirements in the face of noncompliance by the insured."⁷⁹ In *Cox*, the court was persuaded by the facts that the insured immediately notified her agent of the storm damage and that negotiations between the agent and the insured were

73. The policy language was the same in both cases: "We may not be sued unless there is full compliance with all the terms of this policy. Suit must be brought within one year after the loss or damage occurs." *Cox*, 731 N.E.2d at 468; *Summers*, 719 N.E.2d at 415.

74. See *Cox*, 731 N.E.2d at 467-68; *Summers*, 719 N.E.2d at 415.

75. See *Summers*, 719 N.E.2d at 413.

76. See *id.* at 413-14.

77. See *Cox*, 731 N.E.2d at 466.

78. See *id.*

79. *Id.* at 468.

actively ongoing.⁸⁰

The court found that the insured's repeated contact with the agent could lead a reasonable person to infer that "filing suit to collect on the claim was not being insisted upon."⁸¹ In emphasizing the difference between the two cases, the court enunciated that as a general rule, the insurer has no duty to inform the insured of his rights and obligations under the policy.⁸² However, where an insurer "does not deny coverage or liability, *and* proceeds to negotiate . . . toward settlement . . . the law will imply a waiver of the contractual limitation . . . unless and until the insurer puts the insured on notice that litigation is necessary if he desires to pursue the claim further."⁸³

So, while *Cox* and *Summers* come to different results, they are consistent because they adhere to the same framework of Indiana law. Courts will generally uphold a contract provision that reduces the statutory limitations period.⁸⁴ The insurer's conduct, however, must be reviewed to see if the limitation is waived.

E. Adequate Notice of Cancellation of Policy by Insurer

In *Westfield Co. v. Rován, Inc.*,⁸⁵ the court was faced with an issue of first impression in Indiana as to whether an insurer gave adequate notice of cancellation of an endorsement to an insurance policy. The court ultimately held that cancellation of a portion of a policy is the same as cancellation of the entire policy and therefore the same procedures must be followed.⁸⁶

In *Rován*, Cheryl Robinson was the president of Rován, Inc., a company in the business of repairing and renovating automobiles and recreational vehicles. Ms. Robinson, on behalf of Rován, Inc., obtained a commercial package of insurance coverage, which included a commercial auto policy.⁸⁷ In January 1998, Rován, through Ms. Robinson, entered into a lease agreement with Ms. Robinson's son, Brandon, for the lease of a 1995 Chevy pickup truck. As part of the agreement, Rován was required to provide direct primary coverage for Brandon when he drove the 1995 Chevy. Pursuant to the lease agreement, Ms. Robinson notified Rován's insurance agent of the lease agreement and requested coverage for Brandon. The insurer issued an Amended Common Policy Declaration adding to it a Lessor Endorsement. The Lessor Endorsement

80. *See id.*

81. *Id.*

82. *See Summers*, 719 N.E.2d at 416 (citing *Statesman Ins. Co. v. Reibly*, 371 N.E.2d 414, 416, n.4 (Ind. Ct. App. 1978)).

83. *Id.* (quoting *Schafer v. Buckeye Union Ins. Co.*, 381 N.E.2d 519, 523 (Ind. Ct. App. 1978)) (emphasis added).

84. *See, e.g., United Tech. Auto. Sys., Inc. v. Affiliated FM Ins. Co.*, 725 N.E.2d 871 (Ind. Ct. App. 2000) (enforcing twelve month statute of limitations provision in environmental insurance contract).

85. 722 N.E.2d 851 (Ind. Ct. App. 2000).

86. *See id.* at 858.

87. *See id.* at 853-54.

provided coverage for Brandon as an additional insured under the Common Policy when driving a vehicle owned by Brandon, but leased to Rován.⁸⁸

In March 1998, Brandon, with permission from Rován, sold the Chevy pickup and bought a 1998 Ford Mustang. Another written lease agreement was executed with the same terms as the agreement involving the Chevy pickup. Ms. Robinson notified the insurance agent of the replacement and requested coverage for the Mustang. However, she did not send a copy of the new lease agreement to the insurer. The insurer acknowledged the replacement and issued another Amended Common Policy Declaration and, unbeknownst to Rován, deleted the Lessor Endorsement.⁸⁹

On June 8, 1998, Brandon sold the Mustang and purchased a 1997 Dodge pickup. Rován and Brandon orally agreed that the Dodge would replace the Mustang under the same terms of the existing lease agreement. Ms. Robinson immediately notified the insurance agent of the replacement vehicle and requested coverage for the Dodge.⁹⁰

A few days later, Brandon was in a serious accident while driving the Dodge pickup and requested coverage for the loss. The insurer filed a declaratory judgment action stating that the policy did not cover Brandon's liability because the Lessor Endorsement had been deleted. Rován argued that the Lessor Endorsement would have covered the Dodge had it not been deleted, and the insurer canceled the coverage without providing sufficient notice.⁹¹

First, the court analyzed whether the Dodge would have been covered had the endorsement not been deleted.⁹² The Lessor Endorsement covered any leased auto listed in the policy. The term "leased auto" was defined as "an 'auto' leased or rented to you, including any substitute, replacement or extra 'auto' . . . under a leasing or rental agreement that requires you to provide direct primary insurance for the lessor."⁹³ Interpreting the plain language of the endorsement, the court traced coverage to the Dodge as a replacement vehicle leased to Rován under a leasing agreement requiring Rován to provide direct primary insurance for the lessor.⁹⁴ The court found that the Lessor Endorsement was not vehicle specific, but rather covered any auto listed in the policy and subject to a lease agreement.⁹⁵

After concluding that there would have been coverage if the insurer had not deleted the endorsement, the court analyzed whether the insurer properly notified the insured of the Lessor Endorsement deletion. Specifically, the court asked, "what and how much notice of cancellation by the insurer is sufficient to

88. *See id.* at 854.

89. *See id.*

90. *See id.*

91. *See id.* at 855.

92. *See id.* at 856-67.

93. *Id.* at 856.

94. *See id.* at 857.

95. *See id.*

effectively cancel an insurance policy.”⁹⁶ The court looked to both Indiana statutory law as well as the policy language to determine what cancellation procedures the insurer was required to follow. Finding no statute or policy language governing cancellation, the court turned to common law for guidance.⁹⁷

The court explained that “generally in the absence of a specific statutory or policy provision, any form of notice of cancellation is sufficient.”⁹⁸ The court added that the “notice must positively and unequivocally inform the insured of the insurer’s intention that the policy cease to be binding.”⁹⁹ The court concluded that the insurer was required to “positively and unequivocally” inform Rován of its intention that the policy no longer be binding.¹⁰⁰

When the insurer issued the Amended Common Policy, it sent Rován a document which stated: “This endorsement changes your policy. Please attach it to your original policy.”¹⁰¹ The court found that this cryptic explanation did not provide unequivocal notice of what was actually being deleted from the policy. The court explained that the insured should not have to scour its hundred page policy to ascertain what coverage was being canceled. Thus, the court held that Brandon was entitled to coverage for the Dodge pickup under the Lessor Endorsement because cancellation of the Lessor Endorsement was not properly communicated by the insurer.¹⁰²

*F. Town’s Decision to Delay Public Works Projects
Not Covered by Errors and Omissions Policy*

In *Town of Orland v. National Fire & Casualty Co.*,¹⁰³ the town of Orland decided to delay water and sewer projects because of citizen opposition. When the town delayed the projects, an engineering contractor hired for the project was notified to stop working. The engineering contractor sued Orland in federal court asking for amounts owed for the services provided and seeking a declaratory judgment for its further obligations owed under the contract with Orland. In response to the engineers’ complaint, Orland filed a counterclaim to which the engineers asserted an abuse of process claim. Ultimately, the engineers and the town of Orland entered into a settlement agreement in the amount of \$356,460.¹⁰⁴

Orland timely notified its insurer of the lawsuit, but the insurer refused to defend or indemnify. In turn, Orland filed a complaint in state court against its insurer seeking coverage under the policy’s errors and omissions provisions. The errors and omissions provisions provided coverage to Orland for “any claim for

96. *See id.* at 858.

97. *See id.*

98. *Id.*

99. *Id.*

100. *Id.* at 859.

101. *Id.*

102. *See id.*

103. 726 N.E.2d 364 (Ind. Ct. App. 2000).

104. *See id.* at 366-68.

breach of duty made against the *insured* by reason of any negligent act, error or omission, including misfeasance, malfeasance and nonfeasance.”¹⁰⁵ The policy specifically excluded coverage for “any loss caused intentionally by or at the direction of the insured.”¹⁰⁶

Orland argued that coverage extended to breaches of duty arising from contractual relations and that such coverage extends past mere negligence. In urging this result, Orland argued that because the policy included the term “malfeasance” in defining errors or omission, coverage must encompass more than mere negligence to include contractual breaches. Further, Orland argued that the engineers’ complaint could be read as seeking relief for its perceived mismanagement of the sewer and water projects, thereby bringing Orland’s conduct within the definition of negligence.¹⁰⁷

However, the court did not agree with Orland’s reading of the insurance contract. The court found that malfeasance, along with misfeasance and nonfeasance, are commonly referred to as examples of negligence.¹⁰⁸ Indeed, the court stated that “a reasonable person could not conclude that the term [malfeasance] encompassed more than negligence.”¹⁰⁹

Because the court found the delay to be the result of an intentional business decision made by Orland, it was not negligence as covered by the errors and omissions policy: “Orland, whether in good faith or not, deliberately made business decisions which caused [the engineers] to question Orland’s commitment to the contract and, thus, bring the federal lawsuit.”¹¹⁰ Further, the court found that the insurer had no duty to defend Orland against the engineers’ abuse of process claims because these claims were also as a result of the town’s intentional acts.¹¹¹

The court’s analysis discussed the purpose and intent behind a liability insurance policy. The policy is not intended as a bond to satisfy an insured’s business decisions. Instead, the policy is designed to cover accidental conduct by the insured that may produce personal injury or property damage.

G. Insurer’s Duty to Defend and Waiver Of Defenses

At first glance, the case of *State Farm Fire & Casualty Co. v. Bruce*¹¹² appears to be a case interpreting the child care services and sexual molestation exclusions in a homeowners’ policy. However, this case essentially reiterates the long-standing rule in Indiana that an insurer who refuses to defend an insured under a reservation of rights or who seeks declaratory judgment as to coverage

105. *Id.* at 369 (emphasis in original).

106. *Id.*

107. *See id.* at 370.

108. *See id.*

109. *Id.*

110. *Id.* at 371.

111. *See id.* at 371-72.

112. 728 N.E.2d 919 (Ind. Ct. App. 2000).

does so at its own peril.¹¹³

In *Bruce*, the parents of a child brought suit against a babysitter after the child was molested by the babysitter's husband. The babysitter sought coverage under her homeowners' insurance policy. The homeowners' policy excluded coverage for claims arising from childcare services as well as claims for sexual molestation.¹¹⁴

The babysitter timely notified the insurer of the child's claim, but the insurer opted not to defend the insured relying on the childcare services and sexual molestation exclusions. The babysitter and the child entered into an Agreed Judgment, which the trial court accepted. The judgment concluded that the child was a guest in the babysitter's home, that the molestation had no correlation with the childcare services that were being rendered, and that a monetary judgment in favor of the child be entered in the amount of \$375,000. The babysitter assigned all of her rights against her insurer to the child, who filed a petition for proceedings supplemental against the insurer to collect the judgment.¹¹⁵

The court found that the insurer had full knowledge of the lawsuit and opted not to participate in the underlying litigation. Consequently, because the underlying judgment decided factual matters relating to coverage defenses that the insurance company wished to pursue, the insurer was collaterally estopped from re-litigating those issues.¹¹⁶

The insurer argued that it should be able to assert the childcare services and sexual molestation exclusions contained in the policy, but the court rejected this argument finding that the application of those defenses was already decided in the underlying case. The insurer next claimed that the judgment was entered as a result of fraud and collusion amongst the child and the babysitter. The court recognized that the insurer could present these defenses at the proceedings supplemental stage of the litigation, however, the insurer failed to provide any evidence of fraud or collusion.¹¹⁷ Therefore, the court of appeals upheld the trial court's entry of summary judgment finding the insurer responsible for the agreed judgment.¹¹⁸

Insurers must be mindful of the harsh outcome that may occur if they refuse either to provide a defense to an insured or to file a declaratory judgment. If the insurer does not act to preserve its right to assert the coverage defense, it may be collaterally estopped even if the insured and plaintiff collude to form an underlying judgment on liability.

113. See, e.g., *Liberty Mut. Ins. Co. v. Metzler*, 586 N.E.2d 897, 902 (Ind. Ct. App. 1992).

114. See *Bruce*, 728 N.E.2d at 920-21.

115. See *id.* at 921-22.

116. See *id.* at 923-24.

117. See *id.*

118. See *id.* at 926.

H. When Does a Builder's Risk Policy Become Effective?

In *Bosecker v. Westfield Insurance Co.*,¹¹⁹ the Indiana Supreme Court reversed the trial court and the Indiana Court of Appeals when it found that a builder's risk insurance policy, acquired for the specific purpose of repair and renovation of an existing building, became effective when the policy was purchased and not when the owner began repair work. In *Bosecker*, the property owners contacted their insurance agent and described the building they wanted to insure. They told her it was a vacant apartment building on which they were undertaking numerous repairs and renovations. The agent sold the Boseckers a builder's risk policy which provided coverage for the existing buildings while repair and renovation work was being performed. The Boseckers purchased the policy on February 23, 1996. Ten hours after the property was added to the policy, the building was destroyed by fire. The insurer denied coverage on the basis that no repair work had been started on the building, such that the "builder's risk" policy was not activated. The trial court granted summary judgment in favor of the insurer, and the court of appeals affirmed.¹²⁰

However, the supreme court reversed the lower courts, finding that the policy language was ambiguous.¹²¹ Specifically, the supreme court focused on two contradictory provisions in the policy defining "Covered Property" and "Property Not Covered." "Covered Property" was defined as "[b]uildings or structures including foundations while in the course of construction, installation, reconstruction, or repair."¹²² "Property Not Covered" was defined as "[e]xisting buildings or structures to which improvements, alterations, repairs, or additions are being made."¹²³

The court was faced with the issue of whether the repair and renovation work had to be ongoing before coverage attached. It reasoned that to require the work to be ongoing before coverage attached was not practical.¹²⁴ The court noted that to hold otherwise would require an insured to "obtain two separate insurance policies, one to cover the two days before the repairs started, and one to cover the property while it was being repaired."¹²⁵ The court recognized that vacant buildings being held for a long period prior to commencing repair may present another coverage issue, but it is up to the insurer to differentiate between these circumstances in its policy.¹²⁶ This case is another example of the courts construing ambiguous policy language in favor of the insured to extend coverage and to encourage insurers to write clear policies.

119. 724 N.E.2d 241 (Ind. 2000).

120. *See id.* at 242-43.

121. *See id.* at 243-45.

122. *Id.* at 243.

123. *Id.*

124. *See id.* at 245.

125. *Id.*

126. *See id.*

I. Liability for Failing to Purchase Coverage for Additional Insured

Two cases, dealing with similar facts, found that when a party to a contract fails to purchase additional insurance as called for in the contract, that party is liable for the amount of coverage the insurance would have provided. In *Exide Corp. v. Millwright Riggers, Inc.*¹²⁷ and *Doherty v. Davy Songer, Inc.*,¹²⁸ the courts were faced with construction contracts that required contractors or subcontractors to purchase additional insurance coverage for the owner of the premises or the general contractor.

In both cases, the contractors charged with the obligation to purchase additional insurance, failed to do so.¹²⁹ When the contractors' employees were injured on the premises, they named the premises owners and the general contractor as defendants in their lawsuits. In both cases, the insurers denied coverage to the premises owner (*Exide*) and the general contractor (*Davy Songer*) despite the contractual obligation to do so. Both *Exide* and *Davy Songer* sued for breach of contract for failure to obtain additional insurance as called for in the contract.

The courts in both *Exide* and *Doherty* held the contractual provision requiring the purchase of additional insurance to be valid.¹³⁰ Both courts adhered to "the principle that parties may shift, by contract, their burdens of risk, and therefore affect the obligations of their insurers."¹³¹ Further, the court in *Doherty* held that the measure of damages for the party who breached the contract is "the amount that would have been due under the policy [it] should have obtained."¹³²

J. Coverage for Advertising Injury

In *Heritage Mutual Insurance Co. v. Advanced Polymer Technology, Inc.*,¹³³ the court added "another installment in the ongoing debate about the meaning of 'advertising injury.'"¹³⁴ In this case, Advanced Polymer Technology (APT) was being sued for patent infringement by Environ Products, Inc. in a separate action. Environ's lengthy seven count complaint essentially alleged that APT unfairly competed with it by stealing its product and claiming it as its own. The product in question was an underground piping product used in the petroleum industry to transport fuel from storage tanks to fuel dispensers.¹³⁵

APT sought coverage for Environ's lawsuit under the advertising injury

127. 727 N.E.2d 473 (Ind. Ct. App. 2000).

128. 195 F.3d 919 (7th Cir. 1999).

129. See *Doherty*, 195 F.3d at 921.; *Exide*, 727 N.E.2d at 478.

130. See *Doherty*, 195 F.3d at 925-26; *Exide*, 727 N.E.2d at 482.

131. *Doherty*, 195 F. 3d at 926 (citing *Am. Underwriters, Inc. v. Auto-Owners Mut. Ins. Co.*, 454 N.E.2d 876, 877 (Ind. Ct. App. 1983)). See also *Exide*, 727 N.E.2d at 482.

132. *Doherty*, 195 F.3d at 927.

133. 97 F. Supp. 2d 913 (S.D. Ind. 2000).

134. *Id.* at 915.

135. See *id.* at 916-17.

provisions of its policy purchased from Heritage.¹³⁶ The policy provided coverage for four specific types of advertising injury: (1) publication of material that slanders or libels or disparages another's "goods, products or services;" (2) "publication of material that violates a person's right of privacy;" (3) "misappropriation of advertising ideas or style of doing business;" or (4) "infringement of copyright, title or slogan."¹³⁷

To determine whether Environ's lawsuit alleged any of these harms, the court closely examined Environ's complaint. Overall, the court found that Environ's cause of action was not based on wrongs it claimed to have suffered as a result of APT's improper advertising.¹³⁸ Rather, the court found that Environ's suit was a patent infringement action, not an action claiming that APT's advertising efforts harmed it.¹³⁹ Consequently, the court distinguished the advertising injury provisions of the policy accordingly. For example, the court found Environ's complaint did not allege infringement of copyright, title, or slogan. In so finding, the court determined that the term "title" did not mean ownership as it applied to a patent, but rather the term was more akin to the concept of naming, such as the name of a product or a means of describing a process. The court concluded that Environ did not allege that APT infringed upon the name of its piping product. Therefore, there was no coverage for advertising injury under this portion of the policy.¹⁴⁰

Similarly, the court found that Environ's complaint did not allege that APT misappropriated Environ's advertising ideas or its style of doing business.¹⁴¹ Further, the court concluded that Environ was not claiming that APT's advertising efforts disparaged it or invaded its right to privacy.¹⁴² Ultimately, the court determined that none of Environ's allegations fell within the defined instances of advertising injury articulated in the policy.¹⁴³ Thus, the court found that Heritage did not owe APT a duty to defend or indemnify it in Environ's patent infringement lawsuit.¹⁴⁴

"Advertising injury" coverage requires a fact sensitive analysis of the alleged wrong, and whether it involved an "advertising activity" to find such coverage, courts consistently require that the wrong occur during an advertising activity, and will look closely at what involves an "advertising activity."

136. *See id.*

137. *Id.* at 917.

138. *See id.* at 924.

139. *See id.*

140. *See id.* at 923-25.

141. *See id.* at 927-28.

142. *See id.* at 932-35.

143. *See id.* at 934.

144. *See id.*

II. AUTOMOBILE INSURANCE CASES

A. *Who Is an Insured?*

The question of an alleged insured's residency has been the focus of a number of cases over the years.¹⁴⁵ In *Indiana Farmers Mutual Insurance Group v. Blaskie*,¹⁴⁶ the court was faced with the issue of whether an adult son of an insured, home on military leave, was a "resident" of the insureds' household and covered by the full policy limits of the insured's policy. Lynn Miller was involved in an accident while driving his parents' car which was covered by their automobile liability insurance policy. While Lynn was not a named insured, the policy covered a "family member" that is "related to you by blood, marriage or adoption [and] who is a resident of your household."¹⁴⁷ The residency issue was important because it determined the policy limits available. The policy provided coverage of \$100,000/\$300,000 for "family members" and \$25,000 for a non-family member permissive user.¹⁴⁸

After the lawsuit was filed against Lynn, the evidence was closely scrutinized to determine his residence. He was thirty-seven years old at the time of the accident. Since graduating from high school, he had married and divorced his wife. He had a child by his former wife as well. When the accident happened, he was on leave from the U.S. Navy, which occurred every sixteen months. While on leave, he would stay with his parents or relatives for approximately ten days to a month. He kept his clothing in a duffle bag and slept on his parents' couch. He did not own a key to his parents' home, nor did he receive his mail at their house.¹⁴⁹

In determining whether Lynn was a "resident" of his parents' home, and entitled to the full policy limits of coverage, the court focused upon general rules of policy construction; when reviewing an "extension" case, (i.e., cases that involve the issue of whether insurance coverage should be extended beyond the named insured), the court construes the contract terms broadly.¹⁵⁰ In interpreting the term "resident," the court considered the following factors: (1) whether Lynn maintained a physical presence in his parents' home; (2) whether Lynn had the subjective intent to reside there; and (3) the nature of Lynn's access to his parents' home and its contents.¹⁵¹

145. See, e.g., *Jones v. W. Reserve Group*, 699 N.E.2d 711 (Ind. Ct. App. 1998); *Chance v. State Auto Ins. Cos.*, 684 N.E.2d 569 (Ind. Ct. App. 1997); *Erie Ins. Exch. v. Stephenson*, 674 N.E.2d 607 (Ind. Ct. App. 1996).

146. 727 N.E.2d 13 (Ind. Ct. App. 2000).

147. *Id.* at 14.

148. See *id.*

149. See *id.* at 14-15.

150. See *id.* at 15 (citing *Aetna Cas. & Sur. Co. v. Crafton*, 551 N.E.2d 893, 895 (Ind. Ct. App. 1990)). The Court also noted that when construing "exclusion" cases, it construes the term "resident" narrowly. See *id.*

151. See *id.* at 16-18.

In addressing each of the factors, the court concluded that Lynn was not a “resident”, and was not entitled to full policy limit coverage. Lynn maintained a minimal presence at his parents’ home such that he was a temporary visitor rather than a resident.¹⁵²

B. Non-Cooperation Clause

In *Gallant Insurance Co. v. Wilkerson*,¹⁵³ the Indiana Court of Appeals analyzed an insurer’s conduct to determine whether it waived the policy defense of non-cooperation by the insured or was estopped from asserting it to avoid coverage. In *Wilkerson*, the insured was involved in an automobile accident with another driver who filed a lawsuit against the insured. The insurer provided the insured an attorney to defend the lawsuit, but little communication occurred between the insurance company and the insured. Settlement negotiations were unsuccessful and a trial was necessary.¹⁵⁴

At the time of trial, the insured was in prison. However, the insurer did not seek the court’s assistance to secure the insured’s attendance at trial, and proceeded with his defense in his absence. After the injured driver recovered a judgment against the insured, she entered into an agreement with the insured for the assignment of all of the insured’s rights and claims against the insurer.¹⁵⁵

The injured driver filed a motion to enforce the judgment by proceedings supplemental against the insurer to recover the insured’s policy limits in satisfaction of the judgment. In response, the insurer filed an answer alleging the insured had breached his policy’s cooperation clause by failing to appear at trial. The trial court held that the insurer waived the defense of non-cooperation and was estopped from asserting it. The court entered a garnishment order for the maximum policy amount, plus costs and interest.¹⁵⁶

On appeal, the Indiana Court of Appeals began its analysis by determining that a cooperation clause “applies to the conduct of the insured in proceedings subsequent to the notice of loss, claim, or suit, but prior to a determination of an insurer’s liability.”¹⁵⁷ The court further determined that the purpose of a cooperation clause is to “protect insurers by preventing collusion between the insureds and the injured parties.”¹⁵⁸ However, before an insurer can take advantage of the non-cooperation defense, “the insurer must demonstrate that it exercised good faith and diligence in securing the cooperation of its insured before asserting the defense of non-cooperation.”¹⁵⁹

152. *See id.* at 18.

153. 720 N.E.2d 1223 (Ind. Ct. App. 1999).

154. *See id.* at 1225.

155. *See id.* at 1225-26.

156. *See id.* at 1227-30.

157. *See id.* at 1226.

158. *Id.*

159. *Id.* This case may suggest a relaxation of the almost impossible element of an intentional or willful breach of the cooperation clause by an insured. In *Smithers v. Mettert*, 513 N.E.2d 660,

In analyzing whether the cooperation clause defense was waived, the court looked to the insurer's conduct and whether it had knowledge of the non-cooperation when it continued to act on behalf of the insured. The court found that the insurer had "'notice of and the opportunity to control' the proceedings in the underlying tort action."¹⁶⁰ Specifically, the court found that the insurer had full knowledge that the insured was incarcerated at the time of trial. Indeed, the court found that under these unique circumstances, it was impossible for the insured not to violate the cooperation clause, because "it was both physically and legally impossible" for him to appear in court without the insurer intervening on his behalf.¹⁶¹ The court found that the insurer had the opportunity to secure the insured's presence at trial, but failed to do so. Without any evidence in the record to support an inference that the insurer took affirmative steps necessary to procure the insured's attendance, the court of appeals affirmed the trial court's garnishment order, and the insurer was forced to pay its policy limits and costs.¹⁶²

It is a difficult burden for an insurer to successfully establish that an insured failed to cooperate in the defense of a lawsuit. Indeed, the insurer is forced to make every effort to obtain the insured's cooperation. Failure to do so will prevent the insurer from obtaining a judicial declaration that the clause has been violated by the insured.

C. Excess Carrier's Duty to Defend

The case of *PHICO Insurance Co. v. Aetna Casualty & Surety Co.*¹⁶³ is another example of a case in which the courts show little tolerance for insurance companies who do not actively defend their insureds. In *PHICO*, an excess insurer brought suit against the primary insurer claiming that the primary insurer breached a duty to the excess carrier to properly defend an underlying action in which it did not participate. In the underlying tort action brought against its insureds, the plaintiff sustained serious injuries. The primary insurer sent numerous notices to the excess insurer seeking advice in the defense strategy and indicating that the excess policy may be required to provide coverage in that case.¹⁶⁴

Despite these notices from the primary insurer, the excess insurer failed to actively participate in the defense of the underlying tort action. Eventually, the primary insurer tendered its limits, prompting the excess insurer to settle the underlying case close to the scheduled trial date. The excess insurer filed an

662-63 (Ind. Ct. App. 1987), the court indicated that an insurer must show that 1) the insurer used good faith and diligence to obtain the insured's cooperation; 2) the insured intentionally or willfully breached the cooperation clause; and 3) the insured's breach of the cooperation clause prejudiced the insurer.

160. 720 N.E.2d at 1228.

161. *Id.*

162. *See id.*

163. 93 F. Supp. 2d 982 (S.D. Ind. 2000).

164. *See id.* at 985-86.

equitable subrogation lawsuit against the primary insurer alleging that because of the primary insurer's unreadiness for trial, the excess insurer was hampered in its settlement negotiations, and was thus forced to pay more in settlement.¹⁶⁵

The primary insurer sought summary judgment on the excess insurer's claim. Initially, Judge Tinder, from the Southern District of Indiana, determined that the Indiana Supreme Court would recognize a cause of action by an excess carrier against a primary carrier for negligent handling of the underlying claim. Nevertheless, Judge Tinder ruled as a matter of law, that the primary insurer did not breach a duty to the excess carrier. The court reasoned that with all of the notices the excess insurer received in this case, it was well aware that it should have become actively involved in the defense of the underlying action. Further, because the excess insurer refused to act, it could not now come into court and complain. Accordingly, the court found that the doctrines of waiver, estoppel and laches applied to bar the excess insurer's claims against the primary insurer.

¹⁶⁶

D. Reliance on Statements by Insurance Adjuster

In *Darst v. Illinois Farmers Insurance Co.*,¹⁶⁷ the court of appeals was faced with the question of whether statements made by an insurance adjuster about the value of the insured's case could be relied upon by the insured or whether the statements were merely opinions. In April 1996, Sloan was in an automobile accident with Weger. After the accident, a representative from Weger's insurer contacted Sloan and offered him \$4,000 to settle his property damage and bodily injury claims. Not knowing whether to accept the offer, Mr. Sloan called his claims representative, Gaumer. Sloan claims that Gaumer told him that the \$4,000 offer was a fair settlement, and that he should accept it rather than retaining an attorney. Sloan accepted the \$4,000 and released Weger from further liability on the claim.¹⁶⁸

Sloan eventually filed for bankruptcy. The bankruptcy trustee sued Sloan's insurer, claiming that Gaumer's statements to Sloan constituted actual and constructive fraud, negligent misrepresentations, and breached an assumed duty to provide accurate information. The trial court awarded summary judgment in favor of the insurer, and the bankruptcy trustee appealed.¹⁶⁹

The court of appeals examined the elements of both the actual and constructive fraud claims brought by the trustee and determined that each tort required a misrepresentation of fact to be actionable.¹⁷⁰ Further, in order to

165. *See id.* at 988.

166. *See id.* at 995.

167. 716 N.E.2d 579 (Ind. Ct. App. 1999), *trans. denied* 735 N.E.2d 228 (Ind. 2000).

168. *See id.* at 580-81.

169. *See id.* at 581.

170. *See id.* *See also* Spolnik v. Guardian Life Ins. Co. of Am., 94 F. Supp. 2d 998 (S.D. Ind. 2000) (noting misrepresentations of law (not fact), made by insurer's agent, absent a showing of a significant relationship, are not actionable fraud). *But see* Am. Family Mut. Ins. Co. v. Jeffrey,

maintain the fraud actions, Sloan must have had a reasonable right to rely on Gaumer's statements.¹⁷¹ The court found that, as a matter of law, expressions of opinion cannot be considered factual representations.¹⁷² Also, the court explained that an insured may reasonably expect his insurance agent to be knowledgeable about what is covered under the policy or details about the policy itself. But, it is not reasonable to expect that an insurance agent will be aware of the merits of a claim and the value of an insured's case. Based on the evidence in the record, the court found that Gaumer's statements to Sloan were expressions of opinion rather than fact, and Sloan had no reasonable right to rely on them.¹⁷³

With respect to the negligent misrepresentation and breach of duty claims, the court found that, with the limited exception of employment cases, Indiana does not recognize the tort of negligent misrepresentation.¹⁷⁴ The court also found that the cause of action for breach of assumed duty to provide accurate information was essentially a negligent misrepresentation claim disguised under a different name.¹⁷⁵ Thus, the court also found the breach of duty claim was not viable.¹⁷⁶

As such, the court of appeals affirmed the trial court's grant of summary judgment in favor of the insurer. However, in the dissenting opinion, it was suggested that a genuine issue of material fact existed to preclude summary judgment because Gaumer may have had a duty not to misrepresent the information he provided to Sloan.¹⁷⁷ The dissent analyzed whether this case may fit into a limited exception for a viable negligent misrepresentation claim. As was noted in *Eby*, the court of appeals recognized a negligent misrepresentation claim when "[o]ne who, *in the course of his business, profession, or employment, or in any other transaction in which he has a pecuniary interest*, supplies false information for the guidance of others in their business transactions."¹⁷⁸ The dissent did not agree with the majority that the application of negligent misrepresentation as a cause of action was so limited.¹⁷⁹

While existing law demonstrates that an insurer and insured have a special relationship, the adjuster had no interest or duty related to the insured's claim against another, such that the information was merely an opinion, not a fact.¹⁸⁰ Thus, the majority properly concluded that no actionable claim existed.

No. 98-1085, 2000 WL 1206623, *7 (S.D. Ind. Aug. 11, 2000) (citing *Lawyers Title Ins. Corp. v. Pokraka*, 595 N.E.2d 244, 249 (Ind. 1992) (criticizing the distinction under Indiana law between misrepresentation of law and fact)).

171. 716 N.E.2d at 582.

172. *See id.* at 581-82.

173. *See id.*

174. *Id.* at 584.

175. *See* 716 N.E.2d at 584-85.

176. *See id.*

177. *See id.* at 585 (Mattingly, J., dissenting).

178. *Id.* at 586 (citing RESTATEMENT (SECOND) OF TORTS § 552) (emphasis in original).

179. *See id.*

180. *See Erie Ins. Co. v. Hickman*, 622 N.E.2d at 515, 518 (Ind. 1993).

E. Agent's Statements Can Bind Insurer to Coverage

In *Gallant Insurance Co. v. Isaac*,¹⁸¹ the court was faced with the issue of whether an agent's statements to an insured could bind insurance coverage even though the agent's actions were not sanctioned or approved by the insurer. In *Isaac*, Ms. Isaac obtained automobile insurance coverage for her 1986 Fiero through her insurer by purchasing from one of its agents, Thompson-Harris. On the last day of her existing insurance period, Ms. Isaac purchased a 1988 Grand Prix, and needed to be fully insured.¹⁸²

She called Thompson-Harris and explained her need to cancel the coverage on the Fiero and obtain coverage for the Grand Prix. The agent orally indicated that because the office was about to close for the weekend, it would immediately bind coverage on the Grand Prix, and Ms. Isaac could come in on Monday to complete the paperwork and pay the premium.¹⁸³ This practice was against the guidelines of the insurer.¹⁸⁴

On Sunday, Ms. Isaac was in an accident resulting in damage to her new Grand Prix. The next day, as planned, Ms. Isaac went to the agency, completed the paperwork, paid her premium and reported the loss. The agency sent all of the paperwork about the new coverage and accident to the insurer.¹⁸⁵ Later that month, the insurer renewed Ms. Isaac's policy, with an effective date beginning after the accident.

Predictably, the insurer denied coverage for the accident, and sought a declaratory judgment that no coverage existed on the basis that the accident occurred before the policy became effective.¹⁸⁶ Ms. Isaac responded by filing a motion for summary judgment seeking coverage based on the principles of agency law recently articulated by the Indiana Supreme Court in *Menard, Inc. v. Dage-MTI, Inc.*¹⁸⁷ Basically, Ms. Isaac argued that the Thompson-Harris agency had the inherent authority to bind the insurer to coverage when the agent told Ms. Isaac over the telephone, that she was covered.

The court found that *Menard's* three-part agency test was satisfied when Ms. Isaac demonstrated that (1) the agent's conduct was within the usual and ordinary scope of its agency; (2) she was reasonable in her belief that the agent could bind coverage over the phone without payment; and (3) she was not on notice that the agent could not bind coverage on behalf of the insurer.¹⁸⁸ The court found that Thompson-Harris may have violated its insurer's policy not to bind coverage without receiving a premium payment. However, the court intimated that the

181. 732 N.E.2d 1262 (Ind. Ct. App. 2000).

182. *See id.* at 1265.

183. *See id.*

184. *See id.* at 1269-70.

185. *See id.* at 1265-66.

186. *See id.* at 1266.

187. 726 N.E.2d 1206, 1211 (Ind. 2000).

188. *See Isaac*, 732 N.E.2d at 1267.

agent may have followed an accepted practice of the insurer to accept orders from the agents by telephone and facsimile. Further, the court reasoned that of the two innocent parties who suffered from the agent's wrongdoing, the court preferred that the insurer bear the loss because it is in a better position to address the problem in the future.¹⁸⁹

While the outcome of this case appears appropriate from the recited facts, this precedent could lead to expanded insurance coverage from agent's actions in future cases. Using this case, insureds can argue that an agent's representatives, even if without the insurer's permission or knowledge, may lead one to reasonably believe that coverage exists, such that the insurer must be bound. Insurance companies must closely watch the practices of insurance agents and demonstrate a clear showing that certain conduct violates the company's policies to avoid being bound in the future.

F. Underinsured Motorist Coverage for Passenger of Motorcycle

The court in *Veness v. Midland Risk Insurance Co.*¹⁹⁰ was asked to decide whether uninsured/underinsured motorist insurers are required to provide coverage for insureds injured when riding a motorcycle. The insured was thrown from a motorcycle on which she was a passenger and sustained bodily injury. On the date of the accident, the insured had coverage for underinsured motorist liability, but the policy specifically excluded coverage to the insured injured while occupying a motorcycle.¹⁹¹

The insured collected the liability policy limits from the motorcycle driver's insurer, and submitted a claim to her insurer for underinsured motorist benefits. Her insurer denied the claim by relying upon the motorcycle exclusion in the policy. After the insured filed suit, the trial court granted summary judgment in favor of the insurer based on the exclusion.¹⁹² The insured appealed arguing that the motorcycle exclusion violated Indiana's Uninsured/Underinsured Motorist Coverage Statute ("UM/UIM").¹⁹³

Upon review, the court focused extensively upon the purpose and intent of the UM/UIM Statute. The coverage is designed to protect innocent victims of accidents with the uninsured or underinsured motorist. As the Indiana Supreme Court observed, the UM/UIM Statute requires insureds be able to obtain full recovery from an inadequately insured motorist. While insurers can freely include language to limit or exclude coverage, those restrictions must still comply with the spirit and the letter of the UM/UIM statute.¹⁹⁴

The court narrowed the issue to whether a motorcycle fit the definition of

189. *See id.* at 1269-70.

190. 732 N.E.2d 209 (Ind. Ct. App. 2000).

191. *See id.* at 210-11.

192. *See id.* at 211.

193. IND. CODE § 27-7-5-2 (2000).

194. *See id.* at 212-13.

“motor vehicle” under the UM/UIM statute.¹⁹⁵ The court concluded that it met the definition, and that uninsured/underinsured motorist carriers were required to offer the coverage to occupiers of motorcycles.¹⁹⁶

The conclusion in *Veness* follows the intent and purpose of the UM/UIM Statute. As long as operators of motorcycles are permitted upon the roadways, they should be afforded protection from inadequately insured motorists, just as any other motorist would expect.

G. Set-Off in Underinsured Motorist Claim

In *Grain Dealers Mutual Insurance Co. v. Wuethrich*, the Indiana Court of Appeals analyzed the issue of set-off in the context of an underinsured motorist claim.¹⁹⁷ Specifically, the question was whether sums paid by a non-motorist tortfeasor in settlement of the insured’s claim should be applied to reduce the amount available under the uninsured motorist coverage.¹⁹⁸ The court held that all sums paid, either by motorist or non-motorist tortfeasors, should be included in the set-off.¹⁹⁹

The facts were not complicated. Wuethrich’s vehicle was struck by Bartelmann’s vehicle, while she was waiting in a line of construction traffic near a road construction site. As a result of the accident, Wuethrich sustained serious injuries and incurred damages in excess of Bartelmann’s policy limits. Wuethrich sued Bartelmann, Bucko Construction Company, the State of Indiana, and her underinsured motorist carrier, Grain Dealers.²⁰⁰

Wuethrich settled for Bartelmann’s policy limits of \$25,000. She also settled with Bucko and the State for a combined \$150,001. Her carrier advanced \$25,000 to Wuethrich in order to retain a right of subrogation against Bartelmann, but later waived that right. In all, Wuethrich received a total of \$50,000 from Bartelmann and Grain Dealers. Adding the amounts she received from Bucko, the State, Bartelmann and Grain Dealers, Wuethrich recovered a total of \$200,001.²⁰¹

Ms. Wuethrich’s policy with Grain Dealers allowed for underinsured motorist benefits of \$100,000 per person, per incident. All parties agreed that Ms. Wuethrich’s damages exceeded her underinsured motorist policy limits. Ms. Wuethrich argued that Grain Dealers owed the remaining \$50,000 of underinsured motorist limits without a set-off for the amounts paid by Bucko and the State because they were non-motorist tortfeasors. She asserted that Grain Dealers was only entitled to set-off amounts paid by motorist tortfeasors. Grain

195. *See id.* at 213.

196. *See id.* at 215.

197. 716 N.E.2d 596 (Ind. Ct. App. 1999), *trans. denied* 735 N.E.2d 222 (Ind. 2000).

198. *See id.* at 597.

199. *See id.* at 600.

200. *See id.* At 597. Ms. Wuethrich alleged that Bucko and the State were negligent in controlling the traffic flow and placement of signage at the construction site. *See id.*

201. *See id.* at 598.

Dealers argued that the policy language allowed for credit of all sums paid by persons found to be legally liable in settlement of the insured's claim. Further, Grain Dealers asserted that set-off should be allowed for all sums paid by tortfeasors, regardless of whether the tortfeasor was a motorist.²⁰²

The court, although never squarely faced with this question before, interpreted the policy to permit setoff of payments made by "any person or organization which may be legally liable" for Ms. Wuethrich's injuries.²⁰³ Consequently, the sums paid by these non-motorist defendants were subject to a set-off under the policy. The court concluded that neither the policy, nor the underinsured motorist statute limited the setoff sought by Grain Dealers.²⁰⁴

*H. Insurer's Participation in Settlement Negotiations
Does Not Waive Its Right to Notice of a Lawsuit*

An insurance company expects its insureds to provide timely notice of a lawsuit so that the insurer can take steps to perform an investigation and defend the insured. In *Gallant Insurance Co. v. Allstate Insurance Co.*, the court examined how much notice of a lawsuit an insurer may expect.²⁰⁵

An automobile accident occurred between Richey and Moore.²⁰⁶ Richey filed a personal injury lawsuit against Moore, which was tendered to her insurer, Gallant. The personal injury claim was eventually settled. In the meantime, Allstate paid Richie for property damage from the accident, and filed a separate subrogation lawsuit against Moore. Moore never tendered the lawsuit to Gallant. Allstate also failed to forward a "courtesy copy" of the lawsuit to Gallant or its attorney.²⁰⁷

Allstate eventually obtained a default judgment against Moore, and instituted proceedings supplemental against Gallant to recover the property damage.²⁰⁸ Gallant argued that it owed no coverage for Allstate's property damage lawsuit because it did not receive proper notice. The trial court found that Gallant had proper notice based on the negotiations in the other case, and Gallant appealed.²⁰⁹

In analyzing the insurance policy, the court of appeals observed that it specifically excluded coverage when Gallant did not receive actual notice of the lawsuit before entry of judgment. Gallant argued that it did not have actual notice of the lawsuit until after the default judgment had been entered. Allstate contended that Gallant's control of the defense and settlement of the personal injury claim should have led a reasonable insurance company to anticipate a

202. *See id.* at 598-99.

203. *Id.* at 600.

204. *See id.*

205. 723 N.E.2d 452 (Ind. Ct. App. 2000).

206. *See id.* at 454.

207. *See id.*

208. *See id.*

209. *See id.* at 455.

subrogation claim to recover the property damage.²¹⁰

The court concluded that “[k]nowledge of a pending claim or that a lawsuit might be filed is not equivalent to actual notice that a suit has been filed as required under the policy.”²¹¹ Thus, the court upheld Gallant’s expectation of receiving “actual” notice of the lawsuit, rather than requiring it to guess or anticipate a lawsuit may be filed.

Allstate also argued that public policy favored compensation of “innocent victims,” and that the court should find that Gallant waived its right to notice.²¹² However, the court observed that it “was hard pressed to attribute the term ‘innocent’ to Allstate, which knew of Gallant’s duty to defend Moore, yet failed to notify either Moore’s counsel or Gallant of the subrogation lawsuit until it sought a default judgment against Moore.”²¹³ The court cited a recent Supreme Court decision for the proposition that the “administration of justice requires that parties *and their known lawyers* be given notice prior to a lawsuit prior to seeking default judgment.”²¹⁴ Consequently, the court held that Gallant was not liable to indemnify Ms. Moore for Mr. Richey’s property damage.

I. Underinsured Motorist Coverage in Garage Liability Policy

In *Myles v. General Agents Insurance Co. of America, Inc.*,²¹⁵ the Seventh Circuit decided whether underinsured motorist benefits were recoverable under a garage liability policy. When Vivian Myles’ automobile became inoperable, her brother, Richard Rench, the owner of a car dealership, loaned her a car until her car was repaired. Ms. Myles used the car solely for transportation to and from work. The loaner car was insured under a garage liability policy issued to her brother’s dealership.²¹⁶

After driving the car for a few days, Ms. Myles sustained serious injuries in an automobile accident with a driver who only had insurance coverage of only \$25,000. The other driver’s insurance company paid Ms. Myles its policy limits, but because of the cost Ms. Myles’ injuries surpassed \$25,000 and because her own personal automobile insurance coverage had lapsed, she sought underinsured motorist coverage from the car dealership’s policy.²¹⁷

After the trial court granted summary judgment to the insurer finding that no underinsured motorist coverage was available, Ms. Myles appealed. The Seventh Circuit Court of Appeals observed that to be entitled to underinsured motorist

210. *See id.*

211. *Id.* at 456.

212. *Id.*

213. *Id.*

214. *Id.* (quoting *Smith v. Johnston*, 711 N.E.2d 1259, 1264 (Ind. 1999) (emphasis in original)).

215. 197 F.3d 866 (7th Cir. 1999).

216. *See id.* at 867-68.

217. *See id.*

benefits, Ms. Myles must qualify as an “insured” under the dealership’s policy.²¹⁸

The policy defined “insured” as those driving “covered autos” with the policy owner’s permission. Pursuant to the policy, the policy owner was required to designate “covered autos” by listing them on an addendum. Accordingly, the insured’s premium payments varied with the number of designated insureds. The policy language stated that a “covered auto” does not include an auto furnished for the “regular use” of any person unless the driver of the auto is specifically listed in the policy.²¹⁹ Under the policy, coverage extended to the occasional use by a non-listed driver who had the insured’s permission to drive the covered auto.²²⁰

Ms. Myles conceded that she was not listed as a driver of a covered auto in the policy. Nevertheless, she claimed she should be covered under various theories. First, she argued that the term “regular use” was ambiguous, and should be construed against the insurance company. Second, even if the term “regular use” were unambiguous, Ms. Myles contended that she was not a regular user of the vehicle. Finally, even if she were a regular user, Ms. Myles argued that she was also an occasional user for emergency purposes, which was expressly covered.²²¹

The court reviewed the contract term “regular use” and found it to be unambiguous. Finding no ambiguity, the court applied the term “regular use” to the facts and determined that Ms. Myles used the loaner car to drive to and from work for a few days prior to the accident. The court ultimately found that Ms. Myles’ use of the loaner car as transportation to and from work every day, was a “regular use” of the vehicle. The court stated that “transportation to and from work on a routine and recurring basis over the course of several days” was “within the scope of the regular use exclusion” of the policy.²²²

The court also rejected Ms. Myles argument that she was an occasional user for emergency purposes, based upon its prior conclusion that her use of the car was routine.²²³ Thus, the court affirmed the trial court’s grant of summary judgment in favor of the insurer.²²⁴ The court recognized that an insurance company only provides coverage for certain defined risks in which a policy premium has been paid. Because the dealership selected a limited number of potentially covered operators of the vehicles, for which it received a lower premium, the court properly found that no coverage existed.

218. *See id.*

219. *Id.* at 869.

220. *See id.* at 869-69.

221. *See id.* at 869.

222. *Id.* at 870.

223. *See id.*

224. *See id.*

*J. Insurer Breached Insurance Contract by Stopping Payment
of Settlement Check*

In *Gallant Insurance Co. v. Amaizo Federal Credit Union*,²²⁵ the court was asked to determine whether the insurer's attempt to stop payment of a settlement check constituted a breach of the insurance contract. The court ultimately held that a loss is "paid" by the insurer when the check is tendered for payment to the insured, not when the check is deposited in the insured's account.²²⁶ Consequently, stopping payment of a settlement check after it was tendered was a breach of the insurance contract.²²⁷

In the case, the Credit Union was named as a loss payee in the policy for an automobile that was stolen in December of 1995 in Calumet City, Illinois. The insured immediately notified the Credit Union that the vehicle had been stolen. On February 26, 1996, the insurer prepared a check for the value of the car naming the Credit Union and the insured as loss payees. Two days later, the Calumet City Police Department notified the insured that his stolen vehicle had been recovered. On March 1, 1996, the insurer, unaware that the stolen vehicle was recovered, sent the check to the Credit Union, and requested that the Credit Union return the title to the vehicle. On March 7, 1996, the Credit Union forwarded the title to the stolen vehicle to the insurer. On March 8, the Credit Union endorsed the check and deposited it into its account. On March 11, the Credit Union's bank presented the check to the payor bank for payment. On March 14, the insurer learned that the stolen vehicle was recovered and repairable, and notified the Credit Union that it was going to stop payment on the check because of the vehicle's recovery.²²⁸

A few months later, the Credit Union filed a complaint against the insurer alleging that the insurer breached the insurance contract when it stopped payment of the check after the loss had been paid. The Credit Union also sought attorney fees because the insurer stopped payment of the check without valid legal cause. In a summary proceeding, the trial court found in favor of the Credit Union and awarded the Credit Union attorney's fees. The insurer appealed.²²⁹

In deciding whether the insurer wrongfully stopped payment of the check and breached the insurance contract, the court of appeals first determined whether the insurer "paid" the loss as defined by the insurance contract.²³⁰ The loss provision in the insurance contract stated that the insurer "may pay for the loss in money; or may repair or replace the damaged or stolen property; or may, at any time before the loss is paid or the property is so replaced, at its expense return any stolen property to the named insured."²³¹ Consequently, the insurer could elect

225. 726 N.E.2d 860 (Ind. Ct. App. 2000).

226. *See id.* at 866-67.

227. *See id.* at 867.

228. *See id.* at 863.

229. *See id.*

230. *See id.* at 865.

231. *Id.* at 864.

to repair the stolen vehicle, but only *before* it paid a claim for a loss of the stolen vehicle.

The court found that the term “paid,” as it was contained in the policy, was ambiguous. As such, the term was strictly construed against the insurer as the drafter of the policy. The court looked to Indiana’s version of Article 9 of Uniform Commercial Code (UCC)²³² and case law precedent²³³ to derive the meaning of “paid.” The Court found that the settlement check was considered “paid” when it was tendered to the Credit Union, not when it was debited to the Credit Union’s account.²³⁴

Because the loss was considered paid when the insurer tendered the check, the court found that the insurer’s stop payment was a breach of the insurance contract. Furthermore, under Ind. Code § 26-2-7-5-(3), the Credit Union was eligible for, and received, attorney’s fee award as a result of the insurer stopping payment of the check without a valid legal cause.²³⁵

This ruling follows the intent of Indiana’s UCC to establish consistency in transactions. To permit the insurer to unilaterally void the agreement with the Credit Union after issuance of a draft which was received and relied upon by the Credit Union would frustrate that policy.

III. HEALTH, DISABILITY AND ERISA INSURANCE CASES

One case was decided during the survey period that was significant to disability insurance coverage. In *Stinnett v. Northwestern Mutual Life Insurance Co.*,²³⁶ the court was faced with the issue of whether a provision in a disability insurance policy requiring the insured be under the continuing care of a licensed physician during the period of disability was enforceable. The court recognized the requirement that patients be under the care of a physician in disability policies is generally enforceable with limited exceptions. Yet, the insured argued that the continuing physical care requirement “should not be enforced when there is other evidence of an insured’s disability.”²³⁷ The insured also argued that his depression, which was his claimed disability, was a contributing factor in him not seeking continuing treatment. The court ultimately rejected both arguments in following the general rule that absent evidence of futility or unavailability of continuing medical treatment, the care of a physician requirement in the disability policy was enforceable.²³⁸

Only one notable case was published during this survey period which interpreted the Employee Retirement Income Security Act of 1974 (ERISA). In

232. IND. CODE § 26-1-2-511 (2000).

233. *O'Donnell v. Am. Employers Ins. Co.*, 622 N.E.2d 570 (Ind. Ct. App. 1993).

234. *See Amaizo*, 726 N.E.2d at 866-67.

235. *See id.* at 867.

236. 101 F. Supp. 2d 720 (S.D. Ind. 2000).

237. *Id.* at 724.

238. *See id.* at 726.

Midwest Security Life Insurance Co. v. Stroup,²³⁹ the Indiana Supreme Court held that causes of action for breach of contract and bad faith denial of insurance coverage are state law claims preempted by ERISA. The *Stroup* case clarifies Indiana law on the issue of whether breach of contract and bad faith claims were preempted.

However, prior to the publication of *Stroup*, the United States District Court for the Southern District of Indiana in *Reber v. Provident Life & Accident Insurance Co.*²⁴⁰ also found that those state claims were preempted by ERISA. In so doing, the *Reber* court relied on cases that had previously announced that breach of contract and bad faith claims arising out of the processing of health insurance benefit claims under ERISA were preempted.²⁴¹

IV. LIFE AND FUNERAL INSURANCE CASES

One case published during the survey period discussed Indiana's long standing rule that a beneficiary of a life insurance policy who intentionally causes the death of the insured is not entitled to recover benefits of the policy. In *Metropolitan Life Insurance v. Wattley*,²⁴² the court denied the insurer's motion for summary judgment on the basis that there was a question of fact as to the beneficiary's intent when she killed the insured. In *Wattley*, the beneficiary pled guilty to reckless homicide after fatally stabbing her husband.²⁴³ "The requisite *mens rea* for reckless homicide is recklessness, not knowledge or intent."²⁴⁴ Because the court had before it no evidentiary determination as to "precisely how Mr. Merchant was stabbed, and Ms. Wattley's state of mind at that moment," it could not hold as a matter of law that Ms. Wattley was not entitled to benefits.²⁴⁵

Another case dealing with funeral insurance was decided during the survey period. The case of *D.O. McComb & Sons, Inc. v. Feller Funeral Home, Inc.*²⁴⁶ interpreted the Indiana statute governing transfers of funeral insurance policies. In *D.O. McComb*, the original seller of a funeral insurance policy was asked by the purchaser to transfer the policy to another funeral home.²⁴⁷ The original seller transferred the policy, but sued the successor seller to recover the five

239. 730 N.E.2d 163 (Ind. 2000).

240. 93 F. Supp. 2d 995 (S.D. Ind. 2000).

241. *See id.* at 1010 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (stating that state law claims for breach of contract, and bad faith, and fraud in the processing of benefits are preempted by ERISA)). *See also* *Panaras v. Liquid Carbonic Indus. Corp.*, 74 F.3d 786 (7th Cir. 1996); *Tomczyk v. Blue Cross & Blue Shield United of Wis.*, 951 F.2d 771 (7th Cir. 1991).

242. 109 F. Supp. 2d 1017 (N.D. Ind. 2000).

243. *See id.* (citing *Brown v. State*, 659 N.E.2d 652, 656 (Ind. Ct. App. 1995)).

244. *Id.* at 1019.

245. *Id.*

246. 720 N.E.2d 454 (Ind. Ct. App. 1999).

247. *See id.* at 455.

percent transfer fee allowable by statute.²⁴⁸ The court held that the original seller was not entitled to a five percent transfer fee because there was no property held in trust which the original seller was required to transfer. The court noted that the purpose of the transfer fee was to compensate for a party who has managed assets under the funeral planning agreement. Because there were no assets to maintain under the funeral planning agreement, the original seller was not entitled to compensation.²⁴⁹

CONCLUSION

In all, cases decided during this survey period did not drastically alter the landscape of insurance law. There were, however, isolated examples that have the potential to impact this area significantly. Notwithstanding the lack of quantity, the court in *Patel* may have significantly increased the potential exposure for insurance companies sued for bad faith by allowing recovery of emotional distress damages and attorney fees. The courts also made it easier for insureds to escape the intentional acts exclusion by suggesting that an “I did not mean to” defense may survive summary judgment.

248. IND. CODE § 30-2-13-13 (2000).

249. 720 N.E.2d at 456.