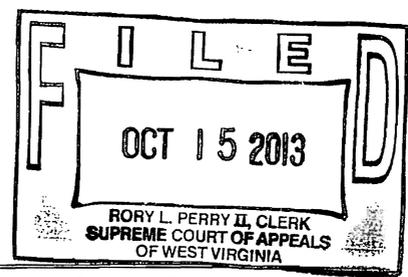


BRIEF FILED
WITH MOTION



No. 13-0692

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA
At Charleston

WEST VIRGINIA MUTUAL INSURANCE COMPANY, INC.

Petitioner,

v.

BETTY J. ADKINS, RAYETTA D. BAUMGARDNER, DIANA L. BOERKE,
LATHA A. BOLEN, CHARLOTTE L. DEAL, CONSTANCE L. DEVORE,
TERESSA D. HAGER, LORENN A. HANKINS, TAMMY H. CLARK,
PAMELA K. HATFIELD, MARCIE J. HOLTON, LINDA L. JONES, PATTY S.
LEWIS, TERESA LOVINS, MARTHA J. MARTIN, LOUELLA PERRY,
SHERRY L. PERRY, JANICE PETTIT, KIMBERLY A. ROE, JANICE
ROUSH, REBECCA SMITH, BEULAH STEPHENS, AND DEBRA L. WISE

Respondents.

BRIEF OF THE PETITIONER,
WEST VIRGINIA MUTUAL INSURANCE COMPANY, INC.

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ASSIGNMENTS OF ERROR

1. The Kanawha Circuit Court erred in failing to find that the Respondents stood in the shoes of United Health Professionals as an assignee.
2. The Kanawha Circuit Court erred in finding that coverage existed under multiple policy periods.
3. The Kanawha Circuit Court erred in finding that separate coverage existed for the Respondents' claims against United Health Professionals.
4. The Kanawha Circuit Court failed to find that statements made by United Health Professionals for purposes of obtaining insurance coverage were part of the subject insurance policies for purposes of determining the ordinary meaning of the subject policies.
5. The Kanawha Circuit Court erred in failing to apply the doctrine of mutual mistake to equitably reform the policies issued by West Virginia Mutual Insurance Company to United Health Professionals to conform to the intent of the parties.
6. The Kanawha Circuit Court's ruling results in unjust enrichment for the Respondents and United Health Professionals.
7. The Kanawha Circuit Court erred by finding that the issues raised in West Virginia Mutual Insurance Company's cross-motion for summary judgment were not ripe for consideration and that additional discovery was warranted.

STATEMENT OF THE CASE

This appeal arises from the Kanawha Circuit Court's grant of declaratory judgment in favor of the Respondents with regard to whether there was coverage pursuant to a medical professional liability insurance policy for claims against a United Health Professionals (hereinafter "UHP") on a theory of vicarious liability based upon the alleged negligence of a former physician-employee, Mitchell Nutt, M.D. Pursuant to the Court's judgment, the Respondents were awarded a windfall of six million dollars (\$6,000,000.00).

In the underlying declaratory judgment action, the Respondents originally named three defendants, the West Virginia Mutual Insurance Company (hereinafter "WVMIC), United Health Professionals, Inc., and Mitchell Nutt, M.D.¹ WVMIC is a professional medical liability insurer, which insures physicians, surgeons, medical practices and others in West Virginia. In addition, WVMIC is licensed to issue professional medical liability insurance policies in Kentucky, Virginia and Ohio. WVMIC's involvement in this action is based upon policies it issued to UHP, a West Virginia company engaged in providing professional medical services to the residents of West Virginia and surrounding states. UHP employs physicians, paraprofessionals and support staff as part of their business of providing professional medical services. UHP's CEO and President is Alan

¹ The Respondents released all claims against UHP and Dr. Nutt as part of a settlement agreement with WVMIC in which WVMIC agreed to tender the undisputed amount of insurance coverage to the Respondents, with the disputed coverage to be determined in this declaratory judgment action.

Chamberlain, M.D., a physician employed by UHP whose responsibilities include making determinations as to the type and extent of insurance coverage that UHP and its employees need to purchase. See Appendix pg. 167-169, Affidavit of Alan Chamberlain, M.D. UHP employed Mitchell Nutt, M.D., an obstetrician and gynecologist, from 2002 to 2008. As part of Dr. Nutt's practice, he performed medical procedures that involved the implantation of a transvaginal mesh in several female patients. See Appendix pg. 167-169, Affidavit of Alan Chamberlain, M.D.

The underlying declaratory judgment action stemmed from medical procedures performed by Dr. Nutt, on the Respondents. While the specific medical procedures varied, all of the Respondents' claims involved complications that arose from the implantation of a transvaginal mesh. Multiple lawsuits and/or claims were brought against Dr. Nutt and the manufacturer of the transvaginal mesh as the result of these complications.² The Respondents either filed suit against or asserted claims to Dr. Nutt. See Appendix pg. 171, Amended Exhibit 4 to WVMIC's Response to Plaintiff's Discovery Request, Table of Dates of Claims and Medical Incidents for Claims Made Against Dr. Nutt. Thereafter, in 2010 the Respondents and Defendants entered into a settlement agreement whereby WVMIC agreed to pay Dr. Nutt's aggregate policy limits of insurance provided under an extended

² Upon information and belief, WVMIC believes that some or all of the Respondents' claims are currently the subject of Multi-District Litigation pending in the United States District Courts.

reporting endorsement (details as to this policy are set forth in the following section). *See Appendix pg. 173-220, Release and Settlement Agreement.* Importantly, the Respondents never asserted a single claim against UHP during the January 1, 2008 to January 2009 policy period or the January 1, 2009 to January 1, 2010 policy period. In fact, when the Respondents in the instant litigation brought their underlying suits, they named only Dr. Nutt and the mesh manufacturer as defendants. It was not until 2010 that the Respondents made claims against UHP within the meaning of the applicable policies. *See Appendix pg. 222-224, Affidavit of Tamara Lively-Huffman, Executive Vice President for WVMIC.* During the settlement process, the Respondents, whom had previously failed to name UHP as a defendant in a single lawsuit, approached WVMIC inquiring as to whether UHP had insurance coverage to cover potential liability for claims premised on a theory of vicarious liability. WVMIC, through counsel, advised the Respondents and UHP that UHP did not have additional coverage. *See Appendix pg. 226-228, Letter to UHP's Counsel Regarding Insurance Coverage.* As part of the aforementioned settlement agreement, the parties agreed to resolve any dispute concerning insurance coverage for UHP through an action for declaratory judgment. The Respondents; and WVMIC agreed to be bound by the Kanawha Court's determination as to the amount of insurance coverage and WVMIC agreed to pay those sums, if any, that the Kanawha Circuit Court determines are available under

the applicable insurance policies. In exchange the Respondents released all claims against UHP and Dr. Nutt.³

Regarding the medical professional liability policies issued to UHP, the WVMIC began issuing a claims-made and reported medical professional liability policy to the physicians employed by UHP in 2005.⁴ WVMIC has since continued to issue policies to UHP and its employees. The policy language has generally remained the same during this period⁵, although the type of coverage and the employees insured through the policy have changed to reflect employment changes within UHP. From January 1, 2005 through January 1, 2008 (three policy periods), WVMIC issued policies to UHP that provided each physician-employee with a separate limit of insurance and provided UHP as well as its paraprofessional employees⁶ with a shared limit of insurance. Separate limit of insurance means that each employed physician, such as Dr. Nutt, had insurance coverage separate and apart from the other physicians employed by UHP and did not share coverage with any other employed physician. Generally, each physician employed by UHP had \$1,000,000 of coverage per medical incident and \$3,000,000 in aggregate

³ Importantly, the WVMIC and the Respondents reserved the right to appeal any decision of Kanawha Circuit Court to the West Virginia Supreme Court of Appeals.

⁴ Prior to the 2005 policy, it is believed that WV Board of Risk and Insurance Management (BRIM) provided coverage to UHP and its employees.

⁵ See Appendix pgs. 265-333 for the 2008 (pgs. 265-287), 2009 (pgs. 288-310) and 2010 (pgs. 311-333) Policies and Appendix pgs. 334-401 for the 2005 (pgs. 334-351), 2006 (pgs. 352-375) and 2007 (pgs. 376-401) Policies.

⁶ Paraprofessionals are non-physician employees that either treat or assist patients in accordance with both the terms of their employment with UHP and their applicable practice acts. (e.g. Physician Assistants, Nurse Practitioners)

coverage for all claims during a policy period. Employees with shared limits of insurance are defined as sharing insureds, i.e., they share liability limits with the individually employed physicians. Pursuant to the WVMIC policies, a sharing insured may not share with more than one insured with a separate limit of insurance for a particular claim. For example, if Dr. Nutt and Dr. Chamberlain were both named as defendants in a single lawsuit, each would have \$1,000,000 in coverage for the claim. If a nurse employed by UHP were also included as a defendant in the same suit, the coverage would still be the same because the nurse would share the limit with a single physician under the terms of the policy. Likewise, prior to purchasing separate limits, if UHP was named as a defendant, no additional coverage would be triggered because it also shares a single limit of insurance with an employed physician with separate limits of insurance.

In January of 2008, Dr. Chamberlain, through his insurance agent, Terry Slusher, employed by Wells Fargo Insurance Services of WV, Inc., contacted WVMIC for the purpose of changing UHP's limit of insurance from shared to separate. See Appendix pgs. 258-259, Email Exchange Between Andrea Lively, WVMIC Employee, and Terry Slusher. As the result of this correspondence, Dr. Chamberlain drafted a letter, dated January 25, 2008, to Wells Fargo Insurance Services of WV, Inc., stating in pertinent part, "Please be advised that we are changing our corporation limits to 'separate corporate limits' effective 01/01/08. Also be advised, there has been no known claims against physicians and/or the

corporation since 01/01/08.” See Appendix pg. 261, Letter from Alan Chamberlain to WVMIC. This letter expresses the clear and unambiguous intent of Dr. Chamberlain to purchase separate coverage for UHP with an effective date of January 1, 2008 and does not evidence intent to procure separate limits of insurance coverage for medical incidents that occurred prior to January 1, 2008. See Appendix pg 261, Letter from Alan Chamberlain to WVMIC. After payment of a premium of \$42,847, WVMIC issued an “Amendatory Endorsement” (see Appendix pgs. 263) amending policy number PL100133 issued for the policy period of January 1, 2008 to January 1, 2009 (hereinafter, the “2008 Policy”)⁷ to change UHP’s policy limits from shared to separate. WVMIC renewed the 2008 Policy for 2009 and 2010, and both policies provide UHP with separate limits of insurance.

The policies, irrespective of policy year, contain substantially the same language from policy year to policy year with regard to the “Professional Liability Insurance Coverage Form,”⁸ which is the portion of the policy that sets forth the “Insuring Agreement.” The “Insuring Agreement” states in pertinent part:

The company will pay those sums that the **insured**⁹ becomes legally obligated to pay as **damages** because of a **claim**¹⁰ that is a result of a

⁷ Defendant will refer to other policy periods throughout this Brief using the year the policy period first became effective followed by the word “Policy”. This notation specifically refers to the policy beginning on January 1 of the year referenced going through January 1 of the subsequent year.

⁸ It should be noted that the policies contain additional forms, as is expressed in the policy declarations and defined by each policy in section VI. Definitions. See Appendix pgs. 275, 298 and 321.

⁹ Defined by the policy to mean, “Insured means any of the following: ...A. the person or entity specified as the insured in the schedule of insureds; or ...”

medical incident¹¹ which occurs on or after the **retroactive date**¹² applicable to such insured and which is first reported by the insured during the **policy period**.¹³ **The Company** has the right and duty to defend any **claim** or **suit** seeking those **damages**; however, **the Company** has no duty to defend any **claim**, or **suit** which seeks **damages** arising from a **medical incident** to which this insurance does not apply. **The Company** has the right to investigate any **medical incident** and settle any **claim** for **damages** which may arise from a **medical incident**. However, the maximum amount **the Company** will pay to settle any **claim**, or **suit**, or verdict, or judgment, is limited as stated in Section IV; Limit of Insurance and in the **policy declarations**; and further, **the Company** has no duty to defend any **claim** or **suit** after the Limit of Insurance stated in the **policy declarations** and described in Section IV; Limit of Insurance has been exhausted by payment of any settlement, or verdict, or judgment.

See Appendix pgs. 272, 294 and 317, 2008 Policy, 2009 Policy and 2010 Policy, respectively. (emphasis in the original denotes a term specifically defined in the policy as set forth in the footnotes). Based on the above insuring agreement, WVMIC contractually assumed an obligation to pay any sum its insured became legally obligated to pay as damages because of a **covered claim** that is a result of a medical incident which occurs on or after the retroactive date applicable to the insured and **which was first reported during the policy period**. The central

¹⁰ Defined by the policy to mean, "Claim, or claims, means a written demand for money or services arising out of a medical incident."

¹¹ Defined by the policy to mean, "Medical incident(s) means:

(a) any act, series of acts, failure to act, or series of failures to act arising out of the rendering of, or failure to render, professional services, to any one person by an insured or nay person for whose acts or omissions an insured is legally responsible which results in damages, claim or suit; or ...

¹² Defined by the policy to mean, "Retroactive date means the date specified as such on the policy declarations."

¹³ Defined by the policy to mean, "Policy period means the period specified as such in the policy declarations."

dispute between the parties is whether UHP has coverage for the Respondents' claims and if so, how much.

WVMIC has already paid aggregate limits of insurance based on an extended reporting endorsement issued to Dr. Nutt on March 14, 2008. As was mentioned above, Dr. Nutt was employed by UHP from 2002 through 2008. UHP purchased the extended reporting endorsement for Dr. Nutt when he resigned in 2008 for purposes of covering claims made against him after Dr. Nutt resigned and which arose by virtue of his employment with UHP. All of the Respondents' claims against Dr. Nutt were satisfied from the extended reporting endorsement and any additional coverage for Dr. Nutt was exhausted upon payment of Dr. Nutt's policy limits of insurance.

The Respondents argued that coverage exists for their claims, on a separate limits of insurance basis, by virtue of the policy referencing a retroactive date of January 1, 2002, in the 2010 Policy. WVMIC and UHP both contend that the January 1, 2002 retroactive date listed under the 2010 Policies, was never intended to confer coverage, on a separate limits of insurance basis for any medical incidents that occurred prior to January 1, 2008. It was the understanding of the parties to the insurance policies that coverage prior to January 1, 2008 was intended to be strictly on a shared limit of insurance basis. UHP and WVMIC provided testimony by way of affidavit, attesting under penalty of perjury, that the WVMIC did not intend to issue and UHP did not intend to receive coverage on a separate limits of

insurance basis prior to January 1, 2008. Despite this clear and unambiguous intent, the Respondents argued for rigid application of the policies, attempting to persuade the Kanawha Circuit Court to ignore the clear equities between WVMIC and UHP and to further ignore the gross unjust enrichment that they would receive if the Court were to find that coverage existed. The Respondents further argued that despite making all of their claims against UHP during the 2010 Policy period, their claims should not be limited to the \$1,000,000 per medical incident and \$3,000,000 in aggregate coverage posed by the face of the instrument. They argued that the policies, despite being claims-made policies under West Virginia law, bestowed limits of insurance for each policy year that was ever purchased (i.e. \$1,000,000/\$3,000,000 for each year UHP purchased coverage), thereby converting a claims-made policy to an occurrence policy.

Tragically, the Kanawha Circuit Court adopted the Respondents' findings of fact and conclusions of law, *in toto*, and found that UHP had coverage for the Respondents' claims. The Kanawha Circuit Court awarded the Respondents a windfall of six million dollars (\$6,000,000) for coverage pursuant to the 2010 Policy that UHP did not intend to purchase and WVMIC did not intend to sell. For reasons set forth in the arguments section of this brief, the Kanawha Circuit Court erred in finding UHP had coverage for the Respondents' claims and further erred in awarding them judgment in the amount of six million dollars (\$6,000,000).

SUMMARY OF ARGUMENT

The Kanawha Circuit Court committed several errors in granting the Respondents' Motion for Summary Judgment and awarding a windfall of six million dollars (\$6,000,000.00). The policies at issue arose from a lengthy transaction history between UHP and WVMIC, which encompasses a multi-year relationship where UHP made frequent changes to the nature and type of coverage that WVMIC issued to UHP and its employees. The Respondents, by and through a settlement agreement, released UHP and Dr. Mitchell Nutt, from any further liability and agreed to be bound by a judicial determination of the nature and extent of the coverage UHP had for claims of vicarious liability arising from Dr. Nutt's alleged negligence in the care and treatment of the Respondents. Because the Respondents are arguing that UHP possesses coverage for their claims, they step in the shoes of UHP as its assignee and are bound by the equities between UHP and WVMIC. As an assignee, they are prohibited from arguing for a rigid interpretation of the subject policies devoid of the transaction history and the indisputable intention of the parties. Nonetheless, the Kanawha Circuit Court failed to find that the Respondents were assignees of the subject policies.

Despite the Respondents' position as an assignee of the policies issued to UHP, the Kanawha Circuit Court not only determined that there was coverage for the Respondents' claims, but erroneously determined there was six million dollars

(\$6,000,000.00) in coverage under the 2010 Policy when the face of the instrument clearly indicates that there was only three million dollars (\$3,000,000.00) in aggregate limits of insurance. In doing so, the Kanawha Circuit Court erroneously determined that the 2006 and 2007 Policies supplied aggregate limits of insurance under the 2010 Policy. By doing so, the Kanawha Circuit Court converted two expired claims-made policies to occurrence policies, which is clearly in contravention to the plain language of the 2010 Policy. Claims-made and occurrence policies are defined by West Virginia statute and case law and the Kanawha Circuit Court's judgment indicates its lack of understanding of the difference of these two types of coverage. The failure of the Kanawha Circuit Court to recognize the type and extent of potential coverage that exist under the 2010 Policy led it to make the erroneous determination that UHP had six million dollars (\$6,000,000.00) in aggregate limits of insurance available to satisfy any potential claims brought during the policy period.

While the Kanawha Circuit Court erred in determining that the 2010 Policy provided six million dollars (\$6,000,000.00) in aggregate limits of insurance to satisfy claims, it further erred in determining that UHP had coverage on separate limits of insurance basis for the Respondents' claims at all. The clear and incontrovertible evidence indicates that UHP intended to purchase and WVMIC intended to issue separate limits of insurance with a retroactive date of January 1, 2008 and shared limits of insurance with a retroactive date of January 1, 2002.

This is supported by communications between UHP and WVMIC as well as applications submitted for coverage when UHP changed its limits of insurance in 2008 from shared to separate. It is further supported by the premium that WVMIC and UHP paid for coverage in 2008, 2009 and 2010 as well as by affidavits of representatives for both UHP and WVMIC. Despite the clear and convincing evidence of the nature and type of coverage intended by UHP and WVMIC, the Kanawha Circuit Court found that UHP had separate limits of insurance with a retroactive date of January 1, 2002, thereby conferring coverage to the Respondents' claims.

As the medical incidents giving rise to the Respondents' claims occurred prior to January 1, 2008, the failure of the Court to find that UHP's limits of insurance for medical incidents that occurred prior to January 1, 2008 were on a shared basis, allowed it to erroneously determine UHP had coverage. The Kanawha Circuit Court was permitted to consider the intent of the parties when it was construing the retroactive date that applies to the Respondents' claims. First, W.Va. Code § 33-6-6 permits the introduction of insurance applications in an action between the insured and insurer. Second, the policies incorporate by reference, the applications that UHP submitted for coverage. While West Virginia Insurance law has not specifically determined the boundaries of what constitutes an insurance application, WVMIC submits that any statements made by the potential insured and/or their authorized agents are part of the application for insurance. Accordingly, by virtue

of W.Va. Code § 33-6-6- and the doctrine of incorporation by reference, the Kanawha Circuit Court was allowed to consider the insurance application and other statements made by UHP for purposes of determining the retroactive date applicable to the 2010 Policy. However, the Court failed to consider such evidence and erroneously determined that there was coverage for the Respondents' claims.

Alternatively, if the Court determines that insurance applications and statements made by UHP for purpose of obtaining insurance coverage were not appropriate for the Court to consider, WVMIC submits that this is a clear case for application of the doctrine of mutual mistake, such that the Kanawha Circuit Court was permitted to equitably reform the 2010 policy to conform to the clear and incontrovertible intent of the parties. Prior case law adopted and cited this Honorable Court has previously held that the doctrine of mutual mistake and reformation are applicable to insurance contracts when the subject insurance agreement does not conform to the intent of the parties. *The Am. Emp. Ins. Co. v. St. Paul Fire & Marine Ins. Co. Ltd.*, 594 F.2d 973 (4th Cir. 1979) case, which is nearly factually identical with regard to the coverage issue, is dispositive on the issue of whether the Kanawha Circuit Court should have applied the doctrine of mutual mistake and reformed the 2010 Policy to conform to the intent of the parties. However, the Court simply ignored this binding precedent and erroneously determined that WVMIC's arguments in favor of finding mutual mistake were

mooted by the Court's determination that there was coverage for the Respondents' claims.

In addition to the clear errors committed by the Kanawha Circuit Court described above, allowing the Court's judgment to stand would lead to unjust enrichment of both UHP and the Respondents. It is an indisputable fact that UHP did not pay the appropriate premium to receive coverage with a retroactive date of January 1, 2002 and only paid a premium that would support separate limits of insurance with a retroactive date of January 1, 2008. Because the UHP never paid the appropriate premium to receive the coverage determined by the Court, the Court's Order unjustly enriches UHP by providing them with coverage that is unsupported by an underlying premium payment. The Court's order further unjustly enriches the Respondents at WVMIC's expense by permitting them to receive a windfall of six million dollars (\$6,000,000.00) when UHP never paid the premium to support such coverage.

Finally, the Kanawha Circuit Court erred in determining that the issues raised in WVMIC's response and Cross-Motion for Summary Judgment were rendered moot by the Court's entry of judgment in favor of the Respondents. The Court's order is illogical in light of the fact that WVMIC raised the issue as to whether there was valid formation of the 2010 Policy by virtue of its claim that the policy was the product of mutual mistake. The Court could simply not hold that there was coverage until it made a determination that it was not the product of

mutual mistake, i.e. there was valid formation of a contract of insurance. The Court was obligated under Rule 52 and 54 of the West Virginia Rules of Civil Procedure to make findings of fact and conclusions of law on all claims and defense of the parties. The Court's order, on its face, does not resolve the issues raised by WVMIC but instead sidesteps them completely. This Honorable Court, at a minimum, should remand this case back to the Kanawha Circuit Court so that findings of fact and conclusions of law can be entered on the claims and defense raised by WVMIC in its response and cross-motion for summary judgment.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

Oral argument is necessary under Rule 18(a) of the West Virginia Rules of Appellate Procedure. This case is appropriate for a Rule 20 argument because it involves issues of issues of fundamental public importance.

ARGUMENT

1. **The Kanawha Circuit Court Erred in Failing to Find That the Respondents Stood in the Shoes of United Health Professionals as an Assignee.**

In *Smith v. Buege*, 182 W. Va. 204, 387 S.E.2d 109 (1989), the West Virginia Supreme Court of Appeals set forth the requirements for finding a valid assignment:

An “assignment” of a right is a manifestation of the assignor's intention to transfer such right, by virtue of which transfer the assignor's right to performance by the obligor is extinguished in whole or in part and the assignee acquires a right to such performance. Restatement (Second) of Contracts § 317(1) (1979). Unless required by statute or by contract, the assignor of a right may make an assignment by manifestation of intention to transfer, without any particular formality. Restatement (Second) of Contracts § 324 comment a (1979). This Court has recognized these concepts: “No formal words are necessary to make an assignment of a chose in action. Anything showing an intent to assign on the one side, and an intent to receive on the other, will operate as an assignment.

Smith v. Buege, 182 W. Va. 204, 210-11, 387 S.E.2d 109, 115-16 (1989). UHP clearly intended to assign its right to seek a determination as to whether it possessed insurance coverage for the Respondents’ claims and the Respondents clearly intended to receive UHP’s right to seek such a determination. In fact, UHP and the Respondents agreed to such in consideration for the Respondents’ full release of their claims against UHP. See Appendix pgs. 173-220, Release and Settlement Agreement.

By virtue of acquiring UHP’s rights in the subject policies for purposes of seeking a determination of coverage, the Respondents stepped into UHP’s shoes for

purposes of seeking a coverage determination. As an assignee, the Respondents did not acquire any greater rights than those which UHP possessed at the time it assigned its rights to the Respondents.¹⁴ “The assignee steps into the shoes of the assignor and takes the assignment subject to all prior equities between previous parties. His situation is no better than that of the assignor.” *Cook v. E. Gas & Fuel Associates*, 129 W. Va. 146, 155, 39 S.E.2d 321, 326 (1946). This is a long-standing principle of American contract law. *See Stockton v. Cook*, 17 Va. 68 (1812) (cited by *Thomas v. Linn*, 40 W. Va. 122, 20 S.E. 878, 880 (1894)). The Respondents, as assignees of UHP, are bound by the transaction history between UHP and WVMIC. Accordingly, any argument posited by the Respondents for purposes of establishing coverage should be viewed through the prism of UHP’s legal perspective and any arguments that UHP would be precluded from making, had they brought this action in their own name, be refracted from the Court’s consideration. The failure of Kanawha Circuit Court to find that the Respondents were assignees of UHP for

¹⁴ The Respondents filed an original action against WVMIC pursuant to W. Va. Code § 55-13-1 *et seq.*, Uniform Declaratory Judgment Act, also naming UHP and Dr. Nutt. Procedurally, the Respondents claims were rendered moot by their settlement and dismissal of UHP and Dr. Nutt *See Dismissal Order*, Appendix pg. 423-424, as they can no longer assert claims against UHP or Dr. Nutt. The Respondents’ sole standing to contest the prior coverage determination of WVMIC is now premised on the assignment from UHP to the Respondents pursuant to the settlement agreement, as they were neither parties to the subject policies nor intended third party beneficiaries. The Respondents must admit as much, otherwise this Honorable Court, along with the Kanawha Circuit Court, were deprived of subject matter jurisdiction when UHP and Dr. Nutt were dismissed as the Respondents lose standing to maintain this action. Irrespective of the how this case has progressed procedurally, it is axiomatic that the Respondents are limited to those arguments that UHP could make and should be deemed to be bound by the same equities that bind UHP and WVMIC, including the issue as to whether there was valid formation.

purposes of determining whether UHP had coverage for the Respondents' claims was an error.

2. The Kanawha Circuit Court Erred in Finding That Coverage Existed for Multiple Policy Periods.

The Kanawha Circuit Court correctly found that the Respondents made all of their claims under the 2010 Policy. See Order Paragraph 28, Appendix pg. 442. However, the Court clearly erred in finding that the aggregate limit of insurance is calculated by the year in which the medical incident occurred. The Kanawha Circuit Court demonstrated a clear lack of knowledge concerning the differences between “claims-made policies” and “occurrence policies” both of which are specifically defined under West Virginia law.

“An ‘occurrence’ policy protects a policyholder from liability for any act done while the policy is in effect, whereas a ‘claims-made’ policy protects the holder only against claims made during the life of the policy.” 7A J. Appleman, *Insurance Law and Practice* § 4503 at 90 (Berdal ed. 1979; Supp.1995). “Thus, an occurrence policy would cover a claim where the alleged malpractice occurred during the term of the policy even if the claim is not made or the malpractice not discovered until after the policy has lapsed...” *PA. Osteopathic Medical Ass’n. v. Foster*, 134 Pa.Cmwlt. 368, 372-373, 579 A.2d 989, 991 (1990).

Auber v. Jellen, 196 W. Va. 168, 174, 469 S.E.2d 104, 110 (1996). This Honorable Court has explained further:

Under a claims-made insurance policy, “coverage is provided based on when a claim is made as opposed to when the circumstances giving rise to the claim came into existence.” 1 Allan D. Windt, *Insurance Claims & Disputes: Representation of Insurance Companies & Insureds* § 1:7, at 1-55 (5th ed.2007) (footnote omitted). ... A claims-made-and-reported policy, such as the policies at issue in the instant case, includes the additional requirement that the insurer be notified of the

claim within the policy period. It has been explained that under a claims-made-and-reported policy, “a claim is not made until notice of the claim is given to the insurance company.” 1 Allan D. Windt, *Insurance Claims & Disputes: Representation of Insurance Companies & Insureds* § 1:7, 1–56. In other words, “ ‘in a claims-made-and-reported policy, notice is the event that actually triggers coverage.’ ” *Id.* at 1–58 n. 4 (quoting *Pension Trust Fund for Operating Engineers v. Federal Ins. Co.*, 307 F.3d 944, 956–57 (9th Cir.2002)).

Lindsay v. Attorneys Liab. Prot. Soc., Inc., 11-1651, 2013 WL 1776465 (W. Va. Apr. 25, 2013) (FN 2). The 2010 Policy is a “claims-made-and-reported policy” pursuant to the plain language of the instrument. Section “I. General Conditions” states as follows:

A. This is a claims-made and reported **policy**. This **policy** applies only to **claim(s)** that arise out of a **medical incident** which occurs on or after the **retroactive date** stated in the **policy declarations** and **schedule of insureds** that are first made against an **insured** and reported to **the Company** by the **insured** during the **policy period**.

See Appendix pg. 314, 2010 Policy (emphasis in the original) The distinguishing feature between a claims-made policies (including “claims-made and reported policies”) and occurrence policies is that under a claims made policy once coverage lapses or expires, the insured no longer has coverage for any claims that arose from events that occurred during the policy period. Conversely, occurrence policies do not lapse or expire; instead, occurrence policies fix coverage, indefinitely, for covered events that occurred during a defined period of time.

The type of coverage an insurance policy confers is significant for determining the limits of insurance available to satisfy a covered claim. Because the triggering event under a claims-made policy, is a claim, a claimant is bound by

the insured's applicable policy limits in the year that they make their claim. Whereas, the triggering event in an occurrence policy, is the occurrence of a covered event and the claimant can look to the policy that provided coverage to the insured on the date of the occurrence for purposes of satisfying their claim. Because the 2010 Policy is clearly a claims-made and reported policy, the Respondents must satisfy their claims exclusively from the 2010 limits of insurance.

The applicable limit of insurance for the 2010 policy is defined under Section "IV. Limit of Insurance" in the "Professional Liability Insurance Coverage Form" and states:

A. The limit of insurance specified in the **policy declarations** and **schedule of insureds** for each **insured** for "each **medical incident**" is the total of **the Company's** liability for **damages** for that **insured** resulting from any one **medical incident** during the **policy period**. The limit of insurance specified in the **policy declarations** for each **insured** as the "annual aggregate" is the total limit of **the Company's** liability for **damages** for that **insured** resulting from all covered **medical** incident(s) during the **policy period**. ...

See Appendix pg. 319, 2010 Policy (emphasis in the original). The Kanawha Circuit Court found that the limits of insurance were dictated by the year in which the medical incidents occurred. This is a clear error on the part of the Court and is unsupported by the plain language of the policy. UHP's limit of insurance is expressly limited to "damages for that insured resulting from all covered medical incidents during the policy period." The key phrase in this provision is "covered medical incident(s)." In order to determine whether a medical incident is a "covered

medical incident,” we must look at the insuring agreement, which states in pertinent part:

The company will pay those sums that the insured becomes legally obligated to pay as damages because of a claim that is a result of a medical incident which occurs on or after the retroactive date applicable to such insured and which is first reported by the insured during the policy period....

See Appendix pg. 217, 2010 Policy (emphasis in the original). Based upon this language, a medical incident must meet to two separate conditions before it is a “covered medical incident” within the meaning of the 2010 Policy. First, the medical incident must occur on or after the retroactive date. Second, the medical incident must be presented, as a claim for damages must by the insured during the policy period. Notwithstanding the fact that the medical incidents giving rise to the Respondents’ claims occurred before the applicable retroactive date for UHP’s separate limits of insurance, all of the medical incidents giving rise to the Respondents’ claims for coverage were presented in/under the 2010 Policy. Thus, for purposes of determining the applicable limits of insurance and ignoring the first condition discussed above, all of the damages incurred by UHP for “covered medical incidents” were incurred during the 2010 Policy by virtue of the Respondents’ claims being presented during the 2010 policy period. Section IV, Limit of Insurance, plainly states: “The limit of insurance specified in the policy declarations for each insured as the “annual aggregate” is the total limit of the Company's liability for damages for that insured resulting from all covered medical

incident(s) during the policy period.” See Appendix pg. 319. The 2010 Policy period began January 1, 2010 and expired January 1, 2011. The Respondents all made claims during this policy period. Thus, any coverage that may be available to the Plaintiff is limited to the policy declarations of the 2010 Policy for UHP. The 2010 Policy declarations clearly limit UHP’s “annual aggregate” to \$3 Million Dollars. See Appendix pg. 211, 2010 Policy. For the Kanawha Circuit Court to find that the Plaintiff is entitled to the aggregate limits that existed for the 2006 and 2007 Policies, is irrational and contradicts the plain language of the policy. The 2006 and 2007 Policies have expired and the Respondents did not present claims in 2006 or 2007 to trigger coverage. Accordingly, any coverage for the Respondents’ claims must be necessarily limited to the one million/three millions dollars limits listed in the 2010 Policy declarations. However, for reasons argued herein, there is no coverage at all and this Court should reverse the determination of the Kanawha Circuit Court.

3. The Kanawha Circuit Court Erred in Finding That Separate Coverage Existed For The Respondents’ Claims Against United Health Professionals.

As discussed in Argument 1, the Kanawha Circuit Court clearly erred by failing to make factual findings and legal conclusions that the Respondents were assignees of UHP under the 2010 Policy. The Court’s failure to find that the Respondents were assignees led it down the erroneous path towards reviewing the subject policies in a vacuum and allowing the Respondents to circumvent issues

regarding whether there was proper formation of the insurance contracts. Furthermore, the Court failed to make findings of fact or conclusions of law with regard to the WVMIC's legal argument that West Virginia insurance law does not bar consideration of parol evidence when interpreting an insurance contract. Instead, the Kanawha Circuit sidestepped the WVMIC's valid legal and equitable arguments and erroneously determined that there was coverage for the Respondents claims by finding that UHP had separate limits of insurance with a retroactive date of January 1, 2002.

The uncontradicted evidence clearly demonstrates: 1) UHP did not intend to purchase separate limits of insurance with a retroactive date of January 1, 2002 but instead intended to purchase separate limits of insurance with a retroactive date of January 1, 2008; 2) WVMIC did not intend to issue separate limits of insurance coverage with a retroactive date of January 1, 2002, but instead intended to issue separate limits of insurance coverage with a retroactive date of January 1, 2008; 3) UHP did not pay the appropriate premium to receive separate limits of insurance with a retroactive date of January 1, 2002, but instead paid the appropriate premium to receive separate limits of insurance with a retroactive date of January 1, 2008. The Kanawha Circuit Court, based on the clear and incontrovertible evidence presented in this case, should have found that UHP did not have separate limits of insurance prior to January 1, 2008, as it was the clear intent of the parties not to purchase and not to issue the coverage that the Respondents' contend exists.

This intent was manifested in UHP's applications and other correspondence regarding converting coverage from shared limits of insurance to separate limits of insurance. It was entirely appropriate for the Kanawha Court to consider this evidence and had the Court done so, it would have determined that UHP did not have coverage for the Respondents' claims.

A. The Kanawha Circuit Court Failed to Find That Statements Made By United Health Professionals For Purposes of Obtaining Insurance Coverage Were Part of The Subject Insurance Policies For Purposes of Determining The Ordinary Meaning of The Subject Policies.

“A valid written instrument which expresses the intent of the parties in plain and unambiguous language is not subject to judicial construction or interpretation but will be applied and enforced according to such intent.” *Davis v. Hardman*, 148 W. Va. 82, 89, 133 S.E.2d 77, 81 (1963) (internal citations omitted). “The rule of interpretation of insurance contracts, and the first object of construction, is to ascertain the intention or meaning of the parties, and the duty of the courts is to construe the contract accordingly.” *Castellina v. Vaughan*, 122 W. Va. 600, 11 S.E.2d 536, 538 (1940) (citing Couch, Cyc. of Ins. Law, § 173). As such, these policies must be applied and enforced in accordance with the intent of the parties. In this case, it was the clear and unambiguous intent of the parties to the insurance policies in question to provide and receive separate limits of insurance for UHP with a retroactive date of January 1, 2008. The evidence in support of this notion could not be stronger. In the process of obtaining coverage, Dr. Chamberlain wrote a

letter to WVMIC, on January 25, 2008, requesting the policy limits of UHP to be changed from shared to separate with an effective date of January 1, 2008. *See* Appendix pg. 261. Dr. Chamberlain's letter affirmatively states that he has no knowledge of any claims on or after January 1, 2008. In order to receive a separate limit of insurance for UHP with a retroactive date of January 1, 2002, Dr. Chamberlain would have been required to affirmatively state that he has no knowledge of any claims on or after January 1, 2002. As is evidenced by Dr. Chamberlain's affidavit, he affirmatively states that he intended to purchase separate limits of insurance on behalf of UHP with a retroactive date of January 1, 2008. Additionally, correspondence between Terry Slusher and WVMIC provides additional evidence that it was the intent of the parties for UHP to purchase a separate limit of insurance with a retroactive date of January 1, 2008. *See* Appendix pgs. 258-259.

Based upon representations made by Dr. Chamberlain and his insurance agent, Terry Slusher, as well as the claims history for UHP and its employees, WVMIC underwrote a separate limits of insurance for UHP with a retroactive date of January 1, 2008 and calculated a premium to reflect the additional risk assumed by the change in coverage. *See* Appendix pgs. 222-224, Affidavit of Tamara Lively-Huffman. WVMIC charged and UHP paid the premium for separate insurance limits beginning on January 1, 2008 and with a retroactive date on the same date. As is evidenced by Tamara Lively-Huffman's, Executive Vice-President and Chief

Operating Officer of WVMIC, affidavit, if UHP desired to purchase separate limits with a retroactive date of January 1, 2002 (the date Respondents claim is the retroactive date for all Subject Policies) in January of 2008 the additional premium charged to UHP would have been \$209,793 instead of the \$42,847 it was charged. Thereafter, UHP renewed its 2008 Policy for the 2009 and 2010 policy periods, charging premiums in accordance with a retroactive date of January 1, 2008. Importantly and in consideration of statements made by Alan Chamberlain, M.D., as well as his insurance agent/agents, WVMIC did not engage in any experience rating with regard to UHP's separate limits in its underwriting process for the 2009 and 2010 policy years to account for claims that could arise because of vicarious liability for the acts or omissions of Dr. Nutt. Both UHP and WVMIC understood that any claim against UHP arising from procedures performed by Dr. Nutt would have been performed prior to January 1, 2008 were not subject to coverage.¹⁵ Based upon the forgoing, it is clear that it was both WVMIC's and UHP's intent to issue and purchase separate limits of insurance for UHP with a retroactive date of

¹⁵ The intent of the parties is further reflected in the rate that WVMIC charged UHP in 2008 for changing its limit of insurance from shared to separate. WVMIC could not legally charge UHP \$42,847 for separate limits of insurance with a retroactive date of January 1, 2002, as it would not comport with the rates prospectively approved by the West Virginia Insurance Commissioner. See W.Va Code § 33-20-4. WVMIC could only charge \$209,793 for separate limits of insurance with a retroactive date of January 1, 2002 to comport with West Virginia Insurance law. Accordingly, the intent of the parties is further manifested by the fact that WVMIC only charged and UHP only paid the premium appropriate for separate limits of insurance with a retroactive date of January 1, 2008. To find that UHP's coverage extends to January 1, 2002 on a separate limit of liability basis would necessarily place WVMIC in violation of W. Va. Code § 33-20-4 (k).

January 1, 2008, and, in essence, exclude separate corporate coverage for the Nutt cases.

i. The Parol Evidence Rule Does Not Bar This Court's Consideration of Pre-Contractual Statements Made by the Parties to the Insurance Policies

“The parol evidence rule, whether regarded as a rule of evidence or as a rule of substantive law, inhibits the introduction of parol evidence to contradict, add to, alter, enlarge, or explain the expressed intention of the parties to a written agreement which is free from ambiguity, or to vary its legal effect.” *Shaffer v. Calvert Fire Ins. Co.*, 135 W. Va. 153, 158, 62 S.E.2d 699, 702 (1950). This widely recognized and long standing principle of common law has been recognized to apply to a variety of contracts, including insurance policies. *Spencer v. Travelers Ins. Co.*, 148 W. Va. 111, 133 S.E.2d 735 (1963). The parol evidence rule does not serve as a bar to this Court considering pre-contractual statements made by the parties for two reasons. First, W.Va. Code §33-6-6, explicitly provides that insurance applications are admissible evidence in an action between the insured and the insurer arising out of the policy so applied. Second, the 2010 Policy explicitly incorporates by reference the UHP’s application(s) for insurance. *See Appendix pg. 268.*

West Virginia Code §33-6-6 states:

(a) No application for the issuance of any life or accident and sickness insurance policy or contract shall be admissible in evidence in any action relative to such policy or contract, unless a true copy of the application was attached to or otherwise made a part of the policy

when issued. This subsection shall not apply to industrial life insurance policies. ...

(c) As to kinds of insurance other than life and accident and sickness insurance, no application for insurance signed by or on behalf of the insured shall be admissible in evidence in any action between the insured and the insurer arising out of the policy so applied for, if the insurer has failed, at expiration of thirty days after receipt by the insurer of written demand therefor by or on behalf of the insured, to furnish to the insured a copy of such application reproduced by any legible means.

While §33-6-6(a) bars introduction of evidence in any action relative to such policy in the context of **life or accident and sickness** insurance when the application is not attached or otherwise made a part of the policy when issued, the Subject Policies are clearly not life or accident and sickness policies and thus do not fall within the purview of this section of the statute. Thus, §33-6-6(c) is applicable to the Subject Policy, which expressly permits the introduction of the application as evidence “in any action between the insured and the insurer arising out of the policy so applied for...” Although §33-6-6(c) is drafted in a manner to bar the introduction of the application as evidence when the insurer fails to provide the insured a legible copy of its application within thirty days of making a written demand, by negative implication the statute expressly provides for its introduction if such a written demand is neither made or the insurer satisfies the demand. *Napier v. Bd. of Educ. of County of Mingo*, 214 W. Va. 548, 553, 591 S.E.2d 106, 111 (2003) (“...although a statute's language may be plain, there may arise circumstances in which we must nevertheless take notice of the logical inferences that may be gleaned from the statutory language at issue...”). The parol evidence rule is a rule rooted in West

Virginia common law. The West Virginia Legislature is entitled to and intended to abrogate the parol evidence rule in the context of applications for insurance subject to the exceptions of W. Va. Code §33-6-6. *Dairyland Ins. Co. v. Conley*, 218 W. Va. 252, 624 S.E.2d 599 (2005). It is within the province of the legislature to enact statutes which abrogate the common law. Const. Art. 8, §21 (1974); W. Va. Code §2-1-1. Because the exception to admissibility contained in W. Va. Code §33-6-6(c) does not apply, the applications were admissible evidence for the Kanawha Circuit Court to consider for purposes of determining the applicable retroactive date for separate limits of insurance for UHP under the Subject Policies.

In addition to being admissible in the instant action by virtue of W. Va. Code §33-6-6(c), the language of the insurance policy incorporates by reference the statements made in UHP's insurance applications giving rise to the Subject Policies. The word "policy" is defined by the 2010 Policy to mean "the policy declarations, the forms listed thereon, and any endorsements issued from time to time." See Appendix pg. 276, 2010 Policy. The policy declarations for the 2010 Policy includes WVMIC-CovForm 01/08, WVMIC's Professional Liability Insurance Coverage Form. See Appendix, pg. 268. WVMIC-CovForm 01/08 contains an introductory provision that states:

IN CONSIDERATION OF THE PREMIUM PAID, and in reliance on the statements made in the application, and subject to all of the terms, agreements, definitions, exclusions, conditions, declarations, certificates and endorsements of this **policy**, the West Virginia Mutual Insurance Company (hereinafter, "**the Company**") agrees with the insured as follows: ...

(emphasis in the original). The phrase, “in reliance on the statements made in the application” clearly manifests WVMIC’s intent to incorporate by reference the applications that gave rise the policies. Nothing in West Virginia statutes or case law precludes incorporation of prior contract provisions by reference to an earlier contract. *Art’s Flower Shop, Inc. v. Chesapeake & Potomac Tel. Co. of W. Virginia, Inc.*, 186 W. Va. 613, 616, 413 S.E.2d 670, 673 (1991). While West Virginia law regarding incorporation by reference has not addressed this particular circumstance, in other instances the West Virginia courts have liberally construed documents to be incorporated by reference into other legally active documents. For example, in the context of a civil complaint, courts have held that any mention of a document not made an exhibit to the complaint is incorporated by reference. *Forshey v. Jackson*, 222 W. Va. 743, 748, 671 S.E.2d 748, 753 (2008). “The complaint is deemed to include any written instrument attached to it as an exhibit or any statements or documents incorporated in it by reference. Even where a document is not incorporated by reference, the court may nevertheless consider it where the complaint relies heavily upon its terms and effect, which renders the document integral to the complaint.” (citing *Chambers v. Time Warner, Inc.*, 282 F.3d 147, 152–53 (2d Cir.2002)). Additionally, in the context of a testamentary instrument:

[i]f a will, executed and witnessed as required by statute, incorporates in itself by reference any document or paper not so executed and witnessed, whether the paper referred to be in the form of a will or

codicil, or of a deed or indenture, or of a mere list or memorandum, the paper so referred to, if it was in existence at the time of the execution of the will, and is identified by clear and satisfactory proof as the paper referred to therein, takes effect as part of the will, and should be admitted to probate as such.

Wible v. Ashcraft, 116 W. Va. 54, 178 S.E. 516, 517 (1935) (citing *Newton v. Seaman's Friend Society*, 130 Mass. 91, 39 Am. Rep. 433). Because documents may be incorporated by reference into a contract and because West Virginia law liberally construes documents to be incorporated by reference when they are mentioned in a legally active document, UHP's applications for insurance should have been deemed incorporated by reference into the Subject Policies and were proper for consideration by the Kanawha Circuit Court.

An unresolved question left by W. Va. Code §33-6-6 is what constitutes an insurance application. The term "insurance application" has not been specifically defined by the West Virginia Legislature or case law. WVMIC submits that regardless of form, an insurance application encompasses any representation made to an insurance company for the purposes of obtaining insurance coverage, irrespective of whether the representation is made by the insured or their agent. This definition is supported by W. Va. Code §33-6-7, a statute that addresses whether representations made by an insured in their application can be construed as a warranty. §33-6-7 states in pertinent part, "[a]ll statements and descriptions in any application for an insurance policy or in negotiations therefor, by or in behalf of the insured, shall be deemed to be representations and not warranties." W. Va.

Code §33-6-7. Based on the foregoing analysis, UHP's representations for the purpose of obtaining coverage, through either Dr. Chamberlain or its insurance agent, Terry Slusher, were part of UHP's application for insurance. While the applications involved in the issuance of the Subject Policies involve applications for modification of an existing policy (2008 Policy) and applications for renewal policies (2009 Policy and 2010 Policy), they were nonetheless proper for the Kanawha Circuit Court's consideration in interpreting the Subject Policies with respect to determining whether UHP has separate limits of insurance for claims made under the 2010 Policy and it was an error for it to not consider this evidence for determining the applicable retroactive date of UHP's separate limits of insurance.¹⁶

ii. UHP's Applications Reveal Only One Plausible Interpretation of the Subject Policies Intended By the Parties

Without the constraints of the parol evidence rule, the Kanawha Circuit Court was permitted to determine the applicable retroactive date under the 2010 Policy in light of the facts and circumstances leading to its issuance. This includes clear and unambiguous evidence that UHP desired and WVMIC intended to issue a

¹⁶ It is admitted that the UHP's application for insurance in 2010 explicitly request separate limits of insurance with a retroactive date of January 1, 2002. See Appendix pgs. 402-405, UHP's 2010 Renewal Application. This statement in the application was an error on the part of UHP's insurance agent employed through the West Virginia Medical Insurance Agency as the parties intended at all times to have separate limits of insurance with a retroactive date of January 1, 2008. See Appendix pgs. 167-169, 222-224 and 407-408, Affidavits of Alan Chamberlain, M.D., Tamara Lively-Huffman, and Steve Brown of West Virginia Medical Insurance Agency, respectively. This is also supported by the fact that UHP was charged a premium for the 2010 Policy year only and not the additional \$166,946.00 necessary to for a separate limits of insurance for UHP with a retroactive date of January 1, 2002.

separate limit of insurance policy during the policy periods of 2008, 2009, 2010 with a retroactive date of January 1, 2008.

While the aforementioned schedules of insureds do create a modicum of uncertainty as to the parameters of coverage for UHP when viewed in isolation, they do represent the correct nature of the UHP's benefits when analyzed without knowledge of the facts and circumstances leading to their issuance. It is readily acknowledged that UHP has a retroactive date of January 1, 2002 with regards to shared limits of insurance. Thus, to the extent that schedule of insureds refers to a retroactive date of January 1, 2002, it is correct to the extent that it refers to a shared limits of insurance. Furthermore, the schedule of insureds is also correct to the extent that it reflects that UHP has separate limits of insurance with a retroactive date from January 1, 2008 extending to the present. Thus any claim for a medical incident that happened on or after January 1, 2008 would be subject to UHP's separate limits of insurance. Whereas claims for medical incidents that happened prior to January 1, 2008 would be subject to UHP's shared limits of insurance. Accordingly, WVMIC's suggested interpretation of the policy with regards to the extent and nature of UHP's coverage is correct, when viewed in context of the transaction history of the parties as well as circumstances leading to the change from shared limit to separate limit. This is the only plausible interpretation that reflects the clear and unambiguous intent of the parties.

B. The Kanawha Circuit Court Erred in Failing to Apply The Doctrine of Mutual Mistake to Equitably Reform The Policies Issued by West Virginia Mutual Insurance Company to United Health Professionals to Conform To The Intent Of The Parties.

If this Court is unwilling to find that West Virginia law permits the admission of insurance applications as evidence for purposes of determining the meaning of specific terms in a policy, then in the alternative, there is ample evidence to find that the subject policies were the product of mutual mistake and are subject to reformation.

“An insurance policy is subject to reformation in equity precisely as any other written instrument. ... And the grounds for, and the limitations which govern, the reformation of an insurance policy are exactly the same as for the reformation of any other instrument, such as accident, fraud or mutual mistake.” *Poindexter v. Equitable Life Assur. Soc. of U.S.*, 127 W. Va. 671, 676, 34 S.E.2d 340, 343 (1945) (internal citations omitted). *Ohio Farmers Ins. Co. v. Video Bank, Inc.*, 200 W. Va. 39, 43, 488 S.E.2d 39, 43 (1997) (“[A]n insurance policy is subject to reformation just as is any other contract”) (cited by *W. Virginia Mut. Ins. Co. v. Vargas*, 1:11-CV-32, 2013 WL 1164338 (N.D.W. Va. Mar. 20, 2013)). In *American Employers Insurance Company v. St. Paul Fire & Marine Insurance Company Limited*, 594 F.2d 973 (4th Cir. 1979), a federal case growing out of an accident which occurred in West Virginia and subsequently cited and adopted by the West Virginia Supreme Court in *Ohio Farmers Ins. Co. v. Video Bank, Inc.*, 200 W. Va. 39, 488 S.E.2d 39 (1997)

discusses in detail the circumstances in which reformation of an insurance contract is appropriate.

A leading commentary, 13A Appleman, Insurance Law and Practice § 7607 (1976), explains the law as follows:

The general rules applying to the reformation of other written contracts apply to contracts of insurance, the courts will reform an insurance policy, like any other instrument, to effectuate the intention of the parties, and make it set forth correctly the contract upon which the minds of the parties met, and equity jurisdiction applies to insurance policies as well as to other agreements. And, like other contracts, fraud, mutual mistake, or accident may give good ground for reformation.

For reformation to be allowed on the basis of mutual mistake, the same commentary goes on to say, § 7608 at 309:

[T]he law requires that the alleged mistake must have occurred through the reduction of the understanding and agreed intent of the parties to writing, so that the written instrument does not represent the real agreement.

The Restatement of Contracts, § 504 (1932), sets forth the critical test of “identical intention”:

(w)here both parties have an identical intention as to the terms to be embodied in a proposed written . . . contract . . . and a writing executed by them is materially at variance with that intention, either party can get a decree that the writing shall be reformed so that it shall express the intention of the parties, if innocent third persons will not be unfairly affected thereby.

There are thus three basic prerequisites for reformation of an insurance policy on the ground of mutual mistake: a bargain between the parties; a written instrument supposedly containing the terms of that bargain; and a material variance between the mutual intention of the parties and the written instrument. See Covington, Reformation of Contracts of Personal Insurance, 1964 Ill.L.F. 543, 549. These elements must be proved by “very strong, clear and convincing

evidence.” *State Farm Mutual Automobile Ins. Co. v. Hanson*, 7 Ill.App.3d 678, 288 N.E.2d 523, 526 (4th Dist. 1972).

Am. Emp. Ins. Co. v. St. Paul Fire & Marine Ins. Co. Ltd., 594 F.2d 973, 977 (4th Cir. 1979) (cited by *Ohio Farmers Ins. Co. v. Video Bank, Inc.*, 200 W. Va. 39, 488 S.E.2d 39 (1997)). The three basic prerequisites for reformation are clearly satisfied in this case by clear and convincing evidence. First, it is indisputable that there was a bargain between the parties with regard to providing UHP with a separate limit of insurance and it was the clear and unambiguous intent of the parties for such a policy to have a retroactive date of January 1, 2008, with UHP coverage prior to January 1, 2008 being on a shared limit of insurance basis. Second, the Subject Policies contain the terms of the bargain.¹⁷ Third, clearly there is a material variation between mutual intentions of the parties and the written instrument to the extent the Subject Policies reflect that UHP as having separate limits of insurance with a retroactive date prior to January 1, 2008, coverage UHP did not intend to purchase and coverage that WVMIC did not intend to provide. Furthermore, at the time that UHP’s separate limit of insurance coverage was bound and issued, the Respondents could not have relied on any representation in the Subject Policies, as they were not a party to those agreements.

The *American Employers* case is factually similar to the case at bar. In that case, an action was instituted on the basis of a dispute between two marine

¹⁷ WVMIC is required by West Virginia statute to include certain information in its insurance policy. See W.Va. Code §33-6-11.

insurers, American Employers Insurance Company and St. Paul Fire and Marine Insurance Company Limited. Giving rise to that action was an explosion of two petroleum barges under tow by a towboat while passing under a railroad bridge in 1972. Both boats and the barge were owned by the MelJoy Transportation Company. The explosion killed two crewmen and damaged the bridge and other property. MelJoy was found liable and its insurance carriers settled the damages claims for more than \$3,000,000. Prior to the accident, in 1971, MelJoy sought to obtain insurance that would indemnify it up to \$10,000,000 for damage caused by its vessels. Through an insurance agent, MelJoy obtained umbrella coverage of \$10,000,000. American Employers Insurance Company wrote the first \$5,000,000 of the umbrella coverage, which required underlying coverage (or self-insurance) of \$654,400 per occurrence. While MelJoy had primary insurance in the amount of \$100,000 through a different carrier, it left a gap that could lead to exposure of up to \$554,400. In order to fill the gap, MelJoy requested an excess coverage policy from St. Paul. After payment of a premium of \$2,400 St. Paul issued the excess coverage policy. While the policy MelJoy requested was a per occurrence policy, St. Paul's policy provided per vessel coverage. Much like the case at bar, the mistake occurred on the "Schedule of Underlying Insurances," which when read out of context and devoid of the intent of the parties indicated MelJoy had \$1,563,200. *Id.*

During the course of litigation in District Court between American Employers and St. Paul, one of St. Paul's defenses was that its written policy did not accurately

reflect its agreement with MelJoy and it sought reformation of the policy. St. Paul was able to prove at the time MelJoy purchased the policy, each party to the contract understood that the insurance would be on a per occurrence basis and not on per vessel basis. In other words, MelJoy and St. Paul each intended to bind per occurrence coverage. Much like evidence offered in this case by way of affidavit, a MelJoy representative testified that he intended only to fill the gap between the primary and umbrella coverage with a maximum exposure of \$554,400 and considered the premium charged to be reasonable. Similarly, a St. Paul representative testified his company wrote excess insurance only on a per occurrence basis for the type of risk involved, unless the insured specifically requested per vessel coverage.

American Empire contested St. Paul's defense claiming that there was uncontroverted evidence that neither St. Paul nor MelJoy specifically mentioned to each other in the course of negotiations that the coverage was to be per occurrence, and (2) the industry did not have a custom of writing excess coverage on a per occurrence basis. In reversing the District Court's determination that St. Paul was not entitled to reformation the appellate Court stated:

where, as here, the insured and the insurer both credibly testify that they intended to have insurance providing coverage different from that in the written policy, the court must reform the policy to conform to their mutual intention unless a third party relied to its detriment on the written agreement or the contracting parties acted fraudulently.

Id. at 978. The Court went on to state that the District Court had correctly found that American Enterprise could not have relied on any representation in the policy as it was not a party to the St. Paul policy. Furthermore, the Court noted that it wasn't until after the explosion that American Enterprise learned St. Paul's policy nominally provided coverage totaling far more than the intended \$654,400. St. Paul promptly notified American Enterprise that its actual maximum exposure was \$544,400, and American Enterprise did not act to its detriment in reliance on the St. Paul policy. *Id.* at 978-9.

The facts of the *American Enterprise* case clearly support reformation in this instance, as UHP and WVMIC both agree on the type and nature of insurance coverage they intended, this is simply indisputable. Furthermore, should this Court find that the retroactive date for UHP's separate limits of insurance for the Subject Policies is actually January 1, 2002, such a determination would clearly deviate from the mutual intent of UHP and WVMIC.

The Respondents could not have possibly relied on the Subject Policies at the point in time they were issued. Furthermore, the Respondents did not rely on the Subject Policies at the time they entered into the settlement agreement with Dr. Nutt as the settlement agreement explicitly recognizes the current dispute. See Appendix pgs. 173-220. In addition, the Respondents were put on notice that WVMIC disputed that UHP had separate limitations for liability for the

Respondents' claims prior to entering the settlement agreement. *See* Appendix pgs. 226-256.

In consideration of the uncontroverted facts and the undisputed intent of the parties showing that they intended insurance coverage for UHP with separate limits of insurance with a retroactive date of January 1, 2008 as well as precedent binding, it was an error for the Kanawha Circuit Court not to enter an order reforming the 2010 Policy in accordance with UHP and WVMIC's intent.

4. The Kanawha Circuit Court's Ruling Results in Unjust Enrichment For The Respondents And United Health Professionals.

UHP paid a premium of \$42,847 in year 2008 in order to amend the 2008 Policy for UHP to have shared limits to separate. *See* Appendix pg. 263. This premium was calculated based upon UHP's representations to WVMIC that it desired separate limits for 2008 with a retroactive date of January 1, 2008. Had UHP desired separate limits of insurance with a retroactive date, the appropriate premium would have been \$209,793. *See* Appendix pgs. 222-224, Affidavit of Tamara Lively-Huffman. Furthermore, the premiums charged for the 2009 Policy and 2010 Policy were also calculated based upon UHP's separate limits having a retroactive date of January 1, 2008. *See* Appendix pgs. 222-224. "A person may be unjustly enriched not only where he receives money or property, but also where he otherwise receives a benefit. He receives a benefit where his debt is satisfied or where he is saved expense or loss." *Prudential Ins. Co. of Am. v. Couch*, 180 W. Va. 210, 215, 376 S.E.2d 104, 109 (1988). "...[N]o one shall be allowed to enrich himself

unjustly at the expense of another...” *Clifton Mfg. Co. v. U. S.*, 1935-2 C.B. 321 (4th Cir. 1935) (*citing* Williston on Contracts, § 1582) (emphasis added). If the judgment of the Kanawha Circuit Court is permitted to stand, UHP and the Respondents will be unjustly enriched by receiving benefits under the 2010 Policy that are not supported by the payment of the appropriate premium. Accordingly, this Court should reverse the judgment of the Kanawha Circuit Court to remedy the unjust enrichment of UHP and the windfall of six million dollars (\$6,000,000.00) to the Respondents created by the Kanawha Circuit Court.

5. The Kanawha Circuit Court Erred by Finding That The Issues Raised in West Virginia Mutual Insurance Company Cross-Motion For Summary Judgment Were Not Ripe For Consideration And That Additional Discovery Was Warranted.

The Kanawha Circuit Court erred in finding that the issues raised in WVMIC’s Response in Opposition to the Respondents’ Motion for Summary Judgment and Cross-Motion for Summary Judgment were not ripe for consideration, that it warranted additional discovery and that it was rendered moot by the Court’s grant of summary judgment to the Respondents. *See* Order, Paragraph 9, Appendix pgs. 438-439.

One issue raised in WVMIC’s Response to the Respondents’ Motion for Summary Judgment was the claim that the policies issued to UHP by WVMIC were the product of mutual mistake and that the Court should order reformation, such that the policies would conform to the intent of the parties. Insurance policies are considered contracts under West Virginia law and are subject to West Virginia

Contract law. See *Blake v. State Farm Mut. Auto. Ins. Co.*, 224 W. Va. 317, 322, 685 S.E.2d 895, 900 (2009). “The fundamentals of a legal ‘contract’ are competent parties, legal subject-matter, valuable consideration, and mutual assent. There can be no contract, if there is one of these essential elements upon which the minds of the parties are not in agreement.” Syl. Pt. 5, *Virginian Exp. Coal Co. v. Rowland Land Co.*, 100 W. Va. 559, 131 S.E. 253, 254 (1926).

In the Kanawha Circuit Court, WVMIC challenged whether there was mutual assent to the policies. “A meeting of the minds of the parties is a *sine qua non* of all contracts.” Syl. Pt. 1, *EurEnergy Res. Corp. v. S & A Prop. Research, LLC*, 228 W. Va. 434, 720 S.E.2d 163 (2011). Because mutual mistake goes towards the mutual assent element of contract formation, a mutual mistake prevents enforcement of an agreement altogether. “This principle [mutual mistake] provides that a contract is reformable or voidable if it can be shown that the parties mutually erred about a basic fact that is material to their agreement.” *McGinnis v. Cayton*, 173 W. Va. 102, 105, 312 S.E.2d 765, 769 (1984). Accordingly, the Kanawha Circuit Court, could not render a judgment finding coverage (enforcing the language of the policy), without first making a finding that the policy was valid and enforceable under West Virginia law. WVMIC’s claim that there was a defect in the formation of the policies precludes summary judgment, until the Court determines that there was no mutual mistake and the agreement is not subject to reformation.

The Court's ruling that other issues raised by WVMIC were premature and mooted by the Court's grant of judgment in favor of the Respondents also violates Rule 54 (b) of the West Virginia Rules of Civil Procedure.

(b) Judgment Upon Multiple Claims or Involving Multiple Parties. When more than one claim for relief is presented in an action, whether as a claim, counterclaim, cross-claim, or third-party claim, or when multiple parties are involved, the court may direct the entry of a final judgment as to one or more but fewer than all of the claims or parties only upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment. **In the absence of such determination and direction, any order or other form of decision, however designated, which adjudicates fewer than all the claims or the rights and liabilities of fewer than all the parties shall not terminate the action as to any of the claims or parties, and the order or other form of decision is subject to revision at any time before the entry of judgment adjudicating all the claims and the rights and liabilities of all the parties.**

W. Va. R. Civ. P. 54. (emphasis added). In construing Rule 54(b), this Court has stated:

Where multiple claims are involved, and a court disposes of less than all of them, the absence of the express determination and direction prevents finality as to the adjudication of such claims. *Wilcher v. Riverton Coal Company*, W.Va., 194 S.E.2d 660. In *Wilcher*, the Court stated that it had long adhered to the principle that it will not decide cases piecemeal.

Dixon v. Am. Indus. Leasing Co., 157 W. Va. 735, 747, 205 S.E.2d 4, 11 (1974). By the Court's own admission, it has not disposed of the WVMIC's claims, it merely stated they were not ripe for consideration and warranted additional discovery. See Order, Paragraph 9, Appendix pgs. 438-439. The Court's statement that issues raised by WVMIC are mooted by entry of judgment in favor of the Respondents is

illogical in light of the Court's duty to enter findings of fact and conclusions of law with regard to each claim or defense. The Court's logic is circular and it clearly indicates that it did not give more than passing consideration the issues raised by the WVMIC, as it could not have entered judgment that the policies are enforceable without first determining that there was no mutual mistake. Furthermore, the Court's ruling that additional discovery is warranted, absolutely precludes a grant of summary judgment, as the Court may only grant summary judgment when there are no issues of material fact. Pursuant to the Court's order, the Court clearly believes that there are issues of material fact that remain unresolved.

Rule 52 (a) of the West Virginia Rules of Civil Procedure provides "In all actions tried upon the facts without a jury or with an advisory jury, the court shall find the facts specially and state separately its conclusions of law thereon, and judgment shall be entered pursuant to Rule 58..." W. Va. R. Civ. P. 52. In construing Rule 52 (a), this Court has stated:

... This Rule is mandatory, and it has been held that where the findings of facts and conclusions of law are not separately made by the trial court, the case should be remanded to the trial court for the purpose of complying with that Rule. The purpose of this Rule is to better enable the reviewing court to apply the law to the facts.

Commonwealth Tire Co. v. Tri-State Tire Co., 156 W. Va. 351, 358, 193 S.E.2d 544, 548 (1972). The Kanawha Circuit Court has neither disposed of the claims of WVMIC nor rendered sufficient findings of fact and conclusions of law such that this Court is better enabled to apply the law to the facts.

While the WVMIC believes the Kanawha Circuit Court's Judgment does not comport with the requirements under the West Virginia Rules of Civil Procedure, this Court is reviewing the Kanawha Circuit Court's findings of fact and conclusions of law *de novo*. "A circuit court's entry of a declaratory judgment is reviewed *de novo*." Syl. Pt. 3, *Cox v. Amick*, 195 W. Va. 608, 610, 466 S.E.2d 459, 461 (1995). Accordingly, the WVMIC submits that this Court has ample evidence available for its review to reverse the judgment of the Kanawha Circuit Court and find in its favor.

CONCLUSION

For all of the foregoing reasons, the Petitioner, West Virginia Mutual Insurance Company, Inc., respectfully prays that this Honorable Court reverse the order by the Kanawha Circuit Court granting judgment in favor of the Respondents, based upon the clear errors of law made by the Kanawha Circuit Court that resulted in a windfall judgment of six million dollars (\$6,000,000.00) that the was neither bargained for, nor desired by the parties to the subject insuring agreements. In the alternative, West Virginia Mutual Insurance Company respectfully prays that this Honorable Court remand this case back to the Kanawha Circuit Court with the directive to enter findings of fact and conclusions of law an all arguments put forth in the West Virginia Mutual Insurance Company, Inc.'s Response in Opposition to Plaintiffs' Motion for Summary Judgment and Cross-Motion for Summary Judgment.

RESPECTFULLY SUBMITTED



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West Virginia Mutual Insurance Company

No. 13-0692

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA
At Charleston

WEST VIRGINIA MUTUAL INSURANCE COMPANY,

Petitioner,

v.

BETTY J. ADKINS, RAYETTA D. BAUMGARDNER, DIANA L. BOERKE,
LATHA A. BOLEN, CHARLOTTE L. DEAL, CONSTANCE L. DEVORE,
TERESSA D. HAGER, LORENNA D. HANKINS, TAMMY H. CLARK,
PAMELA K. HATFIELD, MARCIE J. HOLTON, LINDA L. JONES, PATTY S.
LEWIS, TERESA LOVINS, MARTHA J. MARTIN, LOUELLA PERRY,
SHERRY L. PERRY, JANICE PETTIT, KIMBERLY A. ROE, JANICE
ROUSH, REBECCA SMITH, BEULAH STEPHENS, AND DEBRA L. WISE

Respondents.

CERTIFICATE OF SERVICE

I, D.C. Offutt, Jr., hereby certify that I have this day served a copy of "**Brief of The Petitioner, West Virginia Mutual Insurance Company, Inc.**" upon all parties to this matter by depositing a true copy of the same in the U.S. Mail, postage prepaid, this 15th day of October, 2013, to the following:

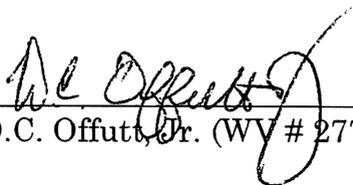
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