FILED
APR 11 2012
RORY L. PERRY II, CLERK
SUPREME COURT OF APPEALS
OF WEST VIRGINIA

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

Docket No. 11-1651

RICHARD LINDSAY and PAMELA LINDSAY D/B/A TABOR LINDSAY & ASSOCIATES,

Defendants/Third-Party Plaintiffs Below, Petitioner,

v.

ATTORNEYS LIABILITY PROTECTION SOCIETY, INC., et al.

Third-Party Defendant Below, Respondent.

RESPONDENT'S BRIEF

By Counsel,

Marc E. Williams, Esq. (WV Bar No.: 4062), *Counsel of Record*
Randy L. Saunders, Esq. (WV Bar No.: 10162)
Nelson Mullins Riley & Scarborough LLP
P.O. Box 1856
Huntington, WV 25719-1856
Main Office Phone: (304) 526-3500
Fax: (304) 526-3549

Regina E. Roman, Esq. (*Pro Hac Vice*)
John G. O'Neill, Esq. (*Pro Hac Vice*)
Sugarman, Rogers, Barshak & Cohen, P.C.
101 Merrimac Street
Boston, MA 02114
Phone: (617) 227-3030
Fax: (617) 523-4001

TABLE OF CONTENTS

Table Of Authorities iii

Statement Of The Case 1

Summary Of Argument 9

Statement Regarding Oral Argument And Decision 12

Argument 12

Standard of Review 12

A. The Circuit Court Properly Granted Summary Judgment In Favor Of ALPS Because It Is Undisputed That TL&A Failed To Report Mr. Smith's Claim In The Policy Period In Which It Was "First Made," As Required Under The ALPS Policy. 14

1. The ALPS Policy Unambiguously And Conspicuously Requires That A Claim Be First Reported In The Policy Period In Which It Is First Made. 14

2. It Is Undisputed That TL&A Did Not Report Mr. Smith's Claim In The Policy Period In Which It Was First Made, And, Therefore There Is No Coverage Under The ALPS Policies. 18

3. The Second Amended Complaint Filed in 2010 Is Not A "New" Claim That Could Properly Be Reported For Coverage Under The 2010 Policy. 19

B. Neither ALPS's Coverage Position Nor The Testimony Given By ALPS's Representative Renders The Coverage Of The ALPS Policy Illusory Or Creates A Genuine Issue Of Material Fact Preventing The Entry Of Summary Judgment In Favor Of ALPS. 23

1. There Is No Legal Or Factual Basis For TL&A's Assertion That Because ALPS Raised Multiple Policy Defenses, The Coverage Afforded By The Policy Was "Illusory." 23

2. *ALPS's Consideration Of Both Mr. Smith's Initial Complaint And First Amended Complaint In Evaluating Coverage Was Appropriate And Does Not Create Any Inconsistency Or Ambiguity In The Coverage Provided By The Policy.* 28

C. There Is No Merit To TL&A's Claim That W.Va. Code § 33-6-14 Bars Application Of Claims-Made Reporting Requirements. 30

D. There Is No Merit, Legally Or Factually, To TL&A's Assertion That ALPS "Waived" Its Right To Rely Upon The Reporting Requirements In The Insuring Agreement. 31

Conclusion 33

TABLE OF AUTHORITIES

CASES

4th Street Investors LLC v. Dowdell, 2008 WL 163052 (W.D. Pa. Jan. 15, 2008) 15

Ackerman v. Westport Ins. Corp., 2008 WL 4205749 (D.N.J. Sept. 8, 2008) 27

Am. Cas. Co. of Reading, Pennsylvania v. Continisio, 17 F.3d 62 (3d Cir. 1994) 17

Apro Mgmt., Inc. v. Royal Surplus Lines Ins. Co., 2007 WL 1238574 (N.J. App. April 30, 2007) 21, 22, 27

Ara v. Erie Ins. Co., 182 W.Va. 266, 387 S.E.2d 320 (1989) 31

Auber v. Jellen, 196 W.Va. 168, 469 S.E.2d 104 (1996) 14, 19

Boggs v. Camden-Clarke Memorial Hospital, 225 W. Va. 300, 693 S.E.2d 53 (2010) 24

Camden-Clark Memorial Hosp. Ass'n v. St. Paul Fire and Marine Ins. Co., 224 W.Va. 228, 682 S.E.2d 566 (2009) 13

Carolina Cas. Ins. Co. v. Draper & Goldberg, P.L.L.C., 2005 WL 1601422, (4th Cir. July 8, 2005) 20

Certain Underwriters At Lloyd's, London, Subscribing To Policy No. B0711 v. Pinnoak Res., LLC, 223 W. Va. 336, 674 S.E.2d 197 (2008) 12

Chas. T. Main, Inc. v. Fireman's Fund Ins. Co., 551 N.E.2d 28 (Mass. 1990) 16, 17, 18

Civic Associates, Inc. v. Security Ins. Co. of Hartford, 749 F. Supp. 1076 (D. Kan. 1990) 15

Emcode Reimbursement Solutions, Inc. v. Nutmeg Ins. Co., 512 F. Supp.2d 603 (N.D. Tex. 2007) 21, 22, 26, 27

Employers Reins. Corp. v. Sarris, 746 F. Supp. 560 (E.D. Pa. 1990) 15, 19

F.D.I.C. v. Mijalis, 15 F.3d 1314 (5th Cir. 1994) 16

Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co., 780 N.W.2d 735 (Iowa 2010) 21

Fleming, Ingram & Floyd, P.C. v. Clarendon Nat. Ins. Co., 2009 WL 5166256 (S.D. Ga. Dec. 29, 2009) 15

Gargano v. Liberty Intern. Underwriters, Inc., 572 F.3d 45 (1st Cir. 2009) 15, 19

Gulf Ins. Co. v. Dolan, Fertig & Curtis, 433 So.2d 512 (Fla. 1983) 16, 17, 30

Hasbrouck v. St. Paul Fire and Marine Ins. Co., 511 N.W.2d 364 (Iowa 1993) 16, 17

Heydar v. Westport Ins. Co., 2005 WL 3159718 (9th Cir. Nov. 29, 2005) 21

Home Ins. Co. of Illinois v. Adco Oil Co., 154 F.3d 739 (7th Cir. 1998) 15

Jarvis v. Pennsylvania Cas. Co., 129 W.Va. 291, 40 S.E.2d 308 (1946) 13

Komatsu v. U.S. Fire Ins. Co., 806 S.W.2d 603 (Tex. App. 1991) 15

Manufactured Hous. Communities. of Washington v. St. Paul Mercury Ins. Co., 660 F. Supp.2d 1208 (W.D. Wash. 2009) 17

Maynard v. Westport Ins. Corp., 208 F. Supp.2d 568 (D. Md. 2002) 17

Moore v. CNA Ins. Co., 215 W.Va. 286, 599 S.E.2d 709 (2004) 12, 13

Napolitano v. Coregis Ins. Co., 2002 WL 34159094 (D. Conn. Aug. 27, 2002), *aff'd*, 67 F. Appx. 74 (2d Cir. 2003) 18

National Mut. Ins. Co. v. McMahon & Sons, Inc., 177 W.Va. 734, 356 S.E.2d 488 (1987) 14

National Union Fire Ins. Co. of Pittsburgh, PA v. Willis, 296 F.3d 336 (5th Cir. 2002) 21, 26

National Union Fire Ins. Co. v. Talcott, 931 F.2d 166 (1st Cir. 1991) 18

Painter v. Peavy, 192 W.Va. 189, 451 S.E.2d 755 (1994) 12

Payne v. Weston, 195 W.Va. 502, 466 S.E.2d 161 (1995) 13

Potesta v. U.S. Fid. & Guar. Co., 202 W. Va. 308, 504 S.E.2d 135 (1998) 31, 32, 33

Riffe v. Home Finders Assocs., Inc., 205 W.Va. 216, 466 S.E.2d 313 (1999) 13

Safeco Title Ins. Co. v. Gannon, 774 P.2d 30 (Wash. App. 1989) 15

Shamblin v. Nationwide Mut. Ins. Co., 175 W.Va. 337, 332 S.E.2d 639 (1985) 13

Soliva v. Shand, Morahan & Co., Inc., 176 W.Va. 430, 345 S.E.2d 33 (1986) 11, 14, 19, 30, 31

Star Ins. Co. v. Berry Ins. Agency, 252 Fed. Appx. 939, 2007 WL 3226533 (10th Cir. 2007) 26

State Auto Mut. Ins. Co. v. Youler, 183 W.Va. 556, 396 S.E.2d 737 (1990) 17

State Bancorp, Inc. v. U.S. Fid. & Guar. Ins. Co., 199 W. Va. 99, 483 S.E.2d 228 (1997) 26

T.H.E. Ins. Co. v. P.T.P. Inc., 628 A.2d 223 (Md. 1993) 15, 17, 18

Tackett v. Am. Motorists Ins. Co., 213 W. Va. 524, 584 S.E.2d 158 (2003) 26

Tennant v. Smallwood, 211 W.Va. 703, 568 S.E.2d 10 (2002) 12

The Doctors Co. v. Health Mgmt. Associates, Inc., 943 So. 2d 807 (Fla. App. 2006) 15

Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire & Marine Ins. Co., 891 P.2d 916 (Ariz. App. 1994) 17

Trek Bicycle Corp. v. Mitsui Sumitomo Ins. Co., Ltd., 2006 WL 1642298 (W.D. Ky. June 7, 2006) 16

West Virginia Fire & Cas. Co. v. Stanley, 216 W. Va. 40, 602 S.E.2d 483 (2004) 29

Zuckerman v. Nat'l Union Fire Ins. Co., 495 A.2d 395 (N.J. 1985) 17

STATUTES

W.Va. Code § 33-6-14 ..... 30, 31

W.Va. Code § 55-13-9 29

STATEMENT OF THE CASE

The Underlying Medical Malpractice Action

Attorneys Pamela Tabor Lindsay and Richard D. Lindsay maintain a law practice specializing in medical malpractice in Charleston. (R.A. 41). The law firm at which they practice, Tabor Lindsay & Associates ("TL&A"), is organized as a professional limited liability company. (*See id.*). Attorney Tabor Lindsay is the sole member and her husband, Attorney Lindsay, is an employee. (*See id.*).

In 1990, Ronnie Smith, and his former wife, Nancy Smith, retained Attorney Rudolph L. DiTrapano and his law firm, DiTrapano, Barrett & DiPerio (formerly known as DiTrapano & Jackson) to represent them in a medical malpractice action. (R.A. 44, 49, 54, 58). Attorney DiTrapano, acting on behalf of the Smiths, enlisted Attorneys Tabor Lindsay and Lindsay to litigate the Smith's medical malpractice action due to their expertise in handling such cases. (R.A. 44, 49). The medical malpractice action was settled in 1995 and the Nancy E. Smith Irrevocable Trust (the "Trust") was established at United National Bank to receive the proceeds of the settlement. Ms. Smith subsequently passed away in 1998. (R.A. 45, 49, 54, 58).

Mr. Smith's Claim Against TL&A and TL&A's Failure to Report It Under The Professional Liability Insurance Policy Issued By ALPS To The Firm In 2007

On January 10, 2008, Mr. Smith filed a complaint *pro se* against TL&A individually and in his capacity as administrator of Ms. Smith's estate. (R.A. 62-64). In his complaint, Mr. Smith asserted that Attorneys Tabor Lindsay and Lindsay owed fiduciary duties of due care and loyalty to him and that Attorney Tabor Lindsay had breached those duties by wrongfully causing a check to be issued in her own name from the Trust account in the amount of $290,000. (*See id.*). Mr. Smith sought recovery against TL&A for compensatory and punitive damages. (*See id.*).

Return receipts attached to the complaint indicate that it was served upon TL&A on February 11, 2008, and TL&A does not dispute receiving the complaint on this date. (R.A. 65-66).

Prior to this, Respondent Attorney Liability Protection Society, Inc., A Risk Retention Group ("ALPS") had issued a claims-made-and-reported lawyers professional liability insurance policy to TL&A with a policy period from March 24, 2007 through March 24, 2008 (the "2007 Policy"). (R.A. 76, 80). The insuring agreement for this policy extended coverage, subject to other provisions in the policy, for "A **CLAIM** FIRST MADE AGAINST THE **INSURED** AND FIRST REPORTED TO THE **COMPANY** DURING THE **POLICY PERIOD**, provided . . . that the claim arises from or is in connection with: . . . an act, error or omission in professional services that were or should have been rendered by the insured . . . ." (R.A. 158).[1] The term **Claim** is defined as "a demand for money or services, including but not limited to the service of suit or institution of arbitration proceedings against the Insured." (R.A. 160).

Although it is undisputed that Mr. Smith's complaint was served upon TL&A on February 11, 2008, while the 2007 Policy was in effect, the firm did not report Mr. Smith's claim to ALPS during that policy period. (R.A. 65-68, 76). Instead, TL&A retained defense counsel on its own, and on February 20, 2008, filed an answer to Mr. Smith's complaint. (R.A. 71-73).

Mr. Smith subsequently also retained counsel and filed an amended complaint in which he expanded his allegations against TL&A for improper handling of Trust account funds. (R.A. 44-47). Mr. Smith's amended complaint asserted that Attorneys Tabor Lindsay and Lindsay owed fiduciary duties to him and his wife based upon the fact that they had been the Smiths' attorneys and had received settlement funds on their behalf. (*See id.*). The amended complaint

[1] As will be discussed below, ALPS issued four insurance policies to TL&A that utilized the same policy form. Rather than reproduce all of these policies in full, ALPS has produced the relevant declarations pages for the 2007, 2008, and 2009 Policies (each of which clearly indicates that policy form PLP002a (2/15/2007) is utilized) and a copy of the 2010 Policy, including the relevant policy forms.

further asserted that Attorney Tabor Lindsay had wrongfully endorsed Mr. Smith's name on a check, and that she failed to deposit certain funds paid over to her from the settlement proceeds into the Trust. (*See id.*). Mr. Smith again sought recovery of the allegedly missing funds as well as punitive damages for TL&A's allegedly willful and wanton conduct. (*See id.*). Mr. Smith also alleged that TL&A had failed to provide an accounting for the allegedly missing funds. (*See id.*). TL&A, through its counsel, answered the amended complaint on June 8, 2008, but did not notify ALPS of Mr. Smith's suit or the attachments. (R.A. 49-52, 76).

At the expiration of the 2007 Policy, ALPS issued to TL&A a subsequent claims-made[2] lawyers professional liability policy with a policy period from March 24, 2008 to March 24, 2009 (the "2008 Policy"). (R.A. 76, 82). At the expiration of the 2008 Policy, ALPS issued to TL&A another claims-made lawyers professional liability policy with a policy period from March 24, 2009 through March 24, 2010 (the "2009 Policy"). (R.A. 76, 84). TL&A did not report Mr. Smith's complaint or his amended complaint during the policy period of either of these policies. (R.A. 76). Moreover, in applying for the 2008 and 2009 Policies, TL&A completed and executed application forms in which it affirmatively responded "no" to questions asking (1) whether any claims had been asserted against the firm or any of its members during the past five years and (2) whether TL&A was aware of any circumstances that could give rise to a claim. (R.A. 87 (Question 14), 104 (Question 6)).

TL&A'S Report Of Mr. Smith's Claim in May 2010, ALPS's Denial Of Coverage, And The Attempt To Create A "New" Claim

It was not until May 20, 2010 that TL&A first sent notice to ALPS of Mr. Smith's claim and enclosed a copy of Mr. Smith's amended complaint. (R.A. 118-51).[3] In its cover letter,

[2] For the sake of brevity, ALPS may in certain instances refer to the policies at issue as "claims-made."

[3] TL&A states on page 3 of its Brief that it reported the claim on May 20, 2008. This is clearly incorrect, however, and is unsupported by any evidence in the record.

TL&A stated that Mr. Smith's suit had been filed "in 2008 from *alleged negligent conduct* in 1995" (emphasis supplied). (R.A. 118-19). TL&A further stated that it had not reported the case to ALPS earlier because the firm "looked upon this as a nuisance case—nothing was done for almost a year." (*Id.*). TL&A then attempted to minimize its failure to report the case in a timely manner by claiming that there was no prejudice to ALPS because TL&A had been represented by an attorney throughout the intervening two years. (*See id.*). TL&A requested that ALPS defend and indemnify the firm in connection with Mr. Smith's claim. (*See id.*).

The ALPS policy in effect at the time when TL&A reported the *Smith* claim had an effective date of March 24, 2010 and an expiration date of March 24, 2011 (the "2010 Policy"). (R.A. 76-77, 154). By letter dated May 25, 2010, ALPS claims attorney Jim Mickelson acknowledged receipt of TL&A's report of the *Smith* claim. (R.A. 77, 208). Mr. Mickelson also confirmed an earlier telephone conversation with Attorney Richard Lindsay in which Attorney Lindsay had again stated that TL&A received the *Smith* claim in 2008, but did not report it until 2010 due to its belief that it was a frivolous suit that would not be pursued. (*See id.*). Mr. Mickelson indicated that the matter was under review, but that ALPS was presently disputing coverage based upon TL&A's failure to timely report the *Smith* claim and because the allegations amounted to a claim for conversion. (*See id.*).

By correspondence dated June 23, 2010, ALPS, through its counsel, denied TL&A's request for coverage. (R.A. 172-190). ALPS's denial was based upon the fact that Mr. Smith's claim was first asserted in 2008, over two years before the inception of the 2010 Policy, and, therefore, it was not "first made" during the policy period as required under the insuring clause. (R.A. 176-78, 186-88). The denial also referred to the fact that Mr. Smith's amended complaint

did not seek damages within the meaning of the 2010 Policy and also fell within an exclusion for claims arising out of the mishandling of client funds. (R.A. 178, 188).

After an additional exchange of correspondence between ALPS and TL&A in which ALPS reiterated its coverage denial, TL&A's counsel approached the Court and Mr. Smith's counsel with a motion to continue the trial date and permit the amendment of the pleadings. (R.A. 192-93). The resulting "second amended complaint" alleges no new facts and consists of two paragraphs. (R.A. 192-94). The first paragraph merely "re-alleges and adopts by reference" all of the factual allegations contained in the earlier amended complaint (which was attached). (R.A. 194-99). The second paragraph asserts that the foregoing "actions, behaviors, omissions, or violations of duty on the part of the defendants were occasioned by their negligence." (R.A. 194). These were the very same actions, behaviors, omissions, and/or violations of duties that had served as the basis for Mr. Smith's earlier amended complaint filed in 2008. (R.A. 194-99).

TL&A through counsel submitted the seconded amended complaint to ALPS on October 1, 2010. (R.A. 192-93). In his transmittal correspondence, TL&A's counsel asserted to ALPS that "this is your insured's first notice of a negligence claim," and demanded that ALPS assume the defense of the Lindsays. (R.A. 192-93). In fact, however, TL&A itself had previously characterized Mr. Smith's claim as based in alleged negligence when it first reported the claim in May 2010. (R.A. 118-19).

By letter dated October 23, 2010, ALPS responded to TL&A's renewed request for coverage and explained that the filing of the second-amended complaint characterizing the conduct complained of in earlier complaints as "negligent" did not create coverage for Mr. Smith's claim. (R.A. 267-70). As an initial matter, the letter pointed out that Lindsays themselves had previously characterized Mr. Smith's claim as one for negligence, and that the

new complaint added no new factual allegations and appeared to be merely a pretext for obtaining coverage. (R.A. 268). The letter further noted that Mr. Smith's claim—his initial demand for money or services—was first made in 2008, but TL&A failed to report it until several years later in 2010. (*See id.*). Moreover, the Lindsays had not offered any basis for concluding that a West Virginia court would disregard the clear reporting requirements in the insuring agreement that unambiguously required a claim to be both "first made" and "first reported" in the same policy period. (R.A. 269).

The ALPS Policy Provisions

As previously noted, the 2007, 2008, 2009, and 2010 Policies each utilize the same policy form, PLP002a (2/15/2007). (R.A. 80 (Item 7), 82 (Item 7), 84 (Item 7), 154 (Item 7)). The first page of this policy form prominently states that coverage is provided on a "Claims Made and Reported" basis and that the insured must immediately report any claim during the policy period, otherwise there will be no coverage. (R.A. 157). The notice expressly states that "no coverage exists under this policy for a claim that is first made against the insured or first reported to ALPS after the policy period . . ." (*See id.*).

The basic Insuring Agreements in the policy form provide:

> Subject to the limit of liability, exclusions, conditions, and other terms of this policy, the **Company** agrees to pay on behalf of the **Insured** all sums (in excess of the **deductible** amount) that the Insured becomes legally obligated to pay as **damages**, arising from or in connection with A **CLAIM** FIRST MADE AGAINST THE **INSURED** AND FIRST REPORTED TO THE **COMPANY** DURING THE **POLICY PERIOD**, provided that the **claim** arises from an act, error, omission or personal injury that happened on or after the **loss inclusion date** and the **retroactive coverage date** set forth in Items 2 and 3 of the Declarations, and that the claim arises from or is in connection with:
>
> 1.1.1 an act error or omission in professional services that were or should have been rendered by the insured . . . .

> and further provided that at the **effective date** of this policy, no **Insured** knew or reasonably should have known or foreseen that the act, error, omission or personal injury might be the basis of a **claim**.

(R.A. 158).

Reinforcing the claims-made nature of the coverage, the declarations pages for the 2007, 2008, 2009, and 2010 Policies each state, "NOTICE: This is a Claims Made and Reported Policy. Except to such extent as may otherwise be provided herein, the coverage afforded under this policy is limited generally to liability for only those claims that are first made against the Insured and first reported to the Company while this policy is in force." (R.A. 80, 82, 84, 154).

The Conditions section of the policy form further provides:

> 4.6.4 In the event an **Insured** fails to give written notice to the **Company** of a **claim,** prior to the end of the **policy period** in which the **claim** is made . . . then no coverage for any such **claim** shall be afforded to the **Insured** under any future policy issued by the **Company**.
>
> 4.2.5 Neither the making of one or more **claims** against more than one **Insured**, nor the making of one or more **claims** by more than one claimant, shall operate to increase the **limit of liability**. All **claims** that arise out of the same or **related professional services**, whenever made and without regard to the number of **claims**, claimants or **Insureds**, shall be considered together as a single **claim** and shall be subject to the same single "each claim" **limit of liability**, "aggregate" **limit of liability**, and **claim expense allowance**.

(R.A. 165-68). The policy form defines a **Claim** as "a demand for money or services, including but not limited to the service of suit or institution of arbitration proceedings against the Insured." (R.A. 160).

The policy form also contains an Exclusions section, which provides:

> 3.1 THIS POLICY DOES NOT APPLY TO ANY CLAIM ARISING FROM OR IN CONNECTION WITH: . . .

> 3.1.13 Any conversion, misappropriation or improper commingling by any person of client or trust account funds or property, or funds or property of any person held or controlled by an **Insured** in any capacity or under any authority, including any loss or reduction in value of such funds or property.
>
> 3.1.1 Any dishonest, fraudulent, criminal, malicious, or intentionally wrongful or harmful act, error or omission committed by, or at the direction of an **Insured** . . .

(R.A. 163-64).

The Proceedings Before The Circuit Court

Shortly after ALPS renewed its coverage denial, TL&A filed a third-party complaint naming ALPS and others as third-party defendants in the underlying legal malpractice suit. (R.A. 201-06). In its third-party complaint, TL&A sought a declaration as to "the rights and obligations of ALPS" under the 2010 Policy. (*See id.*). After completing written discovery and producing a witness to testify at a Rule 30(b)(7) deposition, ALPS moved for summary judgment in its favor, arguing, among other things, that TL&A's delay of *over two years* in reporting Mr. Smith's claim barred coverage under the ALPS Policy as a matter of law, and TL&A cross-moved for summary judgment in its favor. (R.A. 14-18, 374-82).

In a thirteen-page Order dated October 26, 2011, the Circuit Court granted summary judgment in favor of ALPS and denied TL&A's cross-motion for summary judgment. (R.A. 389-401). The Circuit Court found that the unambiguous language of the ALPS Policy required that TL&A first report the claim in the policy period in which it was first made, and that there was no coverage because Mr. Smith's claim was first made in the 2007 Policy period, but TL&A did not report the claim until the 2010 Policy period. (R.A. 398). The Circuit Court further found that the "second amendment" of the complaint in October 2010, by adding a single paragraph characterizing the conduct set forth in the earlier complaint as "negligent," did not

constitute a new "claim" or otherwise cure TL&A's failure to report the claim in the 2007 Policy period. (*See id.*).

The Circuit Court also rejected TL&A's claim of estoppel (first raised at oral argument), finding that there was no competent evidence that TL&A had delayed reporting Mr. Smith's claim in reliance upon a misrepresentation made by ALPS as to coverage. (R.A. 398-400). The Circuit Court found that the undisputed evidence demonstrated that TL&A made a conscious decision to delay reporting the *Smith* claim because the firm believed that it was a "nuisance suit." (R.A. 399-400). The court also found that TL&A had not offered competent evidence to show that it had actually delayed its report of the *Smith* claim because of any alleged belief that it was a potential claim, as opposed to an actual claim, or because of any of the statements in correspondence accompanying the ALPS Policy. (*See id.*). The Circuit Court further found that Mr. Smith's complaint was an actual claim, and that the correspondence from ALPS did not make any representations about actual claims that could serve as the basis for a claim of estoppel. (R.A. 400).

SUMMARY OF ARGUMENT

The Court should affirm the Circuit Court's Order granting summary judgment in favor of ALPS and denying TL&A's cross-motion because the relevant facts are not in dispute, and it is clear that, as a matter of law, there is no coverage for Mr. Smith's claim against TL&A under the claims-made-and-reported professional liability policies at issue.

A. The Circuit Court Properly Granted Summary Judgment In Favor Of ALPS Because It Is Undisputed That TL&A Failed To Report Mr. Smith's Claim In The Policy Period In Which It Was "First Made," As Required Under The ALPS Policy.

The Circuit Court properly found that coverage is precluded by TL&A's undisputed failure to timely report Mr. Smith's claim. The ALPS Policy form conspicuously and

unambiguously requires that a claim be both "first made" and "first reported" during the same policy period in order to qualify for coverage. Because the reporting requirements in claims-made policies such as these define the scope of coverage, it is inappropriate to require the insurer to demonstrate prejudice to its interests (as is often the case with occurrence-based and other types of insurance) before denying coverage based upon a failure to timely report a claim. There is no dispute that TL&A was served with Mr. Smith's complaint, which falls squarely within the definition of a claim, during the 2007 Policy period, but did not report the claim until 2010, well after the 2007 Policy period had expired. Because Mr. Smith's claim was not "first reported" in the policy period in which it was "first made," no coverage is available. Moreover, the language of the ALPS Policies and case law make clear that the second amended complaint filed by Mr. Smith with the blessing of TL&A's counsel in 2010 is not a "new" and separately-reportable claim that would entitle TL&A to coverage under the 2010 Policy.

B. Neither ALPS's Coverage Position Nor The Testimony Given By ALPS's Representative Renders The Coverage Of The ALPS Policy Illusory Or Creates A Genuine Issue Of Material Fact Preventing The Entry Of Summary Judgment In Favor Of ALPS.

There is no basis for TL&A's assertion that the coverage afforded by the ALPS Policy is illusory. The policy form by its terms does provide substantial coverage for claims arising from acts, errors, or omissions in professional services when a claim is timely reported. TL&A is not entitled to coverage, however, because it elected not to report Mr. Smith's claim when it was first made. The evidence in the record does not support TL&A's claim of futility, i.e., that ALPS would have denied a defense even if the firm had reported the claim under the 2007 Policy, and, as a legal matter, an insured such as TL&A who wishes to secure coverage must timely report a claim even where coverage is unclear or doubtful. There is similarly no merit to TL&A's assertion that ALPS's coverage analysis was inappropriate because ALPS evaluated both the

initial complaint and the amended complaint. ALPS correctly considered both complaints, and TL&A fails to explain how doing so could possibly create an ambiguity in the clear language of the policy form or create a factual issue requiring a trial.

C. There Is No Merit To TL&A's Claim That W.Va. Code § 33-6-14 Bars Application Of Claims-Made Reporting Requirements.

By its own terms, Section 33-6-14 applies only to policy provisions that purport to limit the time in which an insured may bring suit against an insurer to enforce the terms of the policy. The statute does not, as this Court held in *Soliva v. Shand, Morahan & Co.*, 176 W.Va. 430, 345 S.E.2d 33 (1986), apply to claims-made policy provisions. Accordingly, the statute has no application to the reporting requirements in the ALPS Policy, and there is no merit to TL&A's suggestion that it precludes ALPS from denying coverage for Mr. Smith's claim.

D. There Is No Merit, Legally Or Factually, To TL&A's Assertion That ALPS "Waived" Its Right To Rely Upon The Reporting Requirements In The Insuring Agreement.

There is no legal or factual basis for TL&A's argument that a statement in correspondence accompanying the ALPS Policy constitutes a "waiver" of ALPS's right to rely upon the reporting requirement in the policy form itself. From a legal perspective, the doctrine of waiver cannot, as TL&A urges, expand the coverage afforded by the insuring agreement in the ALPS Policy. Even assuming that waiver could properly apply, the statement does not demonstrate that ALPS intentionally relinquished its right to rely upon the reporting requirements. Indeed, to the contrary, the statement at issue addresses "potential claims," and is not even applicable to *actual claims* such as Mr. Smith's complaint. For largely the same reason, the statement relied upon by TL&A does not support its contention that ALPS is estopped from denying coverage based upon the reporting requirements. Apart from this, the undisputed evidence demonstrates that TL&A's decision to refrain from reporting the *Smith* claim had

nothing to do with the statement at issue, and was instead based upon the firm's perception of the claim as a nuisance suit.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

ALPS submits that this appeal involves relatively straightforward issues of law that are adequately presented in the briefs and accompanying filings. Accordingly, ALPS believes that the Court's decision-making process would not be aided by oral argument. ALPS requests a Memorandum decision affirming the Circuit Court's decision finding that no coverage is available to TL&A under the applicable claim-made-and-reported insurance policies and dismissing TL&A's third-party complaint.

ARGUMENT

Standard of Review

This Court reviews a circuit court's entry of summary judgment *de novo*. *See Certain Underwriters At Lloyd's, London, Subscribing To Policy No. B0711 v. Pinnoak Res., LLC*, 223 W. Va. 336, 341, 674 S.E.2d 197, 202 (2008) (per curiam) (citing Syl. pt. 1, *Painter v. Peavy*, 192 W.Va. 189, 190, 451 S.E.2d 755, 756 (1994)). In conducting this *de novo* review, the Court applies the same standard for granting summary judgment that is applied by the circuit court. *See id.*

This Court has repeatedly held that the "[d]etermination of the proper coverage of an insurance contract when the facts are not in dispute is a question of law." *Moore v. CNA Ins. Co.*, 215 W.Va. 286, 289-90, 599 S.E.2d 709, 712-13 (2004) (per curiam) (citing Syllabus Point 1 of *Tennant v. Smallwood*, 211 W.Va. 703, 704, 568 S.E.2d 10, 11 (2002)). Moreover, "[t]he interpretation of an insurance contract, including the question of whether the contract is ambiguous, is a legal determination that, like a lower court's grant of summary judgment, shall

be reviewed *de novo* on appeal." *Id.* (citing Syllabus Point 2, *Riffe v. Home Finders Assocs., Inc.*, 205 W.Va. 216, 217, 466 S.E.2d 313, 314 (1999)) (further citation omitted).

"Where the provisions of an insurance policy contract are clear and unambiguous they are not subject to judicial construction or interpretation, but full effect will be given to the plain meaning intended." *Payne v. Weston*, 195 W.Va. 502, 506-07, 466 S.E.2d 161, 165-66 (1995) (citing *Keffer v. Prudential Ins. Co.,* 153 W.Va. 813, 172 S.E.2d 714(1970)). The determination of whether an ambiguity exists in an insurance policy is a question of law for the Court. *Canal Ins. Co. v. Blankenship*, 129 F. Supp.2d 950, 953 (S.D. W.Va. 2001). An ambiguity exists only where the policy language is "reasonably susceptible of two different meanings" or is "of such doubtful meaning that reasonable minds might be uncertain or disagree as to its meaning[.]" *Payne*, 195 W.Va. at 507, 466 S.E.2d at 166 (citing *Shamblin v. Nationwide Mut. Ins. Co.,* 175 W.Va. 337, 332 S.E.2d 639 (1985)). In considering the issue, the Court must read the policy provisions so as to avoid ambiguities, and it should not torture the language of the policy in order to create them. *See id.*

Lastly, it is the insured's burden to establish a *prima facie* case of loss within the coverage of the policy, and it is not until the insured has met this burden that the burden shifts to the insurer to demonstrate that the loss at issue is one for which it is not liable because of an exclusion or some other policy provision. *See Camden-Clark Memorial Hosp. Ass'n v. St. Paul Fire and Marine Ins. Co.*, 224 W.Va. 228, 236, 682 S.E.2d 566, 574 (2009); *Jarvis v. Pennsylvania Cas. Co.,* 129 W.Va. 291, 296-97, 40 S.E.2d 308, 311-12 (1946). As discussed below, the Circuit Court properly applied these principles in determining that the relevant facts were not in dispute and that, as a matter of law, no coverage is available to TL&A under the APLS Policies for Mr. Smith's claim.

A. The Circuit Court Properly Granted Summary Judgment In Favor Of ALPS Because It Is Undisputed That TL&A Failed To Report Mr. Smith's Claim In The Policy Period In Which It Was "First Made," As Required Under The ALPS Policy.

1. The ALPS Policy Unambiguously And Conspicuously Requires That A Claim Be First Reported In The Policy Period In Which It Is First Made.

In order to come within the scope of the insuring agreement of the ALPS Policy, Mr. Smith's claim had to be "first reported" during the policy period of the policy in which it was "first made." The insuring agreement in each of the ALPS Policies plainly and unambiguously extended only to those claims "FIRST MADE AGAINST THE **INSURED** AND FIRST REPORTED TO THE **COMPANY** DURING THE **POLICY PERIOD.**" (R.A. 158) (emphasis in original). This requirement appeared prominently in the insuring agreement, and was repeated on the Declarations page and on the first page of the policy form. (R.A. 80, 82, 84, 154, 157). Further emphasizing this point, each of the ALPS Policies expressly provided that "[i]n the event an **Insured** fails to give written notice to the **Company** of a **claim** prior to the end of the **policy period** in which the **claim** is made, . . . then *no coverage for any such **claim** shall be afforded to the **Insured** under any future policy* issued by the **Company**." (R.A. 168) (emphasis supplied).

"Claims-made" insurance such as this has been accepted and enforced by this Court. *See Soliva v. Shand, Morahan & Co., Inc.*, 176 W.Va. 430, 433, 345 S.E.2d 33, 35-36 (1986) (finding that insuring agreement that limited coverage to "claims that are first made against the insured during the policy period" was unambiguous and was to be enforced in accordance with its terms);[4] *Auber v. Jellen*, 196 W.Va. 168, 174, 469 S.E.2d 104, 110 (1996) (noting that "a 'claims-made' policy protects the holder only against claims made during the life of the policy."). Similarly, the reporting requirement in the ALPS policy, that the claim also be "first

[4] The *Soliva* decision was subsequently reversed in part on other grounds that are not germane to this case. *See National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 356 S.E.2d 488 (1987).

reported" to the company within the policy period, is a common and almost universally enforced feature of claims-made coverage. *See, e.g., Gargano v. Liberty Intern. Underwriters, Inc.*, 572 F.3d 45, 49 (1st Cir. 2009) (affirming finding of no coverage under policy extending to claims "first made against the insured during the policy period and reported to the company during the policy period" where claim was not reported by insured until several years after expiration of policy period in which it was made); *Employers Reins. Corp. v. Sarris*, 746 F. Supp. 560, 563 (E.D. Pa. 1990) (finding no coverage under similar policy language for claim made during policy period but not reported until four months after policy period expired).[5]

In granting summary judgment to ALPS, the Circuit Court properly found that the reporting requirements and other relevant provisions in the policy form are unambiguous and enforceable. (R.A. 398). TL&A offered no argument in the Circuit Court that the language used in the policy form is itself unclear or ambiguous, and it makes no such argument in this appeal. Instead, it argues that this Court should simply disregard the unambiguous language of the insuring agreements and re-write the policy to require the insurer to demonstrate prejudice before it may deny coverage based upon a failure to comply with the claims-made reporting requirements. This argument has been overwhelmingly rejected by courts around the country. *See, e.g., T.H.E. Ins. Co. v. P.T.P. Inc.*, 628 A.2d 223, 228 (Md. 1993) (collecting cases and holding that notice-prejudice rule did not apply to claims-made coverage); *4th Street Investors LLC v. Dowdell*, 2008 WL 163052, *5 (W.D. Pa. Jan. 15, 2008) (noting majority rule that insurer need not demonstrate prejudice to deny coverage for late notice under a claims-made policy); *Civic Associates, Inc. v. Security Ins. Co. of Hartford*, 749 F. Supp. 1076, 1082 (D. Kan. 1990)

---

[5] *See also Komatsu v. U.S. Fire Ins. Co.*, 806 S.W.2d 603, 605 (Tex. App. 1991) (enforcing similar language); *Home Ins. Co. of Illinois v. Adco Oil Co.*, 154 F.3d 739, 742 (7th Cir. 1998) (same); *Fleming, Ingram & Floyd, P.C. v. Clarendon Nat. Ins. Co.*, 2009 WL 5166256, *3 (S.D. Ga. Dec. 29, 2009) (same); *Safeco Title Ins. Co. v. Gannon*, 774 P.2d 30, 35-36 (Wash. App. 1989); *The Doctors Co. v. Health Mgmt. Assocs., Inc.*, 943 So. 2d 807, 810 (Fla. App. 2006).

(discussing majority rule); *Hasbrouck v. St. Paul Fire and Marine Ins. Co.*, 511 N.W.2d 364, 368 (Iowa 1993) (collecting cases and concluding that prejudice is not a relevant consideration). *Trek Bicycle Corp. v. Mitsui Sumitomo Ins. Co., Ltd.*, 2006 WL 1642298 (W.D. Ky. June 7, 2006) (noting and following majority rule).

In rejecting the application of a notice-prejudice rule to claims-made-and-reported policies, numerous courts have recognized the importance of this type of policy in the insurance market, particularly in the realm of professional liability insurance. Claims-made-and-reported policies limit the insurer's exposure to a discrete period, thereby permitting a more accurate calculation of potential exposure and enabling the insurer to offer claims-made coverage at a lower premium than is possible with occurrence-based policies:

> An underwriter who is secure in the fact that claims will not arise under the subject policy . . . after its termination or expiration can underwrite a risk and compute premiums with greater certainty. The insurer can establish his reserves without having to consider the possibilities of inflation beyond the policy period, upward-spiraling jury awards, or later changes in the definition and application of negligence.

Gulf Ins. Co. v. Dolan, Fertig & Curtis, 433 So.2d 512, 516 (Fla. 1983) (further citation omitted); *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28, 30 (Mass. 1990) ("The closer in time that the insured event and the insurer's payoff are, the more predictable the amount of the payment will be, and the more likely it is that rates will fairly reflect the risks taken by the insurer."); *F.D.I.C. v. Mijalis*, 15 F.3d 1314, 1330 (5th Cir. 1994) (observing that notice requirements in claims-made policies allow the insurer to "close its books" on a policy at its expiration and thus to "attain a level of predictability unavailable under standard occurrence policies") (further citation omitted).

Because claims-made reporting requirements define the scope of coverage afforded, and are reflected in the premium calculation, courts routinely reject efforts to alter the parties' bargain by extending the notice period due to a claimed lack of prejudice or otherwise:

> Thus, an extension of the notice period in a "claims made" policy constitutes an unbargained-for expansion of coverage, *gratis,* resulting in the insurance company's exposure to a risk substantially broader than that expressly insured against in the policy. Obviously, such an expansion in the coverage provided by "claims made" policies would significantly affect both the actuarial basis upon which premiums have been calculated and, consequently, the cost of "claims made" insurance.

Zuckerman v. Nat'l Union Fire Ins. Co., 495 A.2d 395, 406 (N.J. 1985); *Dolan, Fertig & Curtis*, 433 So. 2d at 515-16 (declining to extend reporting period in claims-made policy for benefit of insured, as this would "in effect, rewrite the contract between the parties"); *see also P.T.P. Inc.*, 628 A.2d at 227 (observing that after expiration of claims-made policy, it could not be "revived" to provide coverage for a late-reported claim).[6] Accordingly, and as noted, courts have repeatedly rejected insured's efforts to circumvent reporting requirements in claims-made insurance policies by asserting a lack of prejudice to the insurer.

In arguing to the contrary, TL&A relies heavily upon decisions involving the construction of notice provisions in occurrence-based insurance policies, which serve a fundamentally different purpose than reporting requirements in claims-made policies. *See State Auto Mut. Ins. Co. v. Youler*, 183 W.Va. 556, 396 S.E.2d 737 (1990) (discussing purpose of notice provision, which is to permit insurer to conduct timely investigation of accident, and concluding that insurer must show actual prejudice to its investigation in order to deny coverage

---

[6] *See also Chas. T. Main, Inc.*, 551 N.E.2d at 30; *Maynard v. Westport Ins. Corp.*, 208 F. Supp.2d 568, 574 (D. Md. 2002); *Manufactured Hous. Communities. of Washington v. St. Paul Mercury Ins. Co.*, 660 F. Supp.2d 1208, 1213-14 (W.D. Wash. 2009); *Hasbrouck*, 511 N.W.2d at 366-69; *Am. Cas. Co. of Reading, Pennsylvania v. Continisio*, 17 F.3d 62, 68 (3d Cir. 1994); *Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 921 (Ariz. App. 1994).

for untimely notice). The policy reasons cited in support of imposing a prejudice requirement in occurrence policies simply do not apply to claims-made coverage, where the reporting requirement defines the scope of coverage and is directly reflected in the premium price. For this reason, as noted, most courts have rejected efforts to imply such a requirement into claim-made policies. *See P.T.P. Inc.*, 628 A.2d 223 at 226-30 (discussing differences between occurrence and claims-made coverage and holding that notice-prejudice rule did not apply to claims-made coverage); *Chas. T. Main, Inc.*, 863, 551 N.E.2d at 29 (same).[7] Thus, the Circuit Court was correct in holding that the clear language of the ALPS policy form should be applied as written.

2. *It Is Undisputed That TL&A Did Not Report Mr. Smith's Claim In The Policy Period In Which It Was First Made, And, Therefore There Is No Coverage Under The ALPS Policies.*

Applying the unambiguous language of the ALPS Policies to the undisputed facts before the Court establishes that there is no coverage for Mr. Smith's claim against TL&A because it was first made during the 2007 Policy period, but was not reported to ALPS during that policy period. Mr. Smith's initial complaint clearly sets forth a "demand for money or services" and constitutes a "suit" within the policy definition of "claim." (R.A. 62-64, 160). The undisputed evidence demonstrates that Mr. Smith served his complaint upon TL&A by February 11, 2008, well within the effective period of the 2007 Policy, which was in force from March 24, 2007 through March 24, 2008. (R.A. 65-68, 76, 80). The service of a complaint clearly constitutes a

[7] Courts have similarly rejected the argument, half-heartedly advanced by TL&A at various points in its brief, that the issuance of a renewal or replacement policy by the same carrier operates to extend the time in which an insured may properly report a claim. *See National Union Fire Ins. Co. v. Talcott*, 931 F.2d 166, 168 (1st Cir. 1991) (observing that issuance of successive claims-made policies by same insurer did not extend time for reporting claims, which were required to be reported in policy period in which they were made); *Napolitano v. Coregis Ins. Co.*, 2002 WL 34159094, *4 (D. Conn. Aug. 27, 2002), *aff'd*, 67 F. Appx. 74 (2d Cir. 2003) (rejecting argument that a second claims-made policy was merely a continuation of first policy that permitted claim to be reported in later policy period).

"claim" as defined by the Policy, and, accordingly, Mr. Smith's claim was "first made" at the latest by February 11, 2008. As set forth under the clear language of the insuring agreement (and reiterated in the warnings on the front of the 2007 Policy and the 2007 Declarations) (R.A. 80, 157, 158), Mr. Smith's claim had to be reported to ALPS within the 2007 Policy period (March 24, 2007 through March 24, 2008) to potentially qualify for coverage under the 2007 Policy.

The undisputed evidence shows, however, that TL&A made a *conscious decision* not to report Mr. Smith's claim during the 2007 Policy period—allegedly believing it to be a "nuisance suit" that would resolve short of trial—and instead litigated the claim for over two years before notifying ALPS in May 2010.[8] (R.A. 118-19). Because Mr. Smith's claim was not "first reported" within the 2007 Policy period, there can be no coverage for the claim under that policy. *See Gargano*, 572 F.3d at 49; *Sarris*, 746 F. Supp. at 563. Likewise, there can be no coverage for Mr. Smith's claim under the 2008 and 2009 Policies because the claim was neither first made nor first reported to ALPS during either of those policy periods. (R.A. 65-68, 76).

3. The Second Amended Complaint Filed in 2010 Is Not A "New" Claim That Could Properly Be Reported For Coverage Under The 2010 Policy.

There is similarly no coverage available for Mr. Smith's claim under the 2010 Policy in effect when TL&A finally did report Mr. Smith's claim. Although Mr. Smith's claim was "first reported" to ALPS during the 2010 Policy period, it clearly was not "first made" against TL&A during this policy period, as required to come within the insuring clause. *See Soliva*, 176 W.Va. at 433, 345 S.E.2d at 35 (finding no coverage for claim that was made outside policy period); *Auber*, 196 W.Va. at 174, 469 S.E.2d at 110 (same). Moreover, the policy form expressly provided that "[i]n the event that an **Insured** fails to give written notice to the **Company** of a

[8] Throughout this time, moreover, TL&A failed to report Mr. Smith's amended complaint and *affirmatively represented to ALPS* on applications for the 2008 and 2009 Policies *that no claims had been filed against the firm* or any of its members. (R.A. 87 (Question 14), 104 (Question 6)).

claim, prior to the end of the **policy period** in which the **claim** is made . . . then no coverage for any such **claim** shall be afforded to the **Insured** *under any future policy* issued by the **Company**." (R.A. 168) (emphasis supplied). Accordingly, there is no coverage for Mr. Smith's claim under the 2010 Policy.

Nor is there any support for TL&A's suggestion that Mr. Smith's second amended complaint, which was filed in September 2010, somehow constitutes a "new" claim for "negligence" that TL&A properly reported for coverage under the 2010 Policy. Factually, the second amended complaint contains absolutely no new allegations of wrongdoing on the part of TL&A. (R.A. 194). It merely re-characterizes the same conduct set forth in the first amended complaint filed several years earlier as having been occasioned, in the alternative, by TL&A's "negligence." (*See id.*). Indeed, the lack of any new facts in the second-amended complaint, coupled with defense counsel's admitted role in its filing (R.A. 192-93), suggest that rather than asserting a brand new claim, the amendment was orchestrated between TL&A and the plaintiff solely in a fruitless effort to somehow salvage coverage for the late-reported claim.

Equally important, it is clear that the characterization of Mr. Smith's claim as negligent was not "new." TL&A itself described Mr. Smith's "lawsuit" as arising out of "alleged negligent conduct" when it first gave notice to ALPS in May 2010. (R.A. 118-19). Although TL&A fails to refer to the statements in its May 20, 2010 notice in over 40+ pages of appellate brief, those statements remain an undisputed fact on this record.[9] Having already acknowledged that the conduct alleged in the earlier complaint could be viewed as negligent, TL&A is simply not permitted—as a matter of logic, law or equity—to now argue that Mr. Smith's amendment adding this characterization constitutes a new or different claim. *Cf. Carolina Cas. Ins. Co. v.*

[9] Given the uncontradicted written evidence regarding TL&A's view in May 2010 of the nature of Mr. Smith's claim and the reason for the late report, it is puzzling why TL&A challenges in its brief the correctness of the judge's factual finding to this effect. (*See* Petitioner's Brief at 8 n. 10).

Draper & Goldberg, P.L.L.C., 2005 WL 1601422, *6 (4th Cir. July 8, 2005) (holding that insured's report of several non-client claims in response to application question prevented it from later asserting in coverage action that question was ambiguous or that it did not require disclosure of other non-client claims).

Courts considering similar situations have almost universally held that an amendment to an earlier complaint does not constitute a "new" or different claim for reporting purposes under claims-made-and-reported policies. *See, e.g., Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co.*, 780 N.W.2d 735, 741-42 (Iowa 2010) (holding that claim was "first made" when insured was served with complaint in 2002 and that later amendment of complaint to assert fiduciary duty and punitive damages theories in 2005 did not constitute a "new" claim that could potentially trigger coverage in that policy period); *National Union Fire Ins. Co. of Pittsburgh, PA v. Willis*, 296 F.3d 336, 341-42 (5th Cir. 2002) (finding that fourth amendment to complaint adding negligent misrepresentation count did not constitute a separate claim that insured could report in 2000 policy period; insured's failure to report original complaint in 1998 barred coverage); *Emcode Reimbursement Solutions, Inc. v. Nutmeg Ins. Co.*, 512 F. Supp.2d 603, 610-11 (N.D. Tex. 2007) (similar); *Apro Mgmt., Inc. v. Royal Surplus Lines Ins. Co.*, 2007 WL 1238574, *3-*5 (N.J. App. April 30, 2007) (per curiam) (similar); *Heydar v. Westport Ins. Co.*, 2005 WL 3159718, *1 (9th Cir. Nov. 29, 2005) (similar).

In so doing, courts across the country have recognized that treating an amendment to a previously-undisclosed complaint as a "new" claim would potentially permit the claimant to manipulate coverage and the insured to circumvent the reporting requirements that allow insurers to offer claims-made-and-reported policies at reduced cost. As one court succinctly stated:

> The fact that the [insured] provided Royal with timely notice of the claims in the fourth count of the Wang's amended complaint did

> not cure their failure to provide notice of the initial filing of the *Wang* lawsuit and the *Lorenzo* cross-claim. *[The Insureds] may not circumvent the reporting requirements of a claims-made policy by picking and choosing the claims for which they seek coverage when those claims all arise out of the same occurrence or incident. Such a result would be inconsistent with the limitations on coverage inherent in a claims-made policy.*

See Apro Mgmt., 2007 WL 12385784 at *4-*5 (emphasis supplied); *Emcode Reimbursement Solutions,* 512 F. Supp.2d at 610-11 (observing that a fundamental aspect of claims-made-and-reported coverage would be materially compromised if a new theory of recovery based upon same alleged misconduct could qualify as a "new" claim).

Finally, and most fundamentally, the plain, unambiguous language of the policy form establishes that the second amendment to Mr. Smith's complaint is not a "new" claim that could be first reported for coverage under the 2010 Policy. As noted, the term "claim" is defined broadly to encompass "a demand for money or services, including but not limited to the service of suit." (R.A. 160). The 2010 amendment on its face was not a new "suit," but rather the continuation of an existing suit previously commenced by Mr. Smith without any new misconduct alleged or any new relief sought. (R.A. 194). As a matter of common sense and policy language, the amendment therefore does not constitute a new claim against TL&A.

Even if the 2010 amendment had asserted new misconduct or sought new relief, however, it would still be part of a "single claim" by Mr. Smith under the ALPS policy language. The ALPS Policies expressly provided that "[a]ll **claims** that arise out of the same or **related professional services**, whenever made and without regard to the number of **claims**, claimants or **Insureds**, shall be considered together as a single **claim** . . ." (R.A. 166). They further defined "**related professional services**" as professional services that are "connected temporally, logically, or causally, by any common fact, circumstance, situation, transaction, event, advice or decision, including but not limited to work that is part of the same or continuing professional

services." (R.A. 163). It is beyond dispute that all of Mr. Smith's complaints arose out of the same or related professional services, and, therefore, all of those complaints constitute a single claim. That single claim was "first made" against TL&A during the 2007 Policy period, and it therefore does not qualify for coverage under the 2010 Policy.

In sum, the policy language as well as the overwhelming weight of authority make clear that TL&A's failure to report Mr. Smith's complaint under the 2007 Policy bars coverage for his claim, and that TL&A cannot cure this fatal defect by reporting the second amended complaint as a "new" claim under the 2010 Policy.

B. Neither ALPS's Coverage Position Nor The Testimony Given By ALPS's Representative Renders The Coverage Of The ALPS Policy Illusory Or Creates A Genuine Issue Of Material Fact Preventing The Entry Of Summary Judgment In Favor Of ALPS.

In an apparent effort to muddy the waters, TL&A asserts that the multiple grounds cited in the coverage denials render the coverage under the ALPS Policy "illusory" and/or that certain alleged inconsistencies in ALPS's coverage analysis create ambiguity in the policy language. TL&A cites absolutely no legal authority to support these rather novel theories, which are all premised on the notion that *testimony given or correspondence sent after a claim was reported* can alter the static, and otherwise unambiguous language of an insurance policy. For this reason alone, the Court should disregard TL&A's arguments. But even if the Court were to consider these arguments, as discussed in greater detail below, they are factually and legally unsupported, and do not provide a basis for reversing the Order of the Circuit Court.

1. There Is No Legal Or Factual Basis For TL&A's Assertion That Because ALPS Raised Multiple Policy Defenses, The Coverage Afforded By The Policy Was "Illusory."

Throughout its brief, TL&A contends that unless its untimely report of the *Smith* claim is excused by the Court, the coverage afforded by the ALPS policies is "illusory." Although the

basis for this argument is somewhat difficult to discern, it seems to be premised on a contention that since ALPS would have declined coverage for the initial complaint (and for the first amended complaint filed in 2008) for reasons unrelated to late reporting, TL&A was therefore excused from its clear obligation to timely report the claim. But TL&A's argument that ALPS's coverage was "illusory" is contrary to both the law established by this Court and the undisputed facts established below.

Preliminarily, and as TL&A recognizes, coverage is deemed "illusory" only where policy provisions conflict in such a way that the policy "essentially denie[s] coverage for *any* injury that would be expected to occur from any conduct." *See Boggs v. Camden-Clarke Memorial Hospital*, 225 W. Va. 300, 314-15, 693 S.E.2d 53, 66-67 (2010) (emphasis added) (rejecting claim that professional services exclusion rendered umbrella policy issued to an attorney illusory, because policy would still provide coverage under the "appropriate circumstances.") The fact that two or more provisions in the ALPS policies may have simultaneously prevented coverage for some or all of Mr. Smith's particular claim does not, as TL&A urges, render the policy's coverage illusory. Rather, the clear language of the ALPS Policy establishes that it provides significant coverage for appropriate claims *so long as they are timely reported.* On the other hand, where the claim is not timely reported within the same policy period that it was first made, there will be no coverage regardless of the nature of the substantive allegations. Thus, the policy's reporting requirement is simply a valid and enforceable prerequisite to any coverage under the policy—and enforcement of that requirement does not render the policy "illusory."

TL&A's argument that the coverage afforded them by the ALPS Policy was "illusory" is not only without legal support, it is also based on several factual contentions which are directly contrary to the undisputed facts before this Court. The central factual premise of TL&A's

argument, i.e., that a timely report of the *Smith* claim in 2008 would have been futile, rests on its claim that negligence is a prerequisite to coverage under the ALPS Policy and that the policy form bars coverage for all claims "sounding in intentional conduct." Contrary to TL&A's assertions, the insuring agreements in fact extended broadly to claims "first made against the **insured** and first reported to the **company** during the **policy period,** provided ... that the claim arises from or is in connection with ... *an act, error or omission in professional services that were or should have been rendered by the insured.*" (R.A. 158) (emphasis supplied). There is no mention of the word "negligence," much less a requirement that a claimant expressly allege that the insured's conduct was negligent before coverage is triggered. Rather, the clause speaks in terms of a claim against an insured arising from an "alleged act, error or omission in the performance of professional services," which clearly encompasses the type of allegations made by Mr. Smith against TL&A in all three complaints.[10]

Similarly, there is no evidence in the record that ALPS would have denied coverage and a defense if Mr. Smith's claim had been timely reported, as TL&A urges. Contrary to its oft-repeated assertion, the denial letters *did not* assert that coverage is precluded because Mr. Smith had asserted intentional conduct. Rather, the letters focused primarily on TL&A's failure to timely report Ms. Smith's claim. (R.A. 176-78, 186-88). After discussing the untimely report, and consistent with the carrier's obligation to inform the insured of all possible coverage defenses, the letters appropriately noted the other available or potentially available defenses: that Mr. Smith did not appear to seek "damages" within the meaning of the policy and that coverage could be barred for some or all of the claims by virtue of exclusions for mishandling funds,

[10] Indeed, the policy potentially extended coverage not only to a variety of intentional acts, but also expressly to various intentional torts, such as libel, slander and malicious prosecution. (R.A. 158 (insuring agreement extending coverage to "personal injury"), 162 (personal injury defined to include malicious prosecution, libel, slander and other intentional torts)).

disputes over fees and costs, and dishonest acts. (R.A. 178-79, 188-89). Likewise, testimony from ALPS's claims manager, Rob Tameler, indicated that while there might be other bases in the policy to ultimately deny indemnity, the only reason for declining the requested defense was TL&A's failure to timely report the *Smith* claim. (R.A. 646-47).[11] Thus, neither the letters nor the testimony provided by ALPS supports the notion that ALPS would have denied coverage, as distinct from providing a defense while reserving its rights, had the matter been timely reported during the 2007 Policy period. And they certainly do not support an argument that ALPS would have denied coverage based on the fact that "intentional conduct" was alleged by Mr. Smith—indeed, ALPS has *never* raised that as a coverage defense in this matter.

Moreover, as numerous courts have recognized, an insured such as TL&A must report a claim in the first instance, even where coverage is questionable or doubtful, in order to preserve its right to coverage under a claims-made policy. *See, e.g., National Union Fire Ins. Co. of Pittsburgh, PA v. Willis*, 296 F.3d 336, 341-42 (5th Cir. 2002) (concluding that allegations of misrepresentations, omissions, and false promises "implicated" coverage of professional liability policy for purposes of reporting requirements, even though individual insureds might ultimately be found liable for intentional torts); *Emcode Reimbursement Solutions, Inc. v. Nutmeg Ins. Co.*, 512 F. Supp.2d 603, 610-11 (N.D. Tex. 2007) (rejecting insured's argument that its "reasonable and prudent belief of non-coverage" excused late notice under claims-made policy, and observing that such a theory was limited to occurrence-based policies); *see also Star Ins. Co. v.*

[11] Mr. Tameler further testified that he viewed all three complaints as potentially seeking recovery for negligence based upon the inclusion of allegations of "duty," "loyalty," "fiduciary duty," and "breach of duty" and the fact that West Virginia is a notice pleading state. (R.A. 638-39, 658). Such a broad reading of the allegations of the complaint is exactly what is required of insurers in West Virginia in assessing the obligation to defend, and TL&A's attempt to suggest that such an approach was inappropriate flies in the face of extensive case law. *See, e.g., Tackett v. Am. Motorists Ins. Co.*, 213 W. Va. 524, 528, 584 S.E.2d 158, 162 (2003) (discussing insurer's obligation to defend where "allegations in the complaint . . . are reasonably susceptible of an interpretation that the claim may be covered" and noting that "[t]here is no requirement that the facts alleged in the complaint specifically and unequivocally make out a claim within the coverage"); *State Bancorp, Inc. v. U.S. Fid. & Guar. Ins. Co.*, 199 W. Va. 99, 104, 483 S.E.2d 228, 233 (1997) (same) (further citations omitted).

Berry Ins. Agency, 252 Fed. Appx. 939, 943 2007 WL 3226533 (10th Cir. 2007) (finding that insured was not excused from reporting initial complaint that implicated coverage under the claims-made policy at issue).

In a remarkably similar case, *Ackerman v. Westport Ins. Corp.*, an insured lawyer seeking coverage for an amended complaint asserted that he was excused from reporting the claimant's initial complaint because it had alleged only that he was liable for "theft" of certain closing funds, which was excluded from coverage under the policy. *See* 2008 WL 4205749 (D.N.J. Sept. 8, 2008). Although acknowledging that the insured may very well have thought that the initial complaint fell within a policy exclusion for conversion, the court in *Ackerman* nevertheless held that the complaint was a "claim" within the meaning of the policy and that the insured was required to timely report it "if he *even contemplated* indemnification" under the professional liability policy at issue. *See id.* at *4-5; *see also Apro Mgmt., Inc.*, 2007 WL 1238574 at *4 (finding that filing of the lawsuit against insured was a reportable event, even if premised upon intentional conduct for which no coverage would be available, because it was a "claim" as that term was defined in the policy).

The reasoning of *Ackerman* and the other decisions cited above applies with equal force in this case: since Mr. Smith's initial complaint clearly constituted a "claim" within the policy definition, if TL&A wished to preserve its right to any coverage under the ALPS Policy for this claim, it was obligated to provide timely notice of Mr. Smith's complaint in the first instance, even though it may have subjectively believed that no coverage would be afforded. *See Ackerman*, 2008 WL 4205749 at *4-*5; *Emcode Reimbursement*, 512 F. Supp.2d at 610-11. In other words, TL&A was not entitled to circumvent the reporting requirements by "picking and choosing" which complaint to report under its claims-made coverage, *see Apro Mgmt., Inc*, 2007

WL 1238574 at *4, and its failure to report Mr. Smith's initial complaint precludes coverage for his claim in its entirety, including the amended and second amended complaints.

Finally, it must be noted that the undisputed evidence in this case demonstrates that TL&A's decision to refrain from reporting Mr. Smith's claim for over two years had absolutely nothing to do with any alleged "belief" that a report would be "futile" because the claim did not sound in negligence. In fact, TL&A gave notice of Mr. Smith's claim to ALPS in May 2010, at a time when Mr. Smith was still proceeding under his first amended complaint—one which TL&A now argues "sounds in intentional conduct"—and it was not until *five months later* that the amendment that supposedly clarified coverage by adding a count alleging "negligence" was filed. (R.A. 118-51, 192-99). Moreover, TL&A itself, in its first report of the *Smith* claim to ALPS in May 2010, expressly stated that the claim had been filed "in 2008 from *alleged negligent conduct* in 1995." (R.A. 118-19). That same correspondence also makes clear that the firm's decision to delay reporting Mr. Smith's claim had nothing to do with its concern that the original complaint or the first amended complaint would not be covered. (*See id.*). Rather, as TL&A itself expressly stated, it had refrained from reporting the claim to ALPS merely because it viewed the matter as a "nuisance case." (*See id.*).

Thus, as a matter of both law and undisputed fact, there is no basis for TL&A's suggestion that the coverage afforded by the ALPS Policy was illusory.

2. *ALPS's Consideration Of Both Mr. Smith's Initial Complaint And First Amended Complaint In Evaluating Coverage Was Appropriate And Does Not Create Any Inconsistency Or Ambiguity In The Coverage Provided By The Policy.*

In a further fruitless effort to create coverage where none exists, TL&A asserts that ALPS's consideration of both Mr. Smith's initial and amended complaints in evaluating coverage was somehow improper or creates an ambiguity or inconsistency that merits a further

factual inquiry under W.Va. Code § 55-13-9. But as discussed below, ALPS's consideration of both complaints was appropriate—indeed required—and does not render the clear language of the policy ambiguous; nor does it create a dispute of material fact since ALPS readily agrees that it did evaluate both the original and first amended complaints in reaching its coverage determination.[12]

The fundamental problem with TL&A's claim that ALPS's consideration of both the original and amended complaints renders its coverage determination "inconsistent" or "questionable" is that it conflates the temporal aspect of the reporting requirements in the insuring agreements with the other coverage provisions in the ALPS Policy—provisions that speak to the substance of the claim presented for coverage. Thus, ALPS appropriately considered the amended complaint in its June 23, 2010 coverage denial letters *because that was the complaint TL&A reported to ALPS on May 20, 2010 and was the operative complaint at the time.* As required in West Virginia and elsewhere, ALPS correctly considered that complaint, which superseded the original complaint, in analyzing whether Mr. Smith's *substantive allegations* fell within the policy and/or any exclusions. *See West Virginia Fire & Cas. Co. v. Stanley*, 216 W. Va. 40, 47, 602 S.E.2d 483, 490 (2004) (further citation omitted). Moreover, the denial letters appropriately included an analysis of all of the relevant provisions, including the definition of damages and exclusions relative to mishandling funds, billing disputes and dishonest conduct (R.A. 172-90), in order to fully advise TL&A of all relevant coverage issues and to avoid any argument—which TL&A has nevertheless raised—that ALPS had waived one or more of these defenses. (*See* Petitioner's Brief at 38-40).

[12] ALPS also reviewed and considered the allegations of the second amended complaint when it too was presented by TL&A to ALPS in the fall of 2010. (R.A. 267-71).

However, and as discussed in the preceding section, the fact that Mr. Smith had filed an amended complaint was not relevant to determining whether TL&A had complied with the reporting requirements of the ALPS Policies, which separately obligated TL&A to report Mr. Smith's *claim* in the policy period in which it was *first made* in order to qualify for coverage. Both the denial letters and Mr. Tameler's testimony pointed out that Mr. Smith's claim was first made, at the latest, when he served his initial complaint upon TL&A in February 2008. (R.A. 176-78, 186-88, 706). Any suggestion that ALPS's consideration of the substantive allegations in the amended complaint prevented it from considering the initial complaint for purposes of the reporting requirements is absurd, and TL&A offers no explanation as to how this renders any aspect of the policy language ambiguous.[13]

C. There Is No Merit To TL&A's Claim That W.Va. Code § 33-6-14 Bars Application Of Claims-Made Reporting Requirements.

There is no merit to TL&A's argument that ALPS's claims-made policies violate W.Va. Code § 33-6-14. The statute voids policy provisions that purport to shorten the time period in which suit may be brought to enforce policy obligations to a period of less than two years:

> No policy . . . covering a subject of insurance . . . located . . . in West Virginia, shall contain any condition, stipulation, or agreement . . . limiting the time within which an action may be brought to a period of less than two years from the time the cause of action accrues in connection with all insurances other than marine insurances. . . .

West Virginia Code § 33-6-14. As TL&A acknowledges, this Court has already considered and rejected application of the statute to claims-made insurance. *See Soliva v. Shand, Morahan &*

[13] Nor does Mr. Tameler's testimony that ALPS may relax the reporting requirements in certain *de minimis* situations (e.g., for an insured that misses the deadline by a matter of minutes or a single day) assist TL&A in this case. TL&A delayed reporting Mr. Smiths' claim not by hours, *but by years*, and—according its own written statement—not by accident. *Cf. Dolan, Fertig & Curtis*, 433 So. 2d at 516 (declining to rule on hypothetical situation where insured might receive claim letter minutes before policy expired because such a situation was not presented in the facts before it).

Co., Inc., 176 W.Va. 430, 434, 345 S.E.2d 33, 36 (1986) (holding that claims-made policy limiting coverage to claims made within specified one-year period did not violate statute). Moreover, as this Court observed in *Soliva*, "the claims made provision of the insurance policy *defined the coverage of the policy. It did not limit the time in which to bring actions under the policy.*" *Id.* (emphasis supplied).

Here, as in *Soliva*, the reporting requirements at issue are part of the insuring agreement and define the scope of coverage afforded under the ALPS Policies. The reporting requirements do not limit the time in which TL&A can bring a lawsuit to enforce its rights under the ALPS Policies. Accordingly, Section 33-6-14 has no application to the reporting requirements in the ALPS Policies, and it cannot, as TL&A contends, extend the time for reporting Mr. Smith's claim.

D. There Is No Merit, Legally Or Factually, To TL&A's Assertion That ALPS "Waived" Its Right To Rely Upon The Reporting Requirements In The Insuring Agreement.

TL&A's final argument—to the effect that ALPS "waived" its right to rely upon the reporting requirements set forth in the insuring agreements through correspondence accompanying the ALPS Polices stating that insureds were "encouraged" to report "potential claims"—is squarely contradicted by prior opinions of this Court and ignores the undisputed evidence. Waiver is the intentional relinquishment of a known right. *See, e.g., Potesta v. U.S. Fid. & Guar. Co.*, 202 W. Va. 308, 315, 504 S.E.2d 135, 142 (1998) (citing Syl. Pt. 2, *Ara v. Erie Ins. Co.,* 182 W.Va. 266, 387 S.E.2d 320 (1989)). In the context of insurance, however, this Court has adopted the majority rule, which holds that "the principles of waiver and estoppel are inoperable to extend insurance coverage beyond the terms of an insurance contract." *Id.* at 320,

504 S.E.2d at 147.[14] Yet, this is precisely what TL&A asks the Court to do here: expand the coverage available to the firm under the ALPS Policy by holding that ALPS "waived" the unambiguous reporting requirements set forth in the insuring agreements. Such a holding, which would expose ALPS and other claims-made insurers to a much larger risk than they agreed to assume their policies, must be rejected.

Apart from this, the statement cited by TL&A does not support its claim of waiver. The correspondence accompanying the ALPS Policy stated:

> Our claims attorneys are available around the clock, 24 hours a day -- 7 days a week, to assist you regarding claims and potential claims. We encourage firms to notify ALPS as soon as there is a concern with a potential claim. Early intervention may help resolve issues before they become full-fledged claims.

(R.A. 153). Thus, it is clear that the correspondence itself distinguished between "claims" and "potential claims" and that the cited statement "encouraging" insureds to notify ALPS applies to only to "concerns" about "potential claims." The statement does not evidence any intention on the part of ALPS to relinquish its right to rely upon the reporting requirements, which are clearly stated in the insuring agreements and reiterated several times in the policy forms for emphasis. (R.A. 80, 82, 84, 154, 157, 158). Nor does it have any application to Mr. Smith's complaint, which clearly falls within the policy definition of a "claim," and was therefore required to be reported in the policy period in which it was first made.[15]

These same facts undermine TL&A's passing suggestion that ALPS should be estopped from relying upon the reporting requirements in the insuring agreements. In order to prevail on such a claim, TL&A would have to establish a misrepresentation of material fact on the part of

---

[14] The court in *Potesta* noted three exceptions to this general rule; however, none of them has any application in this case. *See id.* at 323, 504 S.E.2d at 150.

[15] Of course, TL&A did not even report Mr. Smith's complaint as a "potential claim" during the 2007, 2008, 2009 Policy periods. (R.A. 76).

ALPS and that it reasonably relied upon the misrepresentation to its detriment. *See Potesta*, 202 W.Va. at 315, 504 S.E.2d at 142. Nothing in the statements cited above could accurately be described as a misrepresentation of fact. Moreover, Attorney Lindsay's affidavit does not, as TL&A urges, state that he (or anyone else at TL&A) *actually refrained* from reporting the *Smith* claim due to his reliance upon the cited statements. (R.A. 272-75). Rather, the only competent evidence on this subject is contained in Attorney Lindsay's May 20, 2010 fax cover sheet to ALPS and Mr. Mickelson's letter confirming his conversation with Attorney Lindsay shortly thereafter, which both indicate that Attorney Lindsay and TL&A delayed reporting Mr. Smith's claim because they believed it was a nuisance claim. Accordingly, there is no basis for a finding of waiver or estoppel. (R.A. 118-19; 77, 208)

CONCLUSION

For the reasons discussed above, ALPS respectfully requests that the Court affirm the October 26, 2011 Order of the Circuit Court entering summary judgment in its favor and dismissing TL&A's third-party complaint against ALPS.

ATTORNEYS LIABILITY PROTECTION SOCIETY, INC., A Risk Retention Group
By Counsel,

Marc E. Williams (WVB#4062), *Counsel of Record*
Randall L. Saunders (WVB#10162)
Nelson Mullins Riley & Scarborough, LLP
949 Third Avenue, Suite 200
Huntington, WV 25701
(304) 526-3500

Regina E. Roman (*pro hac vice)*
John G. O'Neill (*pro hac vice*)
Sugarman, Rogers, Barshak & Cohen, P.C.
101 Merrimac Street
Boston, MA 02114
(617) 227-3030

Counsel for Third-Party Defendant,
Attorney Liability Protection Society, Inc.

No. 11-1651

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

RICHARD D. LINDSAY and
PAMELA LINDSAY d/b/a
TABOR LINDSAY & ASSOCIATES,

Defendants/Third-Party
Plaintiffs Below, Petitioners,

(Circuit Court of Kanawha County
Civil Action No. 08-C-75)

v.

ATTORNEYS LIABILITY PROTECTION
SOCIETY, Inc., et al.,

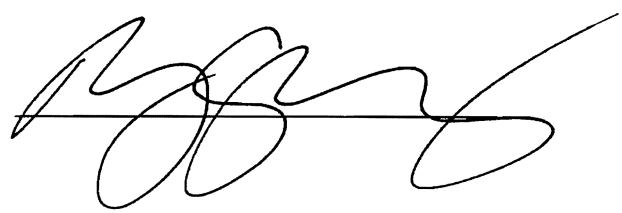
Third-Party Defendant
Below, Respondent,

v.

RONNIE SMITH, Administrator of the
Estate of Nancy Smith, deceased and
RONNIE SMITH, individually,

Plaintiffs Below, Respondents.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that he served the foregoing "***Respondent's Brief***" upon the following individual by depositing a true copy thereof in the regular manner in the United States Mail, postage prepaid, at Huntington, West Virginia, on the 11th day of April, 2012:

James A. Varner, Sr., Esq.
Debra Tedeschi Varner
Jeffrey D. Van Volkenburg
Empire Building - 400 West Main Street
P.O. Drawer 2040
Clarksburg, WV 26302-2040