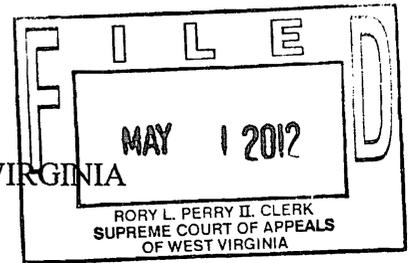


No. 11-1651

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,

v.

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

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

Third-Party Defendants  
Below, Respondents.

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**REPLY BRIEF ON BEHALF OF PETITIONERS, RICHARD D. LINDSAY  
and PAMELA LINDSAY d/b/a TABOR LINDSAY & ASSOCIATES, IN  
FURTHER SUPPORT OF THEIR PETITION FOR APPEAL**

*(re: Petitioners' Notice of Appeal from an Order of the  
Circuit Court of Kanawha County Entered on October 26, 2011)*

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**Defendants/Third-Party Plaintiffs Below,  
Petitioners, RICHARD D. LINDSAY and  
PAMELA LINDSAY, d/b/a TABOR  
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TO: THE HONORABLE JUSTICES OF THE SUPREME COURT OF APPEALS  
OF WEST VIRGINIA

A.) ALPS' Contention That Its Policy "Unambiguously" and "Conspicuously"  
Required TL&A to Report Plaintiff Smith's Suit In 2008 Is Incorrect

1.) *ALPS' Reliance On The Policy Language At Issue Confirms  
That ALPS Was Required To Defend and Indemnify TL&A  
Upon The Reporting Of Plaintiff's Smith's Suit in 2010*

The entirety of the Respondent's Brief filed by Attorney Liability Protection Society, Inc. ("ALPS") relies on the premise that the purportedly clear and unambiguous language of the ALPS' Policy of Insurance mandates that this Court affirm the decision of the Circuit Court, which granted summary judgment to ALPS. See, *Respondent's Brief*, at pgs. 14, 18. A review of the ALPS' policy provisions confirms that the award of summary judgment was in error and that TL&A is entitled to a defense and indemnification. In support of its contention that the policy language mandated dismissal of TL&A's claims for insurance coverage, ALPS has relied on sections 1.1.1; 3.1; 3.1.13; 4.6.4; and 4.2.5 of the policy. See, *Respondent's Brief*, at pgs. 6-8. A review of the plain language of the provisions relied upon by ALPS' in the context of the timing and claims asserted in the amendments to Plaintiff Smith's Complaint demonstrates that the Circuit Court's decision was in error as the coverage through the ALPS' policy was illusory, and that ALPS is required to defend and indemnify TL&A.

2.) *ALPS and The Circuit Court Ignored The Critical Fact That  
Plaintiffs' Complaint and Amended Complaint Did Not Assert Claims  
That Were Covered Under ALPS' Policy of Insurance*

Plaintiff Smith's original, *pro se* Complaint alleged that "Pamela Tabor Lindsay had illegally and wrongfully caused a check to be issued in her name . . ." *App. at p. 2*. Plaintiff Smith further asserted that these actions constituted an "embezzlement." *Id.* Critical for purposes of the instant analysis is the fact that negligence was not asserted, nor could a negligent claim be read into Plaintiff Smith's original Complaint. Plaintiff's Amended Complaint asserted that TL&A had not provided information concerning the deposit and distribution of money to which Plaintiff and Nancy E. Smith

were entitled; signed Plaintiff's name to a check without his consent; and failed to account for costs chargeable to the settlement funds due to Plaintiff and/or Nancy E. Smith. *App.*, at p. 6. There is no assertion of a claim of negligence, or other covered claim under the ALPS' policy, in the Amended Complaint. It is beyond dispute that the collective allegations contained in the Complaint and Amended Complaint sound in intentional, non-covered conduct. This position is supported by the correspondences sent from ALPS' to TL&A after the reporting of the claim, in which ALPS noted that the allegations in the Complaint and Amended Complaint sounded in conduct that fell under the exclusions in the ALPS' policy of insurance. See, *App.*, at pp. 171-190; 207-208; 267-271.

3.) *ALPS' Policy Of Insurance Clearly States That The Policy "Does Not Apply" To Claims That Fell Within the Exclusions In The ALPS' Policy Of Insurance*

In its Respondent's Brief, ALPS contends that its policy of insurance "unambiguously and conspicuously" required that a claim be first reported in the policy period in which it is first made. See, *Respondent's Brief*, at pg. 14. ALPS further cited to *Payne v. Weston*, 195 W. Va. 502, 506-507, 466 S.E.2d 161, 165-166 (1995), for the proposition that "[w]here 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." *Respondent's Brief*, at 13. Utilizing the standard relied upon by ALPS, the clear and unambiguous policy language confirms that the ALPS' policy, including the claims-made-claims-reported (hereafter, "claims-made") requirements did not apply to the allegations contained in Plaintiff's Complaint and Amended Complaint. A review of the ALPS' policy finds the following provision:

3.1 **THIS POLICY DOES NOT APPLY TO ANY CLAIM ARISING FROM OR CONNECTION WITH**

3.1.1. **Any dishonest, fraudulent, criminal, malicious, or intentionally wrongful or harmful act, error or omission caused by, at the direction of, or with the consent of the Insured, or any personal injury arising from such conduct, subject to Section 4.3 of this policy ("innocent insured coverage")**

App. at 163 (emphasis in bold). ALPS contends that the reporting requirements, pursuant to the claims-made provisions of the policy, required TL&A to report Plaintiff Smith's suit within the 2007 policy period, after it was filed in 2008. The clear and unambiguous policy language cited above confirms that the policy did not "apply" to any claim encompassing "dishonest, fraudulent, criminal, malicious, or intentionally wrongful or harmful conduct." *Id.* If the policy did not "apply" to claims in the Complaint and Amended Complaint, the "claims-made" policy provisions also cannot "apply" to eliminate coverage for TL&A, where TL&A reasonably believed it should be covered after a later amendment which for the first time asserted a covered claim under the ALPS' policy.<sup>1</sup>

If the summary judgment in favor of ALPS is permitted to stand, ALPS will have been permitted to selectively choose portions of its policy to strictly apply against its insured, in an attempt to disavow insurance coverage. Applying the "plain meaning" of the policy language, the Circuit Court erred through its reliance on the claims-made components of the policy, while ignoring the language of the policy that confirms that the policy would not "apply" to the allegations contained in the first two complaints filed by Plaintiff Smith.<sup>2</sup> Based on the "clear" and "unambiguous" language of the policy, and the allegations of the Complaint and Amended Complaint, TL&A was not required to report Plaintiff Smith's claims in 2008 and this Court should find that the 2010 reporting of Plaintiff Smith's Second Amended Complaint, alleging negligence, triggered ALPS' duty to defend and indemnify TL&A.

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<sup>1</sup> TL&A maintained its policy of insurance continuously, through all relevant policy periods, through the filing of Plaintiff's Second Amended Complaint, alleging negligence in September 2010.

<sup>2</sup> The applicable policy reserves ALPS' right to recover against its insured any costs paid for any non-covered claim, including non-covered claims that are asserted together with a covered claim. App. 158, ALPS Policy of Insurance, at ¶ 1.2.1. The ALPS' policy contains the mechanism permitting ALPS to seek recovery from TL&A in the event that a jury would return a verdict awarding damages for any intentional or "non-covered" claim. This provision further favors a finding that coverage does exist based on Plaintiff's Smith amendment alleging negligence in 2010.

4.) *The Denial of Coverage Correspondences Sent From ALPS to TL&A Demonstrate ALPS' Acknowledgment That The Complaint And Amended Complaint Asserted Claims That Fell Within The Exclusions Of The Policy*

TL&A's contention that the Complaint and Amended Complaint did not trigger the claims-made provisions of the policy finds ample support in the coverage correspondences exchanged after TL&A's reporting of the claim in 2010. ALPS' correspondences denying coverage to TL&A relied, in part, on the contention that ". . . the allegations in the complaint . . . amount to a claim for conversion and demand for punitive damages." App., at p. 208. ALPS also sought to deny coverage for TL&A because "Mr. Smith seeks an accounting and repayment of amounts *allegedly misappropriated* by you . . . and . . . Mr. Smith's claims appear to fall within the scope of the Policy's exclusions for claims based on *improper handling* . . ." See, *June 23, 2010 ALPS Correspondence*, App., p. 172 (also, App., p. 256) (emphasis added). After the second amendment to the Complaint to assert a claim for negligence, ALPS continued to contend that "Smith's primary claim remains that Ms. Tabor Lindsay received and mishandled funds intended for the Trust, funds that Smith seeks to recover." App., at p. 269. ALPS further stated, after the amendment alleging negligence, that "[f]inally, I note that several of the Policy exclusions originally cited in our June 23 letter correspondence remain applicable to this claim notwithstanding the latest amendment. In particular, the Policy's express exclusion of coverage for any claim based on or arising out of any "conversion, misappropriation or improper comingling by an person of client or trust account funds or property . . ." App., p. 269.

5.) *The Attempted Application of The Claims-Made Provisions Of The ALPS' Policy Of Insurance To Conduct Excluded Under the Policy Renders Coverage Illusory to TL&A*

ALPS' Respondent's Brief is in agreement with TL&A that illusory coverage has been defined by this Court to include situations 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.'"

*Respondent's Brief*, at pg. 24, citing *Boggs v. Camden-Clarke Memorial Hospital*, 225 W. Va. 300, 314-15, 693 S.E.2d 53, 66-67 (2010). The clear and unambiguous policy language states that the policy would not “apply” to claims sounding in misappropriation and improper handling of client funds. It is further undisputed that Plaintiff originally alleged that TL&A had misappropriated and/or improperly handled Plaintiff’s settlement funds. It is also not disputed that ALPS denied coverage in 2010, at least in part, premised upon allegations of misappropriation and/or improper handling.

ALPS’ position throughout this litigation has been that the claims-made portion of the policy must “apply” to deny coverage to TL&A. This position has been maintained despite the policy language stating that the policy, including the claims-made provisions, did not apply to the allegations asserted in the Complaint and Amended Complaint. West Virginia has long held that language in an insurance contract should be given its plain, ordinary meaning. *Blankenship v. City of Charleston*, 223 W. Va. 822, 827, 679 S.E.2d 654, 659 (1997). The plain meaning of the language cited above, and relied by ALPS at pages seven (7) and eight (8) of its Respondent’s Brief, confirms that ALPS policy is illusory as to TL&A, because the policy provisions conflict in such a way as to deny coverage for a claim of negligence asserted when an ALPS’ policy of insurance was in full effect during the 2010 policy period. See, App., at pp. 163-164.

6.) *ALPS’ Contention That There Was No Evidence That It Would Have Denied Coverage In 2008 Had The Claim Been Reported Is Directly Contradicted By The Evidence of Record*

ALPS half-heartedly contends that had TL&A reported Mr. Smith’s suit in 2008, the policy language addressing an “act, error, or omission in the performance of professional services” would have “clearly encompassed the type of allegations made by Mr. Smith against TL&A in all three complaints.” *Respondent’s Brief*, at pg. 25. This representation is directly contradicted by ALPS June 23, 2010 correspondence, cited above, which seeks to disavow coverage based on Plaintiff

Smith's allegations of misappropriation and mishandling client funds. See, App., p. 172; App., p. 256.<sup>3</sup> Additionally, in its October 19, 2010 Correspondence ALPS stated the following:

The final basis for ALPS coverage determination was the exclusion in the policy for claims ***“arising from or in connection with . . . any dishonest, fraudulent, criminal, malicious, or intentionally wrongful act, error, or omission committed by an insured.”***

App., p. 270; *October 19, 2010 Correspondence From ALPS to TL&A* (emphasis added). ALPS also noted that it believed coverage was excluded for “any dispute over fees or costs or any claim that seeks, whether directly or indirectly, the return, reimbursement or disgorgement of fees, costs or other funds improperly held by an insured.” *Id.*, pg. 269. The cited language of the policy clearly implicates intentional conduct by ALPS' insureds. In sum, these correspondences from ALPS confirm that ALPS would have denied coverage in 2008 even if the claim was reported to ALPS. These lead to the inescapable conclusion that, under the unique facts of this case, ALPS coverage was illusory as to TL&A.

TL&A could not control the allegations asserted by Plaintiff Smith in his Complaint and Amended Complaint. As a result, when covered allegations were finally asserted, TL&A was left with no recourse and no coverage. Under these unique facts, the ALPS' policy provides illusory coverage because the “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.’” *Boggs v. Camden-Clarke Memorial Hospital, supra*. The illusory coverage provided by ALPS confirms that the decision granting summary judgment was in error.

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<sup>3</sup> The Respondent's Brief somehow contends that ALPS never attempted to deny coverage premised on allegations of “intentional conduct” in the first two complaints. (“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.”) *Respondent's Brief*, at pg. 26 (emphasis in original). The correspondences cited above note the significant discrepancy between the position taken in Respondent's Brief and the actual denial of coverage letters sent to TL&A.

B.) The Illusory Nature of Coverage Provided By The ALPS' Policy Is Confirmed Through ALPS Contention That There Were Allegations Of Negligence In the Complaint and Amended Complaint

1.) *Correspondences Sent From ALPS Rely On Exclusions Sounding In Intentional Conduct To Deny Coverage*

The Respondent's Brief attempts to place reliance on a May 20, 2010 correspondence where TL&A reported Mr. Smith's claim to ALPS for support of the proposition that TL&A viewed Plaintiff's Smith's claims as sounding in negligence. *Respondent's Brief*, at pg. 4. ALPS argues at page five (5) of its Brief that ALPS receipt of the Second Amended Complaint via correspondence, dated October 1, 2010, was of no consequence because TL&A had already characterized Mr. Smith's claims as based in negligence. *Id.*, at 5. These assertions are not supported by the evidence of record. In its order granting summary judgment, the Circuit Court summarily noted that "[i]n fact, however, TL&A itself had previously characterized Mr. Smith's claim as based in alleged negligence." App., p. 393. This contention is directly contradicted by the correspondences sent from ALPS to TL&A, denying insurance coverage. This unsupported factual finding by the Court alone warrants a finding that there were material issues of fact warranting a denial of summary judgment in favor of ALPS. "Any fact that has the capacity to sway the outcome of the pending litigation under applicable law is a 'material fact.'" Syl. Pt. 5, *Jividen v. Law*, 194 W. Va. 705, 461 S.E.2d 451 (1995).

Critical for purposes of ALPS' contention that it considered all of Plaintiff Smith's Complaints sounding in negligence is that there is not a single correspondence from ALPS to TL&A in which ALPS states that it was analyzing all three (3) complaints as if they alleged claims for negligence. To the contrary, all written documentation sent from ALPS to TL&A following the reporting of the claim in 2010, states that ALPS did not believe coverage existed because the allegations fell within the exclusions of the policy for claims sounding in some form of intentional conduct. App., 77, 208; 172-190; 267-270. In fact, the only reference to ALPS viewing the original complaint and amended

complaint as sounding in negligence was during the deposition of Robert Tamerler, ALPS' Rule 30(b)(7) deponent. App., p. 277: 15-278: 7 (also, App., at p. 310, 638-15-639: 7).<sup>4</sup> His deposition was completed after the exchange of all correspondences between ALPS and TL&A related to coverage.

ALPS' position in this litigation, in part, has been that TL&A was required to report Plaintiff Smith's claim during the original 2008 reporting period, and because the claim was not reported until a later policy period, coverage did not exist. Correspondence provided by ALPS after it received notice of Plaintiff Smith's claims also contended that separate grounds for the denial of coverage exist. *See, June 23, 2010 correspondence from ALPS Coverage Counsel, to Pamela Tabor Lindsay*, App., pp. 172-190 (also, App., pp. 256-264).<sup>5</sup> Through its simultaneous assertion of a denial of coverage through the strict requirements of the claims-made provisions of the ALPS insurance policy and for claims premised upon non-covered, intentional conduct, ALPS has provided coverage that is illusory in consideration of Plaintiff Smith's subsequent assertion of a negligence claim in 2010 and the discovery obtained in the underlying action.<sup>6</sup>

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<sup>4</sup> Tamerler directly contradicted his own testimony later in his deposition:

Q: Can you point to a document anywhere within the ALPS claims file or the ALPS records repository where at any time a letter was sent to the Lindsays advising them that ALPS view of the first Complaint was that it was a negligence complaint?

A: No.

App., p. 713; *Deposition of Tamerler*, at pg. 82, lines 13-19.

<sup>5</sup> ALPS June 23, 2010 correspondence noted the following: (1) "Unfortunately, coverage is not available for Mr. Smith's claims because, *among other things*, they were not 'first made . . . and first reported' during the effective policy period . . ." (2) ". . . Mr. Smith seeks an accounting and repayment of amounts *allegedly misappropriated* by you . . ." (3) ". . . Mr. Smith's claims appear to fall within the scope of the Policy's exclusions for claims based on *improper handling* . . ." *See, June 23, 2010 ALPS Correspondence*, App., p. 172 (also, App., p. 256) (emphasis added).

<sup>6</sup> The contradiction in ALPS' position is further noted in the October 19, 2010 correspondence from coverage counsel for ALPS' to TL&A following the filing of the Second Amended Complaint alleging negligence. In the correspondence, ALPS coverage counsel, at footnote 1, stated, in part:

Whether the second amended complaint indeed set forth a genuine claim for "negligence" is

Under ALPS' theory denying coverage, whether TL&A had reported this claim in 2008 is irrelevant as ALPS maintained that there were entirely separate grounds for the denial of coverage for TL&A in 2008, premised on allegations of non-covered conduct. Consequently, any reporting of the claim by TL&A in 2008 would have resulted in a denial of coverage by ALPS.

2.) *Case Law From Other Jurisdictions Requires The Reporting Of A "Covered" Claim To Deny Coverage*

ALPS has attempted to portray a broad consensus across most jurisdictions that claims-made policies eliminate coverage if an initial complaint is not reported to the insurer within the policy period in which the claim is first made. A more thorough review of case law from other jurisdictions finds a multitude of nuanced positions that have rejected the drastic and harsh application of the policy language that ALPS asks this Court to accept. Other jurisdictions have held that an insured should not be penalized for not reporting a claim that does not constitute a "covered" claim pursuant to a claims-made policy of insurance. In *National Union Ins. Co. v. Willis*, 139 F.Supp.2d 827 (S.D. Texas 2001), the Federal District Court for the Southern District of Texas noted that "Fifth Circuit precedent supports the notion that for a claim or potential claim to trigger the notice requirement of a "claims-made" policy, *it must relate to the type of loss covered by the policy.*" *Id.*, at 832, citing *FDIC v. Mijalis*, 15 F.3d 1314, 1333-34 (5<sup>th</sup> Cir. 1994) (emphasis added). In *Mijalis*, the 5<sup>th</sup> Circuit Court of Appeals noted while analyzing whether a letter from the FDIC recommending uninsured penalties was a covered claim pursuant to the applicable insurance policy "it would be incongruous

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questionable. None of the key allegations contained in the original complaint—including those that are fundamentally inconsistent with any claim of negligence—have been altered in the current amendment.

App. p. 267.

to hold that the threat of an uninsured loss could nevertheless constitute a claim within the meaning of that term as used in an insurance policy.” *Mijalis*, at 1334.<sup>7</sup>

The *Willis* decision is instructive to the instant analysis because it first required a finding that a claim was “covered” pursuant to the policy of insurance before the claims-made provisions of the policy became operable. In this case, ALPS has continually treated the claims in the original and amended complaints as falling within the exclusions of the policy. The correspondences sent from ALPS to TL&A purport to deny coverage on the basis of the reporting requirement **and** the policy exclusions and relief sought by Plaintiff. For these reasons, the claims-made provision of the policy should not have been applied until the filing of the Second Amended Complaint, alleging negligence. The order granting summary judgment from the Circuit Court leaves an insured with no recourse in those very limited circumstances where an original complaint contains allegations not covered under a claims-made policy of insurance and the claim is not reported. This further provides only illusory coverage to the insured. Other courts have noted that “claims-made” policies trigger coverage “*if the negligent or omitted act is discovered and brought to the attention of the insurer within the policy term.*” *United States Fire Ins. Co., v. Fleekop*, 682 So.2d 620 (Fla. App. 1996) citing *Gulf Ins. Co. v. Dolan, Fertiz & Curtis*, 433 So.2d 512, 514 (quoting 7A Appleman, Insurance Law & Practice § 4504.01 at 312 (Berdal ed. 1979)). As acknowledged by ALPS in its coverage denial letters, is undisputed that Plaintiff Smith’s Complaint and Amended Complaint sounded in non-covered, intentional conduct, which was excluded under the ALPS’ policy of insurance. This Court should find that coverage is present pursuant to the allegations of negligence and subsequent timely reporting of the Second Amended Complaint.

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<sup>7</sup> The court in *Willis* ultimately denied the request for coverage, finding that the original claim was a “covered” claim and should have been reported during the policy period it was first made.

C.) Other Jurisdictions Have Recognized Strict Application of the Claims-Made Policy Provision Can Frustrate The Reasonable Expectations of the Insured

- 1.) *The Extended Reporting Options in ALPS' Policy of Insurance Offer Further Evidence That ALPS' Policy of Insurance Should Have Provided For Insurance Coverage Based On The Timing of ALPS' Reporting of Plaintiff Smith's Suit to ALPS*

While ALPS has asked this Court to apply the clear and unambiguous language of the policy, it has ignored several portions of the policy which support a finding of coverage for defense and indemnification in favor of TL&A. Section 4.4 of ALPS' Policy of Insurance contains information for extended reporting of claims by an ALPS's insured. Pertinent for purposes of this appeal is Section 4.41 which provides:

In the event of expiration of this policy, or cancellation *or non-renewal* of the Name Insured or the Company, and except as otherwise provided herein, the Named Insured shall have the right, upon written request to the Company and upon payment of the additional premium specified herein not more than thirty days after the termination of the policy, to have the Company issue an extended reporting endorsement.

App., p. 166, *ALPS' Policy of Insurance*, pg. 10 of 14. (Emphasis added). This Court has previously recognized the doctrine of *expressio unius est exclusio alterius*. The doctrine has been defined by this Court to mean the express mention of one thing implies exclusion of another. *State Farm Mut. Auto Ins. Co. v. Rutherford*, 2011 U.S. Dist. LEXIS 318 (W. Va. 2011), citing Syl. Pt. 3, in part, *Bischoff v. Francesa*, 133 W. Va. 474, 56 S.E.2d 865 (1949). Because ALPS expressly chose to include "non-renewal" of the policy as one of those circumstances mandating the purchase of an extended reporting endorsement, the policy must exclude a "renewal" as a circumstance which demands such a purchase of an extended reporting requirement to permit the reporting of a claim after a given policy period.

This position has been relied upon by Ohio courts to find that insurance coverage should not be denied to an insured, pursuant to a claims-made policy of insurance, despite allegations that the claim was not timely reported within the initial policy period. See, *Helberg v. National Union Fire*

*Ins. Co.*, 102 Ohio App.3d 679, 682-683, 657 N.E.2d 832 (1995); *see also*, *Professionals Direct Ins. Co. v. Wiles*, 2009 U.S. Dist. 109998, at \*51-\*52 (S.D. Ohio. 2009). In *Helberg*, the Court of Appeals of Ohio reversed a trial court decision which strictly applied the terms of a claims-made policy of insurance. The appellate court found that coverage should exist noting that “[t]he insured merely renewed his claims-made policy. Such an event should not precipitate a trap wherein claims spanning the renewal are denied.” *Id.*, at 682.<sup>8</sup>

Importantly, some courts have required that the insurer include language in their policy of insurance, which provides clear and unequivocal notice to the insured that claims first made during an initial policy period and ultimately reported during a subsequent policy period are not covered. It is undisputed that TL&A renewed its policy continuously from 2007 through 2010, which spanned all relevant policy periods in which Plaintiff Smith filed his original Complaint, Amended Complaint, Second Amend Complaint and TL&A reported the claim to ALPS. The plain reading of Section 4.41 of the Policy, cited above, confirms that an insured would expect coverage because the policy was maintained for all critical events related to Plaintiff Smith’s claims.

ALPS expressly chose to include the “non-renewal” of the policy as a basis requiring the purchase an extended reporting endorsement, which would extend the reporting period for claims first made within the policy period. Consequently, an insured who “renews” his or her policy would reasonably expect that there was no need to purchase an extended reporting endorsement to later report a claim.

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<sup>8</sup> The Ohio appellate court relied, in part, on language in the applicable policy of insurance stating that coverage applies “to any claims arising out of any acts or omissions occurring prior to the effective date of the first policy issued to the named insured by this Company and *continuously renewed thereafter* if any insured on such date knew or should have reasonably foreseen that such acts or omissions might be expected to be the basis of a claim or suit.” *Id.*, at 682. (emphasis added).

2.) *The Lack of Clear Language In the ALPS' Policy Informing Insureds About How Subsequent Amendments To A Complaint Would Be Treated Pursuant To The Claims-Made Provisions of The Policy Mandates A Finding That Plaintiff Smith's Second Amended Complaint Was Timely Reported*

In *Professionals Direct Ins. Co. v. Wiles*, 2009 U.S. Dist. LEXIS 109998 (S.D. OH 2009), the Federal District Court for the Southern District of Ohio was asked to rule on a declaratory judgment action filed by Professionals Direct Insurance Company (“PDIC”) in which it sought a declaration that it had no duty to defend or indemnify the defendant law firm from claims asserted in a pending lawsuit. Important for purposes of this Court’s analysis is the reference to policy language at issue in *Wiles*, which stated:

All claims arising out of a single, act, error or omission or a series of related acts, errors or omissions arising from the rendering of or failure to render professional services on behalf of a single client shall be deemed to be one claim and to be first made when the first of such claims is made.<sup>9</sup>

*Id.*, at \*7. The insurance policy at issue in *Wiles* included the cited language, presumably to avoid the type of dispute now before the Court, where a later amendment to an original complaint may be made, which changes a theory of relief from a non-covered claim to a covered claim. Had ALPS included such a provision in their policy of insurance, the analysis to be applied by the Circuit Court and this Court would be more clear. It is not disputed that ALPS has no similar provision in its

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<sup>9</sup> The ALPS’ policy, under Section 4.2, “Limit of Liability”, at 4.2.5, contains the following provision, which is inapplicable to the “claims-made” provisions of the policy:

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 or claimants, or the number of Insureds, *shall be considered a single claim for purposes of this section*, and shall be subject to the same single “each claim” limit of liability, aggregate limit of liability, and claim expense allowance.

(emphasis added). The plain reading of the above cited section of the policy only mentions its application “for purposes of this section” which only addresses the limits of liability. To the extent ALPS would attempt to extend its application to the provisions of the policy addressing the claims-made provisions of the policy, such an argument must be rejected. At page seven (7) of its Response Brief, ALPS attempts to contend that Section 4.2.5 may be applicable to the claims reporting obligations of the policy. A review of the entire policy reveals the fatal fault in ALPS’ attempt to extend the applicability of this section of the policy.

policy of insurance. In consideration of the allegations in the Complaint and Amended Complaint, a reasonable insured could view a right to timely report the Second Amended Complaint in 2010 when it had been continuously insured since the filing of the original complaint in 2008.<sup>10</sup>

The court in *Wiles* ultimately found that the insured should be excused from the strict reporting requirements of the claims-made provisions of the policy of insurance. The court in *Wiles* noted that when reading the policy as a whole, the extending reporting provision in the policy included the option for “non-renewals” of the policy. Because the applicable policy had been renewed during all pertinent policy periods, the court reasoned that the policy had to provide coverage because it had been renewed, thus constituting a circumstance which did not require the purchase of an extended reporting endorsement. *Id.*, at \*51-\*52.<sup>11</sup>

This Court has previously noted the analysis to be applied to policies of insurance:

When deciding cases concerning the language employed in an insurance policy, we look to the precise words employed in the policy of insurance. As a general rule, we accord the language of an insurance policy its common and customary meaning. That is, “[l]anguage in an insurance policy should be given its plain, ordinary meaning.” *Horace Mann Ins. Co. v. Adkins*, 215 W. Va. 297, 301, 599 S.E.2d 720, 724 (2004) (internal quotations and citations omitted). We accept the plain meaning of the policy provisions under review, without interpretation or construction, except where ambiguity warrants such further consideration of the policy language. “Where the provisions of an insurance policy are clear and unambiguous they are not subject to judicial construction or interpretation, but full effect will be given to the plain meaning intended. Syllabus, *Keffer v. Prudential Ins. Co.*, 153 W. Va. 813, 172 S.E.2d 714 (1970).” Syl. Pt. 2, *West*

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<sup>10</sup> Mr. Tameler, ALPS’ 30(b)(7) deponent, testified that if you are one second late in reporting, you have no coverage, yet he proceeded to testify that if there are sequential coverage periods, the strict requirement that claims be reported during the coverage period in which they were made is relaxed. *See, Transcript of Deposition of Robert Tameler*, App., at 734:5-735:7. He did not specify how they would be relaxed or articulate any “bright-line” rule for a cut-off in this type of scenario. Without any bright-line rule about reporting claims in a subsequent policy period, this creates an issue of fact, which requires a finding of error in the Circuit Court’s award of summary judgment in favor of ALPS.

<sup>11</sup> The court in *Wiles*, citing *Helberg*, *supra*, noted that when evaluating notice that is arguably untimely under a claims-made policy of insurance, there must be a determination of whether the late notice was “reasonable.” The Court in *Wiles* held that “[g]enerally, reasonableness of late notice is a fact issue.” *Wiles*, at \*55. As a review of the docket sheet in the instant case demonstrates, there was minimal activity in the matter *sub judice* prior to the report of TL&A to ALPS in 2010. While TL&A would assert that there was no prejudice to ALPS resulting from the timing of the reporting to it, this creates an issue of fact for resolution before the Court further demonstrating the error of the circuit court in granting summary judgment in favor of ALPS.

*Virginia Fire & Cas. Co. v. Stanley*, 216 W. Va. 40, 602 S.E.2d 483 (2004). On the other hand, [w]henver the language of an insurance policy provision 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, it is ambiguous.” Syl Pt. 1, *Prete v. Merchants Prop. Ins. Co. of Indiana*, 159 W. Va. 508, 223 S.E.2d 441 (1976). Further, [w]here a provision in an insurance policy is ambiguous, it is construed against the drafter, especially when dealing with exceptions and words of limitation.

*Boggs v. Camden-Clark Mem. Hosp. Corp.*, at 304-305; 57-58. Because there is no language in the ALPS’ policy of insurance concerning the treatment of multiple or subsequent claims arising from a single alleged act, error or omission, the ALPS’ policy of insurance is “reasonably susceptible of two different meanings” and “reasonable minds might be uncertain or disagree as to its meaning.” *Id.* Consequently, these factors render the specific provision of the policy ambiguous. This ambiguity requires the to construe the policy against ALPS and find that TL&A did timely report Plaintiff Smith’s claim in 2010.<sup>12</sup>

The United States Court of Appeals for the Eleventh Circuit, in *Cast Steel Products, Inc. v. Admiral Ins. Co.*, 348 F.3d 1298 (11<sup>th</sup> Cir. 2003), overturned a decision of the district court that strictly applied a claims-made policy of insurance to deny coverage to an insured. The court in *Cast Steel* found the applicable policy ambiguous and therefore to be construed against the insurer. *Id.*, at 1300. The court noted that the “[d]istrict court’s decision presents a somewhat alarming scenario. Faced with two consecutive insurance policies that created apparently seamless coverage over two policy periods, the court nonetheless found that a claim accruing within the two periods was somehow not covered by either policy.” *Id.*, at 1301. While the reporting of the claim to the insurer in *Cast Steel* was admittedly closer in time to the expiration of the original policy period during which the claim was made in this case, the court further noted the following:

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<sup>12</sup> The Respondent’s Brief argues that TL&A has not asserted that the ALPS’ policy of insurance is ambiguous. See, *Respondent’s Brief*, at pg. 15. This is not true. TL&A asserted in its initial brief that it contended the policy was ambiguous. See, *Brief on Behalf of Petitioners, Richard D. Lindsay and Pamela Lindsay d/b/a Tabor Lindsay & Associates, In Support of Their Petition for Appeal*, at pg. 36. (hereafter, “*Appeal Brief*”).

Though we are sympathetic to the rationale of *Pantropic*, [*Pantropic Power Prods., Inc v. Fireman's Fund Ins. Co.*, 1141 F. Supp.2d 1366 (S.D. Fla 2001)] and would generally agree that the lower premium charged for a claims-made policy should entitle an insured to lesser coverage than a broader, and more expensive occurrence policy, we find it both illogical and inequitable to deny coverage to the insured who chooses to renew its claims-made policy for successive years with the same insurer . . .

*Id.*, at 1303-1304. In a recent unpublished opinion, the Supreme Court of Kentucky, in *AIG Domestic Claims, Inc., et al v. Tussey, et al*, 2010 Ky. App. Unpub. LEXIS 741 (2010), citing the decision in *Cast Steel*, held:

[w]e believe the policy evidences that it was the expectation of the parties that renewal of the policy carried with a continuation of coverage. The “discovery period” provision in the policy states that only if the policy is cancelled or National Union refuses to renew the policy, can coverage be extended by the payment of an additional premium. Thus, following the logic argued by National Union, renewal of the policy leaves the insured with no means of protecting against claims made after the first policy expired. This conclusion is both illogical and inequitable.

*Id.*, at \*9. The above cited decisions confirm that strict application of the claims-made provisions of an insurance policy are not uniform across all jurisdictions. Based on the unique facts of this case, strict application of the claims-made provisions of the policy frustrates the reasonable expectations of the insured and denied coverage where TL&A would reasonably expect it to be present. The review of the policy language and cases from other jurisdictions demonstrate that the Circuit Court erred in granting summary judgment in favor of ALPS.

D.) The Clear Language In the Policy of Insurance and Precedent From Other Jurisdictions Supports The Position That TL&A Was Entitled To A Defense From TL&A Upon Reporting of Plaintiff Smith's Claims in 2010

In addition to its duty to fully indemnify TL&A, ALPS also was required to defend TL&A after being placed on notice of the suit filed by Plaintiff Smith. West Virginia subscribes to the majority position that the duty of an insurer to defend is broader than the duty to indemnify. See, *Aetna Casualty & Property Company v. Pitrolo*, 176 W. Va. 190, 194, 342 S.E.2d 156, 160 (1986). It is also well-established that an insurer's duty to defend is tested by whether the allegations in the plaintiff's complaint are “reasonable susceptible of an interpretation that the claim may be covered

by the terms of the insurance policy. *Camden-Clark Memorial Hospital Association v. St. Paul Fire and Marine Insurance Co.*, 224 W. Va. 228, 682 S.E.2d 566 (2009). This Court has previously noted that:

An insurance company's duty to defend is dependant solely on the allegations in the complaint. These allegations must state or claim a cause of action for the liability insured against or for which indemnity is paid in order for the suit to come within any defense coverage of the policy. Thus, for there to be a duty to defend, there must be allegations in the complaint which would fall within coverage afforded under the policy

....

*Aluise v. Nationwide Fire Ins. Co.*, 218 W. Va. 498, 507-508, 625 S.E.2d 260, 269-270 (2005), quoting, *Qualman v. Bruckmoser*, 163 Wis.2d 361, 471 N.W.2d 282, 284-285 (Wis. Ct. App. 1991). ALPS has taken the position that allegations of negligence were read into each of the three (3) complaints. See, App., at p. 277:15-278:7 (also, App., at 310, 638:15-639:7).

ALPS has asked this Court to sanction its contradictory position that it read allegations of negligence into the all three (3) complaints to avoid a duty to defend and indemnify TL&A following the filing of Plaintiff Smith's Second Amended Complaint, while at the same time contending that there are coverage defenses based on allegations of non-covered conduct. The contention that there was no coverage for alleged non-covered conduct would negate a duty to defend and indemnify ALPS. If ALPS truly believed the Complaint and Amended Complaint contained allegations of negligence, it should have triggered a duty to at least defend TL&A, until such time as the Circuit Court made a determination as to whether there was coverage pursuant to the ALPS' policy of insurance. ALPS did not defend TL&A at any point in this litigation.

As previously noted, ALPS' Response Brief placed heavy reliance on the specific language of the ALPS' policy of insurance to support the contention that there was no duty to defend and indemnify TL&A. The specific language of the policy unequivocally supports the position that ALPS had a duty to defend TL&A. The pertinent policy language states:

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 **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 . . .

App., at 284 (all emphasis in original). It is beyond dispute that the above cited language of the policy *only references the claims-made provisions applicability to the payment of “damages.”*<sup>13</sup> The “claim expenses” are those expenses generated from the defense of a suit.<sup>14</sup> It is not disputed that the term “claim expenses” is not included within Section 1.1 of the Policy which defines the purported “claims-made” terms of the policy. Further, there is no reference in the policy about the “claims-made” provisions being made applicable to the “defense” of insureds.

When the clear and unequivocal policy language cited above is analyzed in conjunction with West Virginia’s long-held maxim that the duty to defend is broader than the duty to indemnify, it is clear that ALPS had a duty to defend TL&A without any consideration or reference to the claims-made provisions of the policy. Consequently, the Circuit Court erred by finding that ALPS did not have a duty to defend TL&A. ALPS is also estopped from asserting that they had no duty to defend

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<sup>13</sup> The term “damages” is defined in the policy to mean “any monetary award by way of judgment or final arbitration, or any settlement, but does not include:

- 2.6.1 punitive, multiple, or exemplary damages, fines, sanctions, penalties or citations; or
- 2.6.2 awards deemed uninsurable by law; or
- 2.6.3 injunctive, declaratory, or other equitable relief, or costs or fees incident thereto; or
- 2.6.4 restitution, reduction, disgorgement or set-off of any fees, costs, consideration or expenses paid to or charged by an Insured, or any other funds or property presently or formerly held by an Insured.

App., at 286-287.

<sup>14</sup> The policy of insurance separately defines “claims expenses” to mean:

- 2.4.1 fees charged by an attorney(s) designated by the Company to defend a claim or otherwise represent an Insured; and
- 2.4.2 all other fees, costs, and expenses resulting from the investigation, adjustment, defense, and appeal of a claim (including a suit or proceeding arising in connection therewith), if incurred by the Company, or by the Insured with prior written consent of the Company

App., at 286-287.

TL&A based on the testimony of Tamer that ALPS read allegations of negligence into all three complaints. See, App., at p. 277:15-278:7 (also, App., at 310, 638:15-639:7). Negligence claims would be covered under the applicable policy of insurance. It would be illogical to permit ALPS to argue that they read negligence into the claims of all three (3) complaints in this case, and at the same time disavow its duty to defend TL&A because there were allegations of conduct which were excluded. The Circuit Court erred by permitting ALPS to selectively change the theory of relief contained in the respective complaints based on whether ALPS is attempting to disavow their duty to indemnify TL&A or their duty to defend.

After receiving notice of Plaintiff Smith's suit, ALPS did not defend its insured, subject to a reservation of rights and did not file a declaratory judgment action seeking a determination of its rights and obligations under the applicable policy of insurance. Even after Plaintiff Smith amended his Complaint to assert a claim for negligence, ALPS did not file a declaratory judgment action and did not assume the defense of its insured. Instead, it forced its insured to file a third-party complaint against ALPS in order to determine the insured's rights and obligations pursuant to the applicable policy of insurance.

Other jurisdictions have recognized that an insurer has a duty to defend an insured, even if the insurer plans to invoke the timeliness provisions of a claims made insurance policy. See, *Uhlich v. Nat'l Union Fire Co.*, 398 Ill. App. 3d 710, 929 N.E.2d 531 (2010). Relying on Illinois law, the court in *Uhlich* held that the general rule of estoppel provides that an insurer that takes the position that a complaint does not allege a covered claim under a policy, which includes a duty to defend, may not simply refuse to defend the insured. *Id.*, at 716, citing *Employers Insurance of Wausau v. Ehlco Liquidating Trust*, 186 Ill.2d 127, 150, 708 N.E.2d 1122, 237 Ill. Dec. 82 (1999). In those instances, the insurer had two options: (1) defend the suit under a reservation of rights or (2) seek a declaratory judgment that there is no coverage. If the insurer fails to take either of these two steps

and is later found to have wrongfully denied coverage, the insurer is estopped from raising policy defenses to coverage. *Uhlich, supra*, citing *Ehlco*, 186 Ill.2d at 150-151. The *Uhlich* decision also recognized that “there is no exception to the estoppel doctrine for late-notice defenses” and held that “[i]f an insurer believes that it received notice too late to trigger its obligations, it should defend its insured under a reservation of rights or litigate the matter in a declaratory judgment action.” *Uhlich*, at 719-720, citing *Ehlco*, at 154.

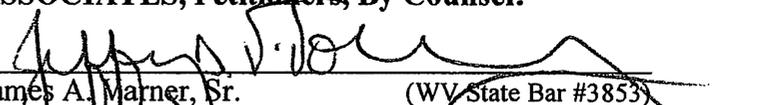
Because the policy language does not include the obligation of the duty to defend as requiring adherence to the claims-made provisions of the policy, the Circuit Court erred in granting summary judgment in finding that ALPS did not owe a duty to defend TL&A. TL&A requests that this Court find that ALPS did have a duty to defend TL&A and because the duty to defend was improperly denied.

**CONCLUSION**

Based on the foregoing, TL&A respectfully renews its request that this Court find that the Circuit Court erred in granting summary judgment in favor of ALPS because of the information and arguments contained herein. TL&A respectfully requests that this Court find that ALPS had a duty to defend and indemnify TL&A..

Respectfully submitted this 30th day of April, 2012.

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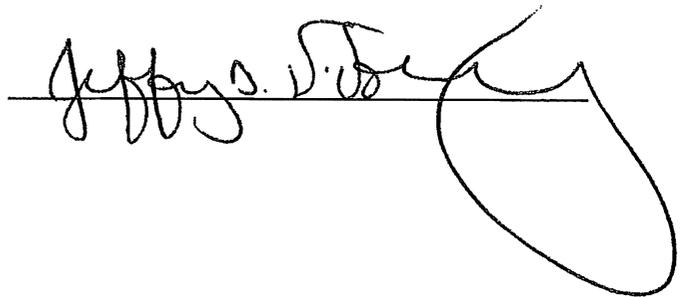
*(Counsel of Record)*

McNeer, Highland, McMunn and Varner  
Of Counsel

**CERTIFICATE OF SERVICE**

This is to certify that on the 30th day of April, 2012, the undersigned counsel served the foregoing ***“REPLY BRIEF ON BEHALF OF PETITIONERS, RICHARD D. LINDSAY and PAMELA LINDSAY d/b/a TABOR LINDSAY & ASSOCIATES, IN FURTHER SUPPORT OF THEIR PETITION FOR APPEAL (re: Petitioners' Notice of Appeal from an Order of the Circuit Court of Kanawha County Entered on October 26, 2011)”*** upon counsel of record by depositing true copies in the United States Mail, postage prepaid, in envelopes addressed as follows:

Marc E. Williams, Esquire  
Randy L. Saunders, Esquire  
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949 Third Avenue, Suite 200  
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***Counsel for Third-Party Defendant,  
Attorneys Liability Protection Society, Inc.***

A handwritten signature in black ink, appearing to read "Jeffrey S. Williams", is written over a horizontal line. The signature is stylized and includes a large, looped flourish extending to the right.