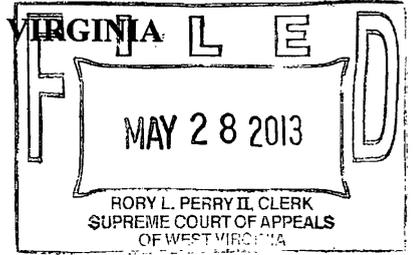


IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA



**National Union Fire Insurance Company
of Pittsburgh, Pa., Third-Party Defendant Below,
Petitioner,**

v.

No. 13-0215

**Dan Cava, Steven Hall, and Dan's Car World,
LLC, d/b/a Dan Cava's Toyota World,
Third-Party Plaintiffs Below, Respondents.**

Petitioner's Brief

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 2. The lower court erred by finding that the EEOC Charge and the Complaint constitute separate and distinct Claims even though they arise from the same transaction or occurrence.

 3. The lower court erred by finding that the Policy is ambiguous and must be strictly construed in favor of coverage.

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ASSIGNMENTS OF ERROR

1. **THE LOWER COURT ERRED IN IGNORING THE POLICY'S INSURING AGREEMENT UPON WHICH NO COVERAGE EXISTS FOR FLUKER'S CLAIM AND BY IMPROPERLY APPLYING THE BURDEN OF PROOF AGAINST NATIONAL UNION TO SUPPORT ITS POSITION THAT NO COVERAGE EXISTED FOR FLUKER'S CLAIM.**
2. **THE LOWER COURT ERRED BY FINDING THAT THE EEOC CHARGE AND THE COMPLAINT CONSTITUTE SEPARATE AND DISTINCT CLAIMS EVEN THOUGH THEY ARISE FROM THE SAME TRANSACTION OR OCCURRENCE.**
3. **THE LOWER COURT ERRED BY FINDING THAT THE POLICY IS AMBIGUOUS AND MUST BE STRICTLY CONSTRUED IN FAVOR OF COVERAGE.**
4. **THE LOWER COURT ERRED IN FINDING THAT THE REASONABLE EXPECTATIONS OF DAN'S CAR WORLD, LLC MANDATE THE EXISTENCE OF INSURANCE COVERAGE WITH RESPECT TO THE CLAIM ASSERTED BY FLUKER.**
5. **THE LOWER COURT ERRED BY FINDING THAT NATIONAL UNION SUFFERED NO PREJUDICE AS A RESULT OF THE EEOC CHARGE FILED BY FLUKER, WHICH WAS DISMISSED IN FAVOR OF THE TOYOTA WORLD APPELLEES BECAUSE A SHOWING OF PREJUDICE TO NATIONAL UNION IS NOT REQUIRED UNDER THE POLICY OR THE LAW.**

STATEMENT OF THE CASE

This appeal involves the lower court's January 24, 2013 order ("the Order") denying National Union Fire Insurance Company of Pittsburgh, Pa.'s ("National Union") motion for summary judgment and granting judgment as a matter of law in favor of Dan Cava, Steven Hall, and Dan's Car World, LLC d/b/a Dan Cava's Toyota World ("Appellees") with respect to liability insurance coverage for allegations asserted against them by Johnnie Fluker, Jr. ("Fluker").(A.R. 0710-0722)¹ National Union requests that this Court reverse the erroneous

¹ References to the Appendix Record—the contents of which were agreed to by the parties—are set forth as "A.R. 0001-0730."

decision of the lower court and find that no liability coverage exists for Fluker's claims against Appellees.

Appellee Toyota World was insured under a "claims-made-and-reported" liability insurance policy provided by National Union for the policy period of February 27, 2009 to February 27, 2010 (the "Policy"). (A.R. 0324-0383) Sometime in April 2007, Appellees allegedly terminated Fluker's employment after Fluker had an altercation with a co-worker, Sonny Nicholson ("Nicholson"). (A.R. 0001-0008) On or about July 20, 2007, Fluker brought an Equal Employment Opportunity Commission ("EEOC") Charge of Discrimination against Toyota World alleging that his employment had been wrongfully terminated in connection with the April 2007 employee altercation ("altercation"), and that he was the victim of racial discrimination and retaliation in connection with the altercation. (A.R. 0543-0544) The EEOC Charge was contested by Appellees and was eventually dismissed and closed by the EEOC. (A.R. 0310-0311, 0583-0584) The EEOC issued Fluker a "Dismissal and Notice of Rights" letter (that was carbon copied to Appellees) on May 30, 2008. (A.R. 0583-0584) Neither Appellees nor their counsel, Gregory Schillace, notified National Union or any of its agents of the EEOC Charge or the Dismissal and Notice of Rights. (A.R. 0399-0401)

On or about April 3, 2009, Fluker filed his Complaint against the Appellees in this lawsuit ("Complaint"), alleging that he was subjected to a racially hostile work environment at Appellees' business, that his employment had been wrongfully terminated in connection with the altercation, that he was the victim of racial discrimination and retaliation in connection with the altercation, that the termination of his employment was a breach of an employment agreement, and that the Appellees had violated West Virginia Code § 21-5-4 by failing to pay certain

moneys owed to him upon his termination. (A.R. 0001-0008)² While the Complaint, which repeated the allegations previously made in the EEOC Charge, was reported to National Union on or about April 7, 2009, Appellees had never previously advised National Union or any of its agents of the July 2007 EEOC Charge. (A.R. 0320) Because Fluker's Claim (as defined by the Policy) was first made against Appellees when he filed his EEOC Charge in July 2007, prior to the inception date of the Policy, and was not reported to National Union until April 2009, National Union denied coverage on the grounds that the Claim was not made and reported during the February 27, 2009 to February 2010 Policy period as mandated by the Policy's Insuring Agreement. (A.R. 0399-0401)

On December 2, 2010, Appellees filed a Third-Party Complaint against National Union alleging bad faith and violations of the West Virginia Unfair Trade Practices Act. (A.R. 0009-0017) The Third-Party Complaint alleges that National Union has failed to defend Appellees in the action by Fluker. (A.R. 0009-0017) As a result, Appellees have requested compensatory damages, attorneys' fees, and punitive damages. (A.R. 0009-0017)

In response, National Union filed a Counterclaim requesting a declaratory judgment that no liability insurance coverage exists under the National Union insurance policy for Fluker's Claim against Appellees and Nicholson. (A.R. 0018-0037) Additionally, National Union requested a declaration that it owed no duty to defend Appellees and Nicholson regarding the allegations made by Fluker against those parties in the original Complaint. (A.R. 0018-0037)

National Union moved for summary judgment on the issue of coverage, and by Order entered January 24, 2013, the lower court denied National Union's motion for summary judgment and concluded that coverage existed under the Policy for Fluker's Claim against

² Sonny Nicholson was sued by Fluker, but Nicholson did not, in turn, sue National Union. "Appellees" does not include Sonny Nicholson.

Appellees. (A.R. 0291-0439, 0595-0643, 0694-0691, 0709-0722) It is from this Order that National Union appeals.

SUMMARY OF ARGUMENT

The lower court's finding that insurance coverage existed for Fluker's Claim against Appellees is based upon an incorrect analysis of the "claims-made-and-reported" insurance policy at issue. The Insuring Agreement of that Policy requires that claims made against an insured be both made and reported to the insurer within the same policy period in order for coverage to apply. Although Fluker's Claim was reported to National Union during the February 27, 2009 to February 2010 policy period, the Claim was first made against Appellees when Fluker filed his EEOC Charge in April 2007, almost two years prior to the inception of the Policy. Thus, the Claim was not made and reported within the policy period. Appellees, as insureds, had the burden to prove the Policy's Insuring Agreement was triggered, but failed to do so. Thus, the lower court was incorrect in ruling that coverage existed for the Claim.

Moreover, the Policy is not ambiguous and the lower court erroneously considered the reasonable expectations of the insurance agent, Mark Pallotta. The doctrine of reasonable expectations does not provide for consideration of the reasonable expectations of an insurance agent. Even assuming *arguendo* that the lower court was correct in a finding of ambiguity and the reasonable expectations analysis was relevant, it is the reasonable expectations of the insured (Appellees) that is to be considered. There is absolutely no evidence that Appellees had a reasonable expectation of coverage for Fluker's Claim against them, and Mark Pallotta's reasonable expectations of coverage are irrelevant. Further, there is no evidence that Mark Pallotta expressed any expectation of coverage to Appellees. Thus, no ambiguity exists in the Policy and the lower court should have applied the clear Policy language as set forth within the

Insuring Agreement without regard to the reasonable expectations analysis to find that National Union correctly denied coverage for Fluker's Claim against Appellees.

STATEMENT REGARDING ORAL ARGUMENT AND DECISION

This case meets the criteria for oral argument under Rule 20 of the Rules of Appellate Procedure and a published, non-memorandum, decision because it involves several issues of first impression for this Court and several issues of key public policy concerns for insurers offering insurance coverage in this State.

This Court has recognized the difference between "occurrence" policies and "claims-made" insurance policies. *See, Auber v. Jellen*, 196 W. Va. 168, 175, 469 S.E.2d 104, 111 (1996). In addition, the Court has recently expressed its views concerning "claims-made-and-reported" insurance policies in the recent memorandum decision of Lindsay v. Attorneys Liab. Protection Soc'y, Inc., 2013 WL 1776465 (W. Va. April 25, 2013). However, this Court has not otherwise issued any precedent regarding "claims-made-and-reported" insurance policies.

This appeal involves the interpretation of a "claims-made-and-reported" insurance policy. Specifically, the appeal includes questions regarding reporting provisions under "claims-made-and-reported" insurance policies. Therefore, precedent is warranted because this case significantly impacts insurance carriers who issue such "claims-made-and-reported" insurance policies in this State as well as the consumers who purchase those insurance policies.

Therefore, a comprehensive public hearing and fully analyzed published decision is warranted in this case.

ARGUMENT

1. THE LOWER COURT ERRED IN IGNORING THE POLICY'S INSURING AGREEMENT UPON WHICH NO COVERAGE EXISTS FOR FLUKER'S CLAIM AND BY IMPROPERLY APPLYING THE BURDEN OF PROOF AGAINST NATIONAL UNION TO SUPPORT ITS POSITION THAT NO COVERAGE EXISTED FOR FLUKER'S CLAIM.

In finding that coverage applied to Fluker's Claim against Appellees, the lower court erroneously ignored the Policy's Insuring Agreement, and instead, focused on the duty to defend and the principle that an insurer must prove facts necessary to exclude coverage.³ Rather, National Union's denial was due to Appellees' failure to comply with the clear and conspicuous reporting terms of the Insuring Agreement as contained within the "claims-made-and-reported" Policy issued to Appellees. While exclusionary language was addressed in the Petitioner's Motion for Summary Judgment, Appellees never met their burden of proving coverage under the Policy's Insuring Agreement and the lower court did not address any of the exclusionary language. Specifically, National Union denied coverage on the grounds that the Claim was not made and not reported during the Policy Period as mandated by the Policy's Insuring Agreement.

In an insurance coverage dispute such as this, it is important for the Court to begin its analysis by determining the type of insurance coverage dispute at issue so that the correct legal standard can be applied. Here, the initial dispute to be determined by the Court, before turning to other Policy conditions or exclusions, is whether the insured Appellees can prove that the terms of the **Insuring Agreement itself** were satisfied in order to trigger coverage for Fluker's Claim against the Appellees.

³ The lower court initially ruled on Petitioner's motion by letter of December 5, 2013. (A.R. 0692-0693) Petitioner submitted objections to Appellees proposed order, primarily asserting that the proposed order did not "identify any exclusionary language" that was to be construed, that it contained findings of fact not supported by reference to exhibits, transcripts or deposition testimony, and additionally, it contained facts that were extraneous to the lower court's ruling. (A.R. 0694-0704) As such, Petitioners are placed in a position of having to speculate as to the lower court's rationale.

In its Order, the lower court erred in failing to address the requirements of the Policy's Insuring Agreement and the marked distinctions associated with a "claims-made-and-reported insurance policy." Additionally, it was further error for the lower court to find coverage based on the court's assertion, and strict construction against National Union, of exclusionary Policy language (which was never even identified or addressed) and without regard to an initial finding of coverage under the Insuring Agreement.

In its Order, the lower court stated that "[a]n insurance company seeking to avoid liability through the operation of an exclusion has the burden of proving the facts necessary to the operation of that exclusion." (A.R. 0717) Moore v. CNA Ins. Co., 214 W. Va. 286, 599 S.E.2d 709 (2004). The court also noted that exclusionary policy language is strictly construed against insurers. (A.R. 0717) *See*, Nat'l Mut. Ins. Co. v. McMahon & Sons, Inc., 177 W. Va. 73, 356 S.E.2d 488 (1987) *overruled on other grounds by* Potesta v. U.S. Fid. & Guar. Co., 202 W. Va. 308, 504 S.E.2d 135 (1998). The court further noted that an insurer's duty to defend is broader than the duty to indemnify and must be liberally construed when a question exists regarding an insurer's obligations. (A.R. 0717) *See*, Tackett v. Am. Motorist Ins. Co., 213 W. Va. 524, 584 S.E.2d 158 (2003).

However, the lower court misconstrued the burden of proof at issue in this case. Although the insurer does bear the burden of proving exclusions, the Appellees bear the burden of first proving coverage under the Policy's Insuring Agreement. National Union denied coverage because the basic requirements of the Insuring Agreement were not satisfied by Appellees. This Court has clearly held that the insured bears the initial burden of "prov[ing] both the existence of an applicable insurance contract and its material terms." Syl. pt. 1, Camden-Clark Mem'l Hosp. Ass'n v. St. Paul Fire and Marine Ins. Co., 224 W. Va. 228, 682

S.E.2d 566 (2009). “It is only when the plaintiffs have established a *prima facie* case of coverage that the burden of production shifts to the defendants.” Payne v. Weston, 195 W.Va. 502, 506, 466 S.E.2d 161, 165 (1995). Clearly, that burden was not met here as Appellees never initially established a *prima facie* case of coverage under the Insuring Agreement.

The first page of the Policy (Declarations) states, in pertinent part, conspicuously and in an all capitalized, bolded font that:

COVERAGE WITHIN THIS POLICY IS GENERALLY LIMITED TO LOSS FROM CLAIMS FIRST MADE AGAINST INSURED DURING THE POLICY PERIOD AND REPORTED TO THE INSURER AS THE POLICY REQUIRES.

(A.R. 0324) The Insuring Agreement of the Policy’s EPL (Employment Practices Liability)

Coverage Section states as follows (in relevant part):

With respect to the Insuring Agreement and the Defense Provisions of this Clause 1, solely with respect to **Claims** first made during the **Policy Period** or the **Discovery Period** (if applicable), and reported to the **Insurer** pursuant to the terms of this policy, and subject to the other terms, conditions and limitations of this policy, this **EPL Coverage Section** affords the following coverage:

This **EPL Coverage Section** shall pay the **Loss** of an **Insured** arising from a **Claim** first made against such **Insured** for any **Wrongful Act**.

(A.R. 0353)

The Policy specifically defines the term **Claim** to include:

“(iii) [a]n administrative or regulatory investigation when conducted by the Equal Employment Opportunity Commission (“**EEOC**”), or similar state, local or foreign agency, which is commenced by the filing of a notice of charges, service of a complaint or similar document of which notice has been given to the Insured.”

(A.R. 0353) Within the Policy, the reporting of Claims as a condition precedent for coverage under the Policy is reiterated:

The **Insureds** shall, as a condition precedent to the obligations of the **Insurer** under this policy, give written notice to the **Insurer** of any **Claim** made against

an **Insured** or a **Crisis Management Event** as soon as practicable after: (i) the **Company's** Risk Manager or General Counsel (or equivalent position) first becomes aware of the **Claim**; or (ii) the **Crisis Management Event** commences, but in all events a **Claim** must be reported no later than either:

(i) anytime during the **Policy Period** or during the **Discovery Period** (if applicable); or

(ii) within ninety (90) days after the end of the **Policy Period** or the **Discovery Period** (if applicable).

(A.R. 0334)

Thus, the Insuring Agreement of the Policy is triggered only when a Claim, including any EEOC Charge, is made during the policy period and reported in accordance with the requirements of the Policy. Here, Appellees never proved that Fluker's Claim against them was made and reported during the Policy Period to trigger coverage under the Insuring Agreement. In fact, it is clear from the record that Fluker's Claim against Appellees was first made in July 2007, prior to the inception date of the Policy, when Fluker filed his EEOC Charge. (A.R. 0543-0544) The EEOC Charge is defined as a "Claim" under the Policy. (A.R. 0353)

Although Fluker's April 2009 Complaint against Appellees was reported to National Union during the policy period, the Claim was actually first made in July 2007 when Fluker filed his EEOC Charge making the exact same allegations later to be repeated in his April 2009 Complaint. Thus, the Claim was **not made and reported** during the Policy Period (a critical requirement of any "claims-made-and-reported" insurance policy) and the Policy Insuring Agreement was not triggered.

In addition to the lower court ignoring the prerequisite of first establishing coverage under the Policy's Insuring Agreement, the lower court also ignored the very significant distinction between "occurrence" insurance policies and "claims-made-and-reported" insurance policies. In doing so, the lower court disregarded plain and conspicuous terms of this Policy

which “should be given [their] plain, ordinary meaning.” Syl. pt. 1, Soliva v. Shand, Morahan & Co., 176 W.Va. 430, 345 S.E.2d 33 (1986), *overruled, in part, on other grounds by* Nat’l Mut. Ins. Co. v. McMahon & Sons, 177 W.Va. 734, 356 S.E.2d 488 (1987).

This Court has previously recognized the distinction between “occurrence” and “claims-made” insurance policies in Auber v. Jellen, 196 W. Va. 168, 469 S.E.2d 104 (1996). However, it has yet to issue an opinion regarding the distinction between “occurrence” and “claims-made-and-reported” insurance policies. Nonetheless, in an April 2013 memorandum decision the Court affirmed summary judgment for insurer Attorneys Liability Protection Society, Inc. (“ALPS”) finding that no coverage existed under a “claims-made-and-reported” insurance policy because the insured in that case (like the Appellees in our case) ignored the insurance policy requirements and failed to report the claim to ALPS within the same policy period in which the claim was first made. *See, Lindsay v. Attorneys Liab. Protection Soc’y, Inc.*, 2013 WL 1776465 (W. Va. April 25, 2013).

This Court noted that “a claims-made-and-reported policy, such as the policies at issue in [Lindsay], includes the additional requirement that the insurer be notified of the claim within the policy period.” *Id.* The Court further noted that “in a claims-made-and-reported policy, notice is the event that actually triggers coverage.” Lindsay at *1 quoting Pension Trust Fund for Operating Eng.’s v. Fed. Ins. Co., 307 F.3d 944, 956-957 (9th Cir. 2002).

The requirement that a claim be first reported to an insurer within the policy period in which the claim was made is a common feature of “claims-made-and-reported” insurance policies. In fact, many other jurisdictions have enforced such a requirement. *See, e.g., Gargano v. Liberty Int’l Underwriters, Inc.*, 572 F.3d 45 (1st Cir. 2009) (finding no coverage under a policy requiring that a claim be “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 the expiration of the policy in which the claim was made); Emp’rs Reinsurance Corp. v. Sarris, 746 F.Supp. 560 (E.D. Pa. 1990) (finding no coverage under similar policy language for claim made during policy period but not reported until four months after period expired).

The Lindsay case is analogous to the instant case. In Lindsay, the law firm of Tabor Lindsay & Associates (“the Lindsay firm”) was insured under a “claims-made-and-reported” policy with ALPS with a policy period of March 24, 2007 through March 24, 2008. Lindsay at *1. The Lindsay firm was sued in January 2008, during the policy period, for misappropriation of settlement proceeds. Id. Although the insuring clause of the policy required the Lindsay firm to report a claim within the policy period in which the claim was first made, the Lindsay firm did not report the lawsuit to ALPS within the policy period, but retained its own counsel to defend the claim. Id. at *1-3.

The Lindsay firm did not report the claim until two years after the lawsuit was first filed. Id. at *2. As a result, ALPS denied coverage because the claim was not reported during the same policy period in which the claim was first made as required by the insuring clause.⁴ Id.

This Court noted that the first page of the policy explained that the type of policy purchased was a “claims-made-and-reported” policy. Id. at *3. The Court also noted that the “policy placed an affirmative duty upon the insured to provide notice of any claim or potential claim of which the insured became aware.” Id. at *4. Furthermore, the Court recognized that the policy stated that “coverage was dependent upon a claim being ‘first made’ against the Lindsay firm and ‘first reported’ to ALPS during the policy period[.]” Id. This Court found that the policy language in this regard was not ambiguous in that it plainly required the Lindsay firm to

⁴ Coverage was also denied due to the nature of the claims against the Lindsay firm. Lindsay at *2.

report to ALPS when the claim was first made. Id. The Court found that the “[the Lindsay firm’s] failure to provide notice as required by the policy precludes coverage for that claim under the 2007 policy.” Id.

In addition, this Court rejected the Lindsay firm’s argument that an amendment of the complaint filed to include a negligence claim in September 2010 should be treated as a new claim for purposes of notice to ALPS. Id. The Court found that there was no new “claim” under the definition of the term “claim” in the policy. Id. Instead, the amended complaint “was founded on the same set of operational facts as the earlier complaints” and simply added a new theory based upon that set of facts. Id. Furthermore, this Court noted that the Lindsay firm could not provide notice under its renewed 2010 policy because that policy term was subsequent to the 2007 policy period when the Lindsay firm first knew about the lawsuit. Id. Thus, no coverage applied under the policy. Id.

The Lindsay case is analogous to the instant case in that the insurance policies at issue are both “claims-made-and-reported” insurance policies, which place an affirmative duty upon the insureds to report any claim or potential claim of which the insureds became aware. Like the insured law firm in Lindsay, here Fluker’s July 2007 EEOC Charge against the Appellees was not made and reported to National Union during the applicable policy period. Instead, Appellees chose to handle the EEOC Claim “in house” with their own personal counsel, Greg Schillace. Similar to the Lindsay firm failing to report a 2008 lawsuit until the suit was amended two years later, Appellees did not report the 2007 EEOC Charge to National Union until 2009, after the same allegations previously made in the EEOC Charge were repeated in the 2009 Complaint.

Similar to ALPS, National Union denied coverage to Appellees because the Claim was not made and reported within the same policy period as required under the Policy’s Insuring

Agreement. Thus, the lower court in the instant matter erred by ignoring the Insuring Agreement requirements and improperly shifting the burden of proof to National Union. Appellees never proved a *prima facie* case of coverage under the policy in accordance with West Virginia law. Likewise, the lower court put the cart in front of the horse construing exclusionary Policy language (which it failed to identify) against National Union for the purpose of finding coverage for Appellees before examining, determining or ever even addressing whether Appellees had met their burden to prove coverage under the Insuring Agreement. The lower court seemingly ignored the Policy's Insuring Agreement.

As a result, the lower court's Order is clearly erroneous because it ignored the Policy Insuring Agreement's plain language and Appellees' obligations pursuant to that language. The lower court's Order is also erroneous as it improperly shifted the burden of proof to National Union by incorrectly advancing to unidentified exclusionary provisions of the Policy without initially establishing coverage for Plaintiff's Claim. Therefore, this Court should reverse the Order.

2. THE LOWER COURT ERRED BY FINDING THAT THE EEOC CHARGE AND THE COMPLAINT CONSTITUTE SEPARATE AND DISTINCT CLAIMS EVEN THOUGH THEY ARISE FROM THE SAME TRANSACTION OR OCCURRENCE.

In its ruling regarding the coverage issues in this case, the lower court held that the EEOC Charge and the 2009 Complaint filed by Fluker arise from the same transaction or occurrence, but are separate and distinct claims. However, the lower court's Order contains no legal bases or Policy language to support its finding that the Complaint is a "new claim." Moreover, the lower court's finding is inconsistent with the as the EEOC Charge and the Complaint are not separate and distinct, but clearly arise from the same set of operational facts.

As previously noted above, the Policy's plain language indicates that a condition precedent to coverage is that Claims be first made during the Policy Period and reported within the terms of the Policy, i.e. during the Policy Period or no later than 90 days after the end of the Policy Period. The Insuring Agreement of the Policy further states that coverage will apply to a Claim first made against an insured for a "Wrongful Act." (A.R. 0353) The Policy defines **Wrongful Act** to include an **Employment Practices Violation**, which includes any actual or alleged:

- (i) wrongful dismissal, discharge or termination (either actual or constructive) of employment, including breach of an implied contract;
- (ii) harassment (including sexual harassment whether "quid pro quo", hostile work environment or otherwise);
- (iii) discrimination (including, but not limited to, discrimination based upon age, gender, race, color, national origin, religion, sexual orientation or preference, pregnancy, or disability);
- (iv) **Retaliation**[.]

(A.R. 0356, 0354)⁵

⁵ Exclusions do exist within the National Union Policy, were addressed in Petitioner's Motion for Summary Judgment, and apply to exclude coverage for the Claim made by Fluker, but Appellees were not initially entitled to coverage for Fluker's Complaint under the "claims made and reported" pursuant to the Insuring Agreement.

Exclusions 3(c) of The Policy states as follows:

The insurer shall not be liable to make any payment for **Loss** in connection with any **Claim** made against an **Insured**:

Alleging, arising out of, based upon or attributable to, as of the **Continuity Date**, any pending or prior: (i) litigation; or (ii) **EEOC** (or similar state, local or foreign agency) proceeding or investigation of which an **Insured** had notice, or alleging any **Wrongful Act** which is the same or **Related Wrongful Act** to that alleged in such pending or prior litigation or EEOC (or similar state, local or foreign agency) proceeding or investigation.

(A.R. 0356-0357)

Both the EEOC Charge filed in July 2007 and the Complaint filed in April 2009 allege the same “Wrongful Acts” of wrongful termination and discrimination arising out of Fluker’s April 2007 altercation with Sonny Nicholson. Recall that the Policy specifically defines the term **Claim** to include “[a]n administrative or regulatory investigation when conducted by the Equal Employment Opportunity Commission (“EEOC”).” (A.R. 0353) Here, Appellees had notice of the prior EEOC Charge and the Complaint that was later filed alleged the same Wrongful Acts.

In Fluker’s July 2007 EEOC Charge, he alleged that his employment had been wrongfully terminated in connection with the April 2007 employee altercation, and that he was the victim of racial discrimination and retaliation in connection with the altercation. (A.R. 0543-0544) Fluker’s Complaint makes the same allegations of “Wrongful Acts” as defined by the Policy. (A.R. 0001-0008, 0356, 0354)⁶ Thus, the lower court erred in finding that the Complaint was a “new claim.”

The Policy defines the term **Continuity Date** as February 27, 2009. (A.R. 0331) The Policy’s General Terms and Conditions also define “**Related Wrongful Act(s)**” as any **Wrongful Act(s)** “which are the same, related or continuous, or **Wrongful Act(s)** which arise from a common nucleus of facts. (A.R. 0332) **Claims** can allege **Related Wrongful Act(s)** regardless of whether such **Claims** involve the same or different claimants, **Insureds** or legal causes of action.” (A.R. 0332)

Additionally, the Policy excludes coverage for Claims that, as of February 27, 2009, allege or arise out of a prior EEOC investigation of which the insured had notice, or alleging any wrongful act (or related wrongful act) which is the same as that alleged in the prior EEOC investigation. (A.R. 0344-0345) Thus, even if Appellees had established coverage under the Insuring Agreement, coverage for Fluker’s Claim is excluded by Exclusion 3(c).

⁶ For example, Count II of Fluker’s Complaint describes the alleged disparaging comments made to Fluker: “I’m going to kick your black ass, N****r[.]” (A.R. 0004) “[Fluker] expected that his employer would correct a racial hostile work environment...[.]” (A.R. 0004) “[Fluker] was suspended and his employment wrongfully terminated[.]” (A.R. 0004) and, “When [Fluker] continued to object to the discrimination and racial hostile work environment, his employment was wrongfully terminated.” (A.R. 0004) Compare this to the July 2007 EEOC Charge of Discrimination wherein Fluker alleged, in part: “Mr. Nicholson came up close in my face and said to me, “I’ll whip your black ass, N****r[.]” (A.R. 0543) “On April 20, 2007, I was discharged from my position of Car Salesman[.]” (A.R. 0543) and, “I believe that the Respondent [Appellees] discriminated against me because of my race, black...” (A.R. 0544)

Remarkably, while the lower court found that the EEOC Charge and the Complaint both “are[use] from the same transaction or occurrence,” it did not factually, or legally, reconcile that finding with the Policy’s definition of a “Claim” or with the inconsistent finding that the Complaint was “separate and distinct” from Fluker’s EEOC Charge. (A.R. 0709-0722) In Syl. pt. 3, State ex rel. Taylor v. Nibert, 220 W.Va. 129, 640 S.E.2d 192 (2006) our Court held that “[C]laims and counterclaims **arise out of the same transactions or occurrence** when there is a **logical** relationship between the claim and counterclaim.” (citation omitted) (emphasis added). The “logical relationship” between Fluker’s 2007 EEOC charge and his 2009 Complaint is abundantly clear, the alleged disparaging treatment he received in his workplace as an African-American.

As this Court found in Lindsay that a newly asserted negligence allegation in an amended complaint did not constitute a “new claim” under the policy’s definition of the term “claim” for purposes of notice to ALPS, here this Court should reverse the lower court and find that the 2009 Complaint is not a “new claim” first made during the National Union Policy. Just like the amended complaint in Lindsay, Fluker’s Complaint was founded on the same set of operational facts as the earlier EEOC Charge. Furthermore, just like the amended complaint at issue in Lindsay, the claims assert in Fluker’s 2009 Complaint were not first made during the 2009-2010 Policy. They were first made in his 2007 EEOC Charge. The Appellees in this case could not report under the 2009-2010 Policy period, a 2007 Claim that they had previously failed to report. Clearly Appellees 2009-2010 Policy period was subsequent to the 2007 policy period when the Claim first started and Appellees first knew about the EEOC Charge.

Appellees admit that they did not report Fluker’ 2007 EEOC Charge to National Union. (A.R. 0440-0458) In fact, National Union was not made aware of the 2007 EEOC Charge until

after Fluker's Complaint was filed in 2009. (A.R. 0399-0401) Because Appellees ignored the plainly worded Policy requirements and chose not to report the claim within the policy period in which the Claim was made, National Union asserted that no coverage applies for this Claim and this Court should reverse the lower court's ruling.

3. THE LOWER COURT ERRED BY FINDING THAT THE POLICY IS AMBIGUOUS AND MUST BE STRICTLY CONSTRUED IN FAVOR OF COVERAGE.

The lower court relied upon the testimony of Mark Pallotta, the insurance agent who sold the Policy to Appellees, to find that the "policy purchased by Dan's Car World, LLC is ambiguous." (A.R. 0719-0720) Specifically, the lower court noted that Mr. Pallotta testified that one particular provision of the Policy was "difficult to understand, confusing and ambiguous." (A.R. 0709-0722) While, the lower court only cited this one Policy provision (a provision not relied upon by National Union in its denial) as ambiguous, the lower court then apparently extrapolated this single provision to find the entire Policy ambiguous. The particularly referenced section is Section 1 of the EPL Coverage under the Defense Provisions, which states:

The Insurer does not assume any duty to defend; provided, however, the **Named Entity** may at its sole option tender to the **Insurer** the defense of a **Claim** for which coverage is provided by this **EPL Coverage Section** in accordance with Clause Six of this **EPL Coverage Section**. Regardless of whether the defense is so tendered, the **Insurer** shall advance **Defense Costs** of such **Claim**, excess of the applicable Retention amount, prior to its final disposition.

(A.R. 0709-0722, 0353)

This Court has previously held that "[l]anguage in an insurance policy should be given its plain, ordinary meaning." *See, Soliva v. Shand, Morahan & Co., Inc.*, 176 W. Va. 430, 433, 345 S.E.2d 33, 35 (1986), *overruled in part on other grounds by Nat'l Mut. Ins. Co. v. McMahan & Sons*, 177 W. Va. 734, 356 S.E.2d 488 (1987) (finding that insurance policies that

limit coverage to “claims that are first made . . . during the policy period” to be unambiguous and enforceable.). “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.” Keffer v. Prudential Ins. Co., 153 W. Va. 813, 815-816, 172 S.E.2d 714, 715 (1970). Thus, the unequivocal notice conditions in a claims-made-and-reported policy cannot be subject to judicial construction or interpretation. *See*, Payne v. Weston, 195 W. Va. 502, 507, 466 S.E.2d 161, 166 (1995) (recognizing the well-settled principle of law that “this Court will apply, and not interpret, the plain and ordinary meaning of an insurance contract in the absence of ambiguity or some other compelling reason”).

The complexity of an insurance policy does not in and of itself create ambiguities. *See*, McCann v. Hobbs Lumber Co., 150 W.Va. 364, 370, 145 S.E.2d 476, 481 (1965). “The mere fact that parties do not agree to the construction of a contract does not render it ambiguous. The question as to whether a contract is ambiguous is a question of law to be determined by the court.” Syl pt. 1, Berkeley Cnty. Pub. Serv. Dist. v. Vitro Corp. of Am., 152 W. Va. 252, 162 S.E.2d 189 (1968).

The lower court found, in reliance upon Tackett v. Am. Motorist Ins. Co., 213 W. Va. 524, 584 S.E.2d 158 (2003), that it is within the court’s discretion to determine whether contract language is ambiguous, or otherwise, reasonably susceptible of two different meanings. However, the above-referenced section does not deal with coverage issues, but rather the Defense Provisions of the Policy. (A.R. 0353) An examination of the Policy’s Defense Provisions is only appropriate after it is established that coverage is provided under the Insuring Agreement and no exclusionary language applies. In this instance the Insuring Agreement was never triggered. In finding the Defense Provisions section of the Policy ambiguous, the lower

court again improperly shifted the burden of proof to National Union in failing to address any aspects of the Insuring Agreement or any other related sections of the Policy that are necessary for the initial establishment of coverage.

Clearly, the lower court blurred issues regarding its interpretation of the Policy's Defense Provisions with National Union's obligation to provide coverage for the loss under the Insuring Agreement. The Defense Provisions are separate and apart from the initial establishment of coverage under the Insuring Agreement. In fact, the Defense Provisions of the Policy are only triggered when coverage is found. Again, coverage was never established. Thus, the Defense Provisions were not triggered and the lower court erroneously interpreted these provisions in the context of providing coverage, absent any analysis of the Insuring Agreement.

The lower court also found ambiguous the Defense Provision's "retention" clause and the "issue of whether the insured was mandated to tender all claims within its retention to National Union." (A.R. 0709-0722) The lower court had to rely solely upon the Defense Provision language to reach this conclusion as there was no other Policy language referenced in the Order to establish the lower court's reasoning in reaching this conclusion. In fact, the lower court did not even reference Paragraph 5 of the EPL section of the Policy conveniently entitled "Retention Clause". (A.R. 0358)

The lower court's interpretations of the Defense Provisions as ambiguous erroneously "extend[ed] coverage beyond the terms of [the] insurance contract." Syl. pt. 5, Potesta v. U.S. Fid. & Guaranty Co., 202 W. Va. 308, 310, 504 S.E.2d 135, 137 (1998). The first page of the Policy plainly and unambiguously stated that the Insuring Agreement of the Policy extended coverage only to "loss from claims first made against an insured during the policy period and reported to [National Union] as the policy requires." (A.R. 0324) In addition, the Policy placed

an affirmative duty to provide notice of any claim as soon as practicable after becoming aware of the Claim, but no later than 90 days after the end of the Policy Period. (A.R. 0334)

There is simply no Policy language or provisions identified by the lower court's Order that can be reasonably susceptible of different meanings. Clearly the lower court did not identify the "claims made and reported" language of the Policy's Insuring Agreement to be either ambiguous or susceptible to different meanings. Moreover, this Court found a similar "claims-made-and-reported" insurance policy language to be unambiguous in Lindsay. See, Lindsay at *4. Thus, it was improper for the lower court to ignore the Insuring Agreement language and assert that the Policy was ambiguous as a whole, ostensibly based upon the Defense Provisions, and as such find in favor of coverage. This Court should reverse that finding.

4. THE LOWER COURT ERRED IN FINDING THAT THE REASONABLE EXPECTATIONS OF DAN'S CAR WORLD, LLC MANDATE THE EXISTENCE OF INSURANCE COVERAGE WITH RESPECT TO THE CLAIM ASSERTED BY FLUKER.

The lower court improperly held that the doctrine of reasonable expectations applies in favor of coverage because the Policy is ambiguous. First, as indicated above, the Policy language is not ambiguous. Second, there is absolutely no evidence that Appellees had a reasonable expectation that coverage would apply to Fluker's Claim against them and Nicholson.

According to this Court, "the doctrine of reasonable expectations is that the objectively reasonable expectations of **applicants** and **intended beneficiaries** regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." Syl. pt. 8 of Nat'l Mut. Ins. Co. v. McMahan & Sons, Inc., 177 W. Va. 734, 356 S.E.2d 488 (1987) (emphasis added). In McMahan, this Court noted that "[a]n insurance contract should be given a construction which a reasonable person standing in the shoes of the insured would expect the language to mean." Id. at 741. And, "[w]here an

insured has a reasonable expectation of coverage under a policy, he should not be subject to technical encumbrances of hidden pitfalls.” Id. at 742.

Moreover, this Court has noted that “[a] party to a contract has a duty to read the instrument.” Soliva at Syl. pt. 5; *see also*, Am. States Ins. Co. v. Surbaugh, 2013 WL 490809, *24-25 (W. Va. Feb. 6, 2013) (finding that the insurer fulfilled its obligation to bring a policy exclusion to the attention of the insured but that the insured failed to carry out his duty to read the policy). “Failing to read a policy . . . is not sufficient reason to hold a clear and conspicuous policy provision unenforceable.” Surbaugh, 2013 WL 490809 at *25 *quoting* Mission Viejo Emergency Med. Assocs. v. Beta Healthcare Group, 128 Cal.Rptr.3d 330, 338 (Cal.App. 4 Dist. 2011).

In Soliva, the plaintiff alleged that his “reasonable expectation” of coverage should have been given effect despite plan policy language limiting coverage to claims made during the policy period. However, the Court disagreed finding that, where the policy clearly and unambiguously limited coverage in such a way, “a man could not, having read this provision, reasonably expect the contract to provide such coverage.” Soliva, 176 W. Va. at 133, 345 S.E.2d at 36. Likewise, where an insurance policy unambiguously limits coverage to claims made and reported during the policy period, as in this case, no reasonable person could expect coverage to be available for a claim that was made prior to the issuance of the Policy.

There is simply no evidence that Appellees had a reasonable expectation of coverage under the 2009-2010 Policy for Fluker’s Claim of discrimination, wrongful termination and retaliation first made in 2007. Appellees were the applicants and intended beneficiaries of the insurance policy at issue. However, the lower court’s Order cites no evidence that **Appellees themselves** had a reasonable expectation of coverage. Instead, the lower court’s Order cites only

the deposition testimony of Appellees' insurance agent, Mark Pallotta, who expressed confusion regarding the Policy's Defense Provisions, not the Insuring Agreement or coverage issues. (A.R. 0709-0722, 0044-0067) The lower court erroneously considered Mr. Pallotta's testimony in spite of the fact that he was neither an applicant nor intended beneficiary of the Policy.

The reasonable expectations and opinions of Mr. Pallotta are completely irrelevant in regard to both alleged ambiguities of the Policy as well as the reasonable expectations of the insureds. Appellees presented absolutely no evidence to the lower court that any of the Appellees had a reasonable expectation of coverage. There was no testimony from Dan Cava or any of the other Appellees or representatives, no affidavits, and no documentation to offer any proof.

Moreover, there is no evidence or allegation that Mr. Pallotta created any expectations, reasonable or otherwise, in the minds of the Appellees. Specifically, there is no evidence that Mr. Pallotta conveyed to Dan Cava, or any other Appellee, any information that created any expectation that the Policy covered Fluker's Claim against them and Sonny Nicholson. There is also no evidence that Dan Cava or any other Appellee relied on any information provided by Mr. Pallotta to create a reasonable expectation of coverage. Where there is no evidence that Dan Cava or any other insured or intended beneficiary of the policy had a reasonable expectation of coverage, a reasonable expectation cannot be established through the expectations of an insurance agent.

There are simply no other findings of fact that can support the reasonable expectation holding of the lower court. Any representations by Mr. Pallotta that the lower court might have possibly relied upon were all *post hoc* representations and have no bearing upon whether Appellees had a reasonable expectation of coverage. There was no testimony by Mr. Pallotta,

Mr. Cava, or anyone else that Appellees specifically relied upon any pre-loss or post-loss representations of Mr. Pallotta in regard to coverage. (A.R. 0044-0067) As this Court has held, “representations of a soliciting agent of the insurer made subsequent to an accident for which recovery is sought under the policy, relating to coverage or liability afforded by the policy, are not binding on the insurer.” Syl. pt. 3, McGann v. Hobbs Lumber Co., 150 W. Va. 364, 145 S.E.2d 476 (1965). As a result, the doctrine of reasonable expectations does not apply and the Policy language should be interpreted as it is plainly written.

The Policy’s Insuring Agreement language clearly sets forth, without ambiguity, that an EEOC “administrative or regulatory investigation” is a Claim. *See, supra*. Such was the Claim made against the Appellees by Fluker in 2007 that was not reported to National Union until after Fluker filed his 2009 Complaint asserting the very same allegations. Appellees failed to comply with the clear terms of the Insuring Agreement. (A.R. 0353) However, instead of applying the unambiguous Policy language of the Insuring Agreement to determine if coverage even existed, the lower court appears to have bypassed the Insuring Agreement language to improperly arrive at the decision that the “reasonable expectations of Dan’s Carworld, LLC” mandate the existence of coverage. (A.R. 0720-0721) This Court should reverse that finding.

5. THE LOWER COURT ERRED BY FINDING THAT NATIONAL UNION SUFFERED NO PREJUDICE AS A RESULT OF THE EEOC CHARGE FILED BY FLUKER, WHICH WAS DISMISSED IN FAVOR OF THE TOYOTA WORLD APPELLEES BECAUSE A SHOWING OF PREJUDICE TO NATIONAL UNION IS NOT REQUIRED UNDER THE POLICY OR THE LAW

The lower court erroneously found that National Union was required to show that it was prejudiced by the actions of Appellees to support its position that there was no coverage for Fluker’s Claim. The lower court found a lack of prejudice to National Union as a result of

Appellees' late notice of the Claim.⁷ However, the lower court's finding of a "lack of prejudice" to National Union is an otherwise improper application of the law as it relates to "claims-made-and-reported insurance policies."

The parties agree that there is no West Virginia case law on point that addresses the "notice-prejudice" rule in relation to "claims-made-and-reported insurance policies." Although West Virginia law has not yet addressed this issue, the majority of jurisdictions have rejected the argument that an insurer must demonstrate prejudice before it may deny coverage based upon a failure to comply with the "claims-made-and-reported" requirements of these types of insurance policies. See, Gargano, 572 F.3d at 51 *quoting* Chas. T. Main, Inc. v. Fireman's Fund Ins. Co., 551 N.E.2d 28, 30 (Mass. 1990) (rejecting plaintiffs' assertion that the insurer must demonstrate prejudice from untimely notice in a "claims-made-and-reported" policy because to require such a demonstration "'would defeat the fundamental concept on which claims-made policies are premised,' with the likely result that" such policies would vanish); City of Harrisburg v. Int'l. Surplus Lines Ins. Co., 596 F.Supp. 954, 960 (M.D. Pa. 1984) (rejecting the plaintiffs' argument that "[there is a] duty upon the insurer . . . to show prejudice from the late notice before coverage can be denied"); Zuckerman v. National Union Fire Ins. Co., 495 A.2d 395, 405-406 (N.J. 1985) (rejecting an argument that the court should require the insurer to prove "appreciable prejudice" in order to avoid coverage in a case where a claim has not been reported until after expiration of the policy); T.H.E. Ins. Co. v. P.T.P. Inc., 628 A.2d 223, 228 (Md. 1992) (holding that a notice-prejudice provision did not apply to an insurer's denial of coverage under a claims-made policy for a claim made and reported after expiration of the policy period); 4th Street Investors LLC v.

⁷ While the lower court has addressed this as a "notice" issue, the issue for the purposes of coverage analysis under a "claims made and reported policy" is the insurance policy requirements that the claim be "made" and "reported" within the same policy period. Additionally, while prejudice is not a factor in the majority of jurisdictions as set forth herein, the Appellees raised the issue of a lack of prejudice to National Union. Therefore, it was necessary to address this issue in this appeal.

Dowdell, 2008 WL 163052, *5 (W.D. Pa. Jan. 15, 2008) (noting the majority rule that insurers need not demonstrate prejudice to deny coverage for late notice under claims-made insurance policies); Civic Assocs., Inc. v. Security Ins. Co. of Hartford, 749 F.Supp. 1076, 1082 (D.Kan. 1990) (holding that insurer would not have to demonstrate actual prejudice arising from late notice in order to enforce reporting requirement of “claims-made” policy); Trek Bicycle Corp. v. Mitsui Sumitomo Ins. Co. Ltd., 2006 WL 1642298 (W.D. Ky. June 7, 2006) (noting that the majority rule in jurisdictions that have addressed the application of the notice-prejudice rule to a claims-made policy is that failure to notify within the specified time will defeat coverage).

In rejecting the notice-prejudice rule in regard to “claims-made-and-reported” insurance policies, the majority of courts have recognized the differences between these types of insurance policies and occurrence insurance policies. Most Courts have found that “claims-made-and-reported” insurance policies are important in the insurance market. Occurrence insurance policies insure against the peril of the occurrence itself, which may not invoke coverage for some time after the occurrence. *See*, Zuckerman, 495 A.2d at 310-311. Alternatively, “claims-made” insurance policies insure against the peril of the making of the claim itself regardless of when the occurrence took place. *See*, Id. at 311.

Furthermore, the significance of a reporting provision is different in an occurrence based policy versus a “claims-made-and-reported” policy. In an occurrence policy, “notice provisions are written to aid the insurer in investigating, settling, and defending claims.” Dowdell, 2008 WL 163052 at *4. They “do not define coverage and should be liberally and practically construed.” Id. However, “[i]n a claims-made policy, the provision requiring notice before the end of the policy period . . . provides a certain date after which an insurer knows that it no longer is liable under the policy, and accordingly, allows the insurer to more accurately fix its reserves

for future liabilities and compute premiums with greater certainty.” City of Harrisburg, 596 F.Supp. at 962.

Consequently, in a claims-made type of policy, prejudice does not need to be shown in order for coverage to be denied because this type of policy “represents a distinct bargained-for exchange between insurer and insured. An insurer obtains the benefit of a clear and certain cut-off date for coverage. In return the insured typically pays a lower premium.” Emp’rs Reinsurance Corp. v. Sarris, 746 F.Supp. 560, 564 (E.D.Pa. 1990). Because liability does not extend beyond the end of a policy term, 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 and Curtis, 433 So.2d 512, 516 (Fla. 1983). *See also*, Chas. T. Main, 551 N.E.2d at 30 (finding that “[t]he 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) (noting that notice requirements in claims-made insurance policies allow insurers to “close [their] books” on insurance policies at expiration and thus to “attain a level of predictability unavailable under standard occurrence policies.”).

Likewise, “[i]n return for this certainty, an insured pays a lesser premium and receives broader coverage than under an occurrence policy because conduct occurring before the policy term is covered.” *See*, Gulf Ins. Co., at 516 (internal citation omitted). Thus, “[i]f a court were to allow an extension of reporting time after the end of the policy period, such is tantamount to an extension of coverage to the insured *gratis*, something for which the insured has not bargained.” Id. at 515-516. Such an extension of coverage by the court, which is “so very

different from a mere condition of the policy, in effect rewrites the contract between the two parties.” Id. In addition, “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, 495 A.2d at 406.⁸

In this case, because the reporting requirements in this “claims-made-and-reported” Policy define the scope of coverage, it was inappropriate for the lower court to rule that National Union had to demonstrate prejudice to its interests before denying coverage based upon Appellees’ failure to initially comply with the terms of the Insuring Agreement or, for that matter, to assert applicable exclusions if coverage was first found under the Insuring Agreement. Appellees were aware of the EEOC Charge, which falls squarely within the definition of a Claim, during the 2007 Policy period but did not report the Claim until after a Complaint was filed in 2009, well after the expiration of the 2007 Policy period. Because the claim was not “first reported” in the policy period in which it was “first made,” National Union correctly denied coverage. Moreover, as explained above, the filing of the Complaint in 2009 did not constitute a new claim that would entitle Appellees to coverage under the 2009-2010 Policy.

Furthermore, the lower court misapplied West Virginia law to the extent that it examined the legal issues presented in this matter as “prejudice to an insurer...[for] an alleged failure to notify the insurance carrier of a **potential claim.**” (A.R. 0718) The EEOC Charge was not a “potential claim.” To the contrary, it was a Claim as expressly defined under the terms of the insurance Policy, which Claim was not made and reported by written communication to the

⁸ See also, P.T.P. Inc., 628 A.2d at 227; 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 Wash. v. St. Paul Mercury Ins. Co., 660 F.Supp.2d 1208, 1213-1214 (W.D. Wash. 2009); Hasbrouck v. St. Paul Fire and Marine Ins. Co., 511 N.W.2d 364, 366-69 (Iowa 1993); Am. Cas. Co. of Reading, Penn. v. Continisio, 17 F.3d 62, 68 (3^d Cir. 1994); Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire and Marine Ins. Co., 891 P.2d 916, 921 (Ariz. App. 1994).

insurer during the Policy Period.⁹ Because the Claim was not made and reported to National Union during the 2009-2010 Policy Period as required by the terms of the Insuring Agreement, coverage was not triggered for Fluker's Claim of discrimination, wrongful termination and retaliation.

Although the majority of jurisdictions do not apply the notice-prejudice rule to "claims-made-and-reported" insurance policies, assuming, *arguendo*, that prejudice was the standard for a "claims-made-and-reported" policy, the lower court erroneously found that National Union did not identify any prejudice. In fact, National Union identified the need for an insured to report all claims that are made pursuant to the terms and conditions of a "claims-made-and-reported" policy. Also, as part of the bargained for agreement between an insurer and an insured, it is necessary that a Claim, such as Fluker's, be reported for both underwriting purposes and to preclude the expansion of coverage outside of defined policy terms. Likewise, if there is in fact an issue of prejudice to an insurer, it is a question of fact that should preclude summary judgment in Appellees favor. *See, Dairyland Ins. Co. v. Voshel*, 189 W. Va. 121, 428 S.E.2d. 542 (1993).

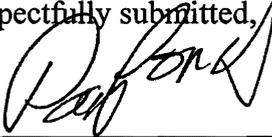
Regardless, the lower court's erroneous ruling that National Union suffered no prejudice for Fluker's Claim is clearly an improper application of the "notice-prejudice" rule to "claims-made-and-reported insurance policies." The ruling inappropriately expands coverage beyond the Policy's terms and conditions providing Appellees coverage for which they did not bargain and, in effect, rewriting the insurance contract between Appellees and National Union. The ruling also ignores well established insurance underwriting principle and the clear prejudicial effect of the costs incurred by National Union in litigating the matter herein. Thus, this Court should join the majority of jurisdictions and hold that a notice-prejudice requirement is not applicable when

⁹ "[a]n administrative or regulatory investigation when conducted by the Equal Employment Opportunity Commission ("EEOC")." (A.R. 0353)

coverage is denied on the basis of a claim (as defined within an insurance policy) not being made and reported in the same policy period under “claims-made-and-reported” insurance policies. In addition, this Court should reverse the lower court’s ruling in this regard.

CONCLUSION

For the reasons set forth herein, and for other reasons that may be apparent, this Court should reverse the lower court’s January 24, 2013 Order denying National Union’s motion for summary judgment and granting judgment as a matter of law in favor of Appellees. The issue should be remanded with instructions to enter summary judgment in favor of National Union.

Respectfully submitted,


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IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

**National Union Fire Insurance Company
of Pittsburgh, Pa., Third-Party Defendant Below,
Petitioner,**

v.

No. 13-0215

**Dan Cava, Steven Hall, and Dan's Car World,
LLC, d/b/a Dan Cava's Toyota World,
Third-Party Plaintiffs Below, Respondents.**

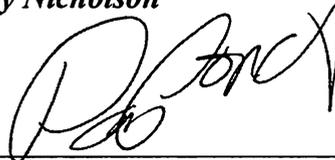
CERTIFICATE OF SERVICE

I, Don C. A. Parker, hereby certify that service of the foregoing **Petitioner's Brief** has been made upon counsel of record by placing a true copy thereof in the regular course of the United States Mail, with postage prepaid, on this 28th day of May 2013, addressed as follows:

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