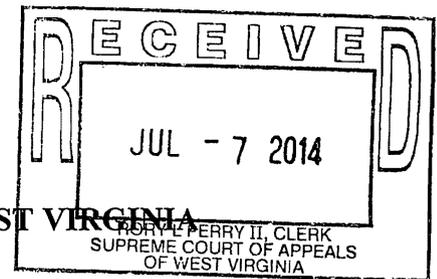


BRIEF FILED
WITH MOTION

14-0243
NO. ~~13-0692~~



IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

THE TRAVELERS INSURANCE COMPANY,

Defendant Below, Petitioner,

v.

**U.S. SILICA COMPANY,
FORMERLY KNOWN AS PENNSYLVANIA GLASS SAND CORPORATION,**

Plaintiffs Below, Respondents.

**From the Circuit Court of Morgan County, West Virginia
Civil Action No. 06-C-2**

**BRIEF OF THE WEST VIRGINIA INSURANCE FEDERATION
AS *AMICUS CURIAE* IN SUPPORT OF BRIEF OF PETITIONER
THE TRAVELERS INSURANCE COMPANY**

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I. INTRODUCTION

The terms of an insurance policy must govern the actions of the parties to the policy. The West Virginia Insurance Federation (the “Federation”) files this brief as *amicus curiae* in support of Petitioner The Travelers Indemnity Company, on behalf of The Travelers Insurance Company (“Travelers”).¹ This case has significant implications for insurers in West Virginia, the interpretation and application of insurance policies by West Virginia courts, and the duties of an insured and its insurer under the plain and unambiguous terms of insurance policies.

II. STATEMENT OF INTEREST

The Federation is the state trade association for property and casualty insurance companies doing business in West Virginia. Its members insure approximately 80% of the automobiles and homes in West Virginia and more than 80% of the workers’ compensation policies insuring West Virginia’s employees. The Federation is widely regarded as the voice of West Virginia’s insurance industry and has served the property and casualty insurance industry for more than thirty years. It has a strong interest in promoting a healthy and competitive insurance market in West Virginia to ensure that insurance is both available and affordable to West Virginia’s insurance consumers. The Federation files this brief in support of Travelers’ Petition to underscore the importance of honoring the express terms and provisions of a bargained-for insurance policy.

¹ Pursuant to Rule 30(b) of the Rules of Appellate Procedure, the Federation provided notice on July 1, 2014 to all parties of its intention to file an *amicus curiae* brief. Moreover, the undersigned counsel authored this brief in its entirety. Neither party nor their respective counsel contributed to or made a monetary contribution specifically intended to fund the preparation or submission of this brief. This disclosure is made pursuant to Rule 30(e)(5).

III. BACKGROUND

The Federation will rely largely on the parties' recitation of the facts and procedural history and highlight only the relevant interactions between the parties and the language of the relevant insurance policies as they implicate the broader insurance community.

A. **The Travelers' Policies**

The policies at issue in this appeal are three general comprehensive liability policies issued by Travelers to U.S. Silica's predecessor, Pennsylvania Glass Sand Corporation ("PGS") (collectively, the "Travelers' Policies"). The Travelers' Policies covered claims for the period from April 1, 1949 to April 1, 1958.

Under the terms of the Travelers' Policies, several restrictions were placed on covered claims. Specifically, the Travelers' Policies required that the insured (PGS and/or U.S. Silica) provide "immediate" notice of a claim or suit against the insured to Travelers ("Immediate Notice Provision") and that the insured abide by the Assistance and Cooperation of the Insured Clause ("Assistance and Cooperation Provision").

The Immediate Notice Provision states:

4. Notice of Claim or Suit. If claim is made or suit is brought against the insured, the insured shall immediately forward the company every demand, notice, summons or other process received by him or his representative. (JA 1032; JA 1047; JA 1062) (Emphasis Added).

In addition to the Immediate Notice Provision, the Travelers' Policies also contained a Assistance and Cooperation Provision that stipulated:

5. Assistance and Cooperation of the Insured . . . The insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for such immediate medical and surgical relief to others as shall be imperative at the time of the accident. Id. (Emphasis Added).

B. The Silica Claims

U.S. Silica defended and settled claims (the “Silica claims”) with Silica claimants who were allegedly harmed due to their exposure to U.S. Silica products and manufacturing processes from 1975 until at least 2005 when, on November 22, 2005, U.S. Silica informed Travelers that it had located Travelers’ Policies and was seeking reimbursement from Travelers for defense costs and settlements extended to Silica claimants. *See* Travelers’ Notice of Appeal, Nature of the Case.

U.S. Silica did not provide Travelers with actual copies of any of the claims made against it, allegedly covered under the Travelers’ Policies, until approximately 2008. In total, U.S. Silica demanded \$8,037,745 in defense costs and paid settlement funds.

Based on the explicit language contained in both the Immediate Notice Provision and Assistance and Cooperation Provision of the Travelers’ Policies, Travelers denied U.S. Silica’s demand for already-incurred defense costs and indemnification. Thereafter, U.S. Silica sued Travelers to recover its defense costs and the payments it previously made to Silica claimants.

IV. ARGUMENT

This Court should apply our state’s established rules interpreting insurance policies and give the Travelers’ Policies their intended effect. The Immediate Notice and Assistance and Cooperation provisions of the Travelers’ Policies are clear and unambiguous. The Circuit Court’s tortured interpretation of these provisions in order to find coverage in the face of contrary and express contract terms undermines the very basic notion that parties to a contract should be able to rely on their terms. The Court also erroneously applied a joint and several allocation method and should have applied a *pro rata* method to any award of damages in order to facilitate the expectations of the parties to the Travelers’ Policies.

A. U.S. Silica had a duty to comply with the terms of its insurance policies in order to benefit from the coverage the policies afforded; U.S. Silica did not satisfy conditions precedent to coverage.

The Immediate Notice Provision contained in the Travelers' Policies is clear and unambiguous. It required that the insured, U. S. Silica, provide notice to Travelers of claims made against it *immediately*. In this case, however, in violation of this requirement, U.S. Silica notified Travelers of the claims made against it more than *thirty years* after the first claims were filed and more than *forty years* after the Travelers' Policies expired. As such, this Court should reverse the Circuit Court's determination of coverage and give the language of the Immediate Notice Provision its intended effect. In the alternative, this Court should not permit the jury verdict to stand because, even if this Court finds that the language of the Immediate Notice Provision required interpretation by the lower court – which it did not – the jury's verdict amounts to an absurd construction of the insurance policy.

The law governing the interpretation of insurance policies in West Virginia is long established. This Court has held that insurance policies are governed by the same rules of construction that apply to other types of contracts. Payne v. Weston, 195 W. Va. 502, 506-07, 466 S.E.2d 161, 165-66 (1995). In addition, this Court has held that, “where a definite meaning has been ascribed to language used in an insurance policy, that meaning should be given to the language by the courts.” Joy Technologies, Inc. v. Liberty Mut. Ins. Co., 187 W. Va. 742, 421 S.E.2d 493 (1992). Even where a reviewing court must make a determination as to the meaning of the language of an insurance policy and thus to the intent of parties to the policy, however, “an insurance contract should be given a construction which a reasonable person standing in the shoes of the insured would expect the language to mean.” Riffe v. Home Finders Assocs., 205 W. Va. 216, 221, 517 S.E.2d 313, 318 (1999).

In West Virginia, these notice provisions are *conditions precedent* to coverage, and an insured's failure to provide notice results in the forfeiture of coverage. Colonial Ins. Co. v. Barrett, 208 W. Va. 706, 711, 542 S.E.2d 869, 874 (2000); Maynard v. National Fire Ins. Co. of Hartford, 147 W. Va. 539, 129 S.E.2d 443 (1963); Adkins v. Glob Fire ins. Co., 45 W. Va. 384, 32 S.E. 194 (1898). Insurers include notice requirements in their contracts because they need to know about the claims in order to, among other things, investigate, evaluate liability, pay or defend the claim, and establish reserves. This Court has acknowledged the value of these notice requirements: insurers need the opportunity to investigate claims when both the events in question and witness' memories are fresh, and they allow insurers to calculate their potential liabilities under a claim. Barrett, 208 W. Va. at 711, 542 S.E.2d at 874.

An insurer's denial of coverage under a policy where a policyholder fails to notify, or timely notify, an insurer, however, is not automatic. In order to deny coverage under an insurance policy, the insurer must demonstrate that it has been prejudiced by the policyholder's delay. Barrett, 208 W. Va. at 710, 542 S.E.2d at 873. Succinctly, this Court has held that, in reviewing an insurer's denial of liability under the notice provision of an insurance contract, reviewing courts should consider the following:

The length of the delay in notifying the insurer must be considered along with the reasonableness of the delay. If the delay appears reasonable in light of the insured's explanation, the burden shifts to the insurance company to show that the delay in notification prejudiced their investigation and defense of the claim. If the insurer can provide evidence of prejudice, then the insured will be held to the letter of the policy and the insured barred from making a claim against the insurance company. If, however, the insurer cannot point to any prejudice caused by the delay in notification, then the claim is not barred by the insured's failure to notify.

Syllabus Point 2, Dairyland Ins. Co. v. Voshel, 189 W. Va. 121, 428 S.E.2d 542 (1993).

Applying these rules here, it is clear that the Circuit Court erred in failing to rule as a matter of law that U.S. Silica's claims were barred by their failure to comply with the Immediate Notice Provision of the Travelers' Policies and immediately notify Travelers of the Silica claims.

First, Travelers clearly was prejudiced by U.S. Silica's failure to provide immediate notice of the claim. After a delay in notice of over thirty years on some of the Silica claims, Travelers cannot perform investigations into the merits of the claims. Even if Travelers were able to perform investigations into the claims, however, the credibility of the evidence gathered, including testimony from witnesses, would be greatly diminished. In addition, Travelers has been deprived of the ability to close its liability under policies that ended almost fifty years earlier. In short, Travelers has been stripped of its ability to defend claims made against U.S. Silica which U.S. Silica now claims coverage for under the Travelers' Policies. Instead, U.S. Silica has been permitted by the Circuit Court to recover reimbursement in excess of \$8,000,000 that it did not report to its insurer, thus depriving its insurer from the opportunity to defend the claims and limit its liability. Travelers and U.S. Silica bargained for the language of the policy and, under that language, U.S. Silica was to give Travelers notice of any claims immediately so that Travelers could defend its interest. By failing to immediately notify Travelers, U.S. Silica breached their duty under the Travelers' Policies.

Also relevant to this Court's analysis under Dairyland, however, is that U.S. Silica did not provide a "reasonable" explanation for its breach of the Travelers' Policies. It is undisputed that the Silica claims U.S. Silica seeks compensation and coverage for began in 1975. Instead of immediately notifying Travelers as is required under the express terms of the Travelers' Policies, however, U.S. Silica waited over forty years after coverage under the Travelers' Policies expired,

all the while paying out over \$8,000,000 in Silica claim settlements and defense fees, before informing Travelers of at least a portion of the claims.

In short, there is no reasonable explanation for waiting over forty years to report at least a portion of the claims. Even if this court finds that there is some reasonable explanation, however, the prejudicial effect of the delay in notifying Travelers has completely stripped Travelers of its ability to defend the Silica claims and limit its liability as bargained for under the clear terms of the Travelers' Policies.

In addition to U.S. Silica's breach of the language of the Travelers' Policies and inability to provide a reasonable explanation for a delay of, in some cases, more than thirty years, allowing the jury's verdict to stand would give an effect to the policy language that no reasonable person would expect. U.S. Silica did not bargain for an open ended notification policy. Instead, U.S. Silica, in exchange for its appropriately-priced premium, agreed to notify Travelers *immediately* of any claims made against it. Had U.S. Silica chosen to bargain for a policy devoid of notification requirements, it would not be required to provide a rationale for its delay. Here, however, U.S. Silica attempts to skirt the express terms of the Travelers' Policies and enjoy coverage in excess of the bargain it struck with Travelers under the Travelers' Policies.

U.S. Silica failed to uphold its bargained-for responsibilities under the Travelers' Policies when it failed to notify Travelers of the Silica claims immediately. Further, Travelers has been significantly prejudiced by U.S. Silica's delay and U.S. Silica can provide no reasonable explanation for a delay of, in some cases, over thirty years in reporting claims to Travelers. As such, this Court should give effect to the clear and unambiguous language of the insurance policy

and overturn both the jury verdict and Circuit Court rulings that leave the language of the Travelers' Policies devoid of its intended meaning.

B. U.S. Silica's payment of claims is a violation of the clear, unambiguous language of the Assistance and Cooperation Provision contained in the Travelers' Policies.

Much like it did when it failed to meet its obligation of providing immediate notice of the Silica claims to Travelers under the Immediate Notice Provision of the Travelers' Policies, U.S. Silica similarly failed to meet its obligation under the Assistance and Cooperation Provision of the Travelers' Policies when it voluntarily paid settlements to claimants and incurred defense costs without first notifying Travelers.

The Assistance and Cooperation Provision of the Travelers' Policies provided that "[t]he insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for such immediate medical and surgical relief to others as shall be imperative at the time of the accident." (JA 1032; JA 1047; JA 1062) (Emphasis Added.)

This provision is clear and unambiguous. It cannot be disputed that U.S. Silica was prohibited from voluntarily making "any payment, assum[ing] any obligation or incur[ring] any expense" other than immediate medical expenses that were necessary at the time of the accident if it intended to seek coverage under the bargained-for Travelers' Policies. U.S. Silica nevertheless paid or incurred more than \$8 million in settlement and defense related costs and did so voluntarily and without notifying or involving its insurer. The Travelers' Policies make clear that U.S. Silica did so at its own cost.

Allowing U.S. Silica now to collect reimbursement for costs incurred under the Travelers' Policies, in spite of U.S. Silica's clear violation of the language of the Assistance and Cooperation Provision, would allow U.S. Silica to gain the benefit of a contract that explicitly prohibits exactly what occurred here.

It also would render all similar assistance and cooperation provisions contained in existing liability policies meaningless. These provisions serve an important function, as the United States Court of Appeals for the Seventh Circuit explained in upholding an insurer's right to deny coverage based on an insured's violation of a nearly-identical assistance and cooperation provision under Indiana law:

The purpose of this reasonable and prudent provision is obvious. [The Insurer] must have the opportunity to protect itself and its insured by investigating any incident that may lead to a claim under the policy, and by participating in any resulting litigation or settlement discussions. Any insured that settles a claim without [the insurer's] knowledge or consent does so at the insured's own expense under the express language of this provision.

West Bend Mut. Ins. Co. v. Arbor Homes, LLC, 703 F.3d 1092, 1095 (7th Cir. 2013).

These provisions also prevent an insured from taking on unnecessary risk or "running up the bill." Some courts have acknowledged the "moral hazard" resulting from an insured's tendency to assume additional risks or run up extra costs when another party is financially liable. See e.g., Metavante Corp. v. Immigrant Savings Bank, 619 F.3d 748, 773 (7th Cir. 2010).

Thus, the Circuit Court's failure to rule as a matter of law that U.S. Silica's violation of the Assistance and Cooperation precluded recovery under the Travelers' Policies ignores the plain language of the policies and renders it meaningless. West Virginia's insurance community urges this Court to recognize that where an insured refuses to comply with the clear and unambiguous terms of an assistance and cooperation provision, by failing to involve its insurer before paying claims, and later seeks reimbursement from its insurer after the insured's prohibited act, recovery is wholly improper.

C. This Court should reject the Circuit Court’s joint and several allocation method in favor of a *pro rata* method because the latter embraces equity and facilitates the expectations of the parties.

An insurer must be able to rely on the terms, coverage periods, and the corresponding risk assumed by issuing an insurance policy. Here, the Circuit Court’s September 11, 2013 ruling holding Travelers liable on a joint and several basis, rather than a *pro rata* basis, for claims covering multiple policy periods by multiple insurers undermines insurers’ ability to rely on the terms of their policies and offends basic fairness principles that insurers are responsible for their respective portion of the loss and the risk associated with a particular policy.

First, the Travelers’ Policies made clear that coverage applied only to “accidents which occur during the policy period.” (JA 1031; JA 1046; JA 1061.) To allocate damages based on events that occurred outside that timeframe further offends our recognized rule that the policy language should be given its intended meaning.

Also, this Court has not yet decided which allocation method will apply to these types of claims in West Virginia, and the Federation’s members feel strongly that the proper method is the *pro rata* approach. Under the *pro rata* approach, an insurer providing coverage for a loss is responsible for its respective portion of the loss. This method allocates damages across applicable policies based on the time that insurance policies covered the risk.

Under the joint and several allocation approach, which the Circuit Court applied here, an insurer issuing a policy covering a loss could have full responsibility for the loss up to the monetary limit of each policy. This is what happened here: the Circuit Court ordered Travelers to take full responsibility for U.S. Silica’s entire loss.

According to Travelers’ Notice of Appeal, “the evidence showed that U.S. Silica received \$6.025 million in settlement payments from [other insurers] and all its defense and indemnity

costs associated with any exposures that would have triggered Travelers policies.” Travelers’ Assignments of Error ¶ 3. Where there are multiple liability insurance policies issued by multiple insurers that span various time periods, the Court should not burden a single insurer for all claims covered by many insurers or policies. Equity and public policy demand that the risk should be shared.

Because risk dictates premium, policyholders benefit from accurately-priced premiums or suffer from subsequent rate hikes or insurer insolvency depending on whether insurers price the risk properly. Pricing, in turn, is conditioned on accurately evaluating risk at the front-end issuance of the policy. Here, U.S. Silica (or its predecessor) bargained for policies and paid the corresponding premiums, yet the Circuit Court’s application of a joint and several allocation method undermines the initial risk assumed by Travelers as well as the premiums U.S. Silica paid.

West Virginia’s insurers and policyholders cannot afford (literally) for courts to impose the obligation to pay claims of unforeseen risks on insurers. Indeed, the Connecticut Supreme Court recently applied the *pro rata* method consistent with these principles. In Security Inc. Co. of Hartford v. Lumbermen’s Mut. Cas. Co., 264 Conn. 688 (2003), the Connecticut Supreme Court allocated defense and indemnity costs associated with long latency personal injury claims for asbestos exposure that implicated multiple insurance policies on a *pro rata* basis. The Court chose this method over the joint and several method, concluding “the *pro rata* method of allocation does not violate the reasonable expectations of the parties to the insurance contracts.” Id. at 710. The United States Court of Appeals for the Sixth Circuit also adopted the *pro rata* method, opining that imposing the full cost of defense on an insurer because it is difficult to apportion costs between an insured and uninsured claim in some situations does not apply to

insurance situations: “The duty to defend arises solely under contract. An insurer contracts to pay the entire cost of defending a claim which has arisen within the policy period. The insurer has not contracted to pay defense costs for occurrences which took place outside the policy period.” Ins. Co. of North America v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1224 (6th Cir. 1980), clarified, 657 F.2d 814 (6th Cir.), cert. denied, 454 U.S. 1109, 102 S. Ct. 686 (1981)(Citation omitted; internal quotation marks omitted; emphasis added).

The Federation further urges this Court to adopt this rationale, which the Supreme Court of New Jersey in Owens-Illinois, Inc. v. United Ins. Co., supra, 138 N.J. 437 (1994) (superseded on other grounds)², also adopted. That state’s Supreme Court reversed a lower court’s joint and several allocation, applied the continuous trigger of coverage, as the Circuit Court of Morgan County did here, and held:

[T]he theory of insurance is that of transferring risks. Insurance companies accept risks from manufacturers and either retain the risks or spread the risks through reinsurance. . . . Because insurance companies can spread costs throughout an industry and thus achieve cost efficiency, the law should, at a minimum, not provide disincentives to parties to acquire insurance when available to cover their risks. Spreading the risk is conceptually more efficient.

* * *

² The New Jersey Supreme Court subsequently determined that the allocation method is subject to a carve out for the state’s Guaranty Association as it is a carrier of last resort:

The purpose of the [*pro rata*] methodology is to make insurance coverage available, to the maximum extent possible, to redress such matters as toxic contamination of property. However, the Legislature has designated the Guaranty Association as an insurer of last resort when substituting for an insolvent carrier. N.J.S.A. 17:30A-5 and -12(b) specifically exempt the Guaranty Association from the Owens-Illinois allocation scheme until all solvent insurance companies' policy limits are exhausted.

Farmers Mut. Fire Ins. Co. of Salem v. New Jersey Property-Liability Ins. Guar. Ass'n, 215 N.J. 522, 527-528 (N.J. 2013).

A fair method of allocation appears to be one that is related to both the time on the risk and the degree of risk assumed. When periods of no insurance reflect a decision by an actor to assume or retain a risk, as opposed to periods when coverage for a risk is not available, to expect the risk-bearer to share in the allocation is reasonable. Id. at 473, 479.

These Courts resoundingly followed the common theme that insurance is about assumption of risk and fairness. The Federation's members respectfully urge this Court to embrace public policy and equity by requiring *pro rata* allocation in these cases because the joint and several allocation approach forces insurers like Travelers to pay claims for which it did not contract, foresee or underwrite.

V. CONCLUSION

Based on the foregoing, it is clear the Circuit Court of Morgan County erred by ignoring the plain terms of the Travelers' Policies. This is significant to West Virginia's insurance community because insurers underwrite and charge a premium for policies with the expectation they can rely on their explicit terms. Failing to uphold the policies and the plain terms would render similar provisions in other policies meaningless. As such, this Court should hold that the Circuit Court's rulings were erroneous.

WEST VIRGINIA INSURANCE FEDERATION

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NO. 13-0692

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THE TRAVELERS INSURANCE COMPANY

CERTIFICATE OF SERVICE

I, Jill C. Rice, hereby certify that on the 7th day of July, 2014, I have this day served a copy of The West Virginia Insurance Federation's Motion for Leave to File Brief as *Amicus Curiae* in Support of Travelers Insurance Company's Petition and the Brief of the West Virginia Insurance Federation as *Amicus Curiae* in Support of Brief of Petitioner The Travelers Insurance Company upon all parties to this matter by depositing a true copy of the same in the U.S. Mail, postage prepaid, properly addressed to the following:

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Exhibits on File in Supreme Court Clerk's Office