

**Interpreting Coverage Under The  
Insurance Contract**

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In the current economic environment financial issues become increasingly paramount for both individuals and companies. In an effort to minimize disruptions to the operations of a company, or an individual's life, and various types of insurance policies are often purchased. While individuals and companies are attempting to minimize their exposure to a shifting landscape of risks, insurance companies are equally interested in attempting to minimize their own exposure to a difficult economic and risk environment.

Given the foregoing when claims arise that may trigger coverage under an insurance policy, both the insurer and the insured look to protect their respective interests under the insurance policy involved. In such a situation, the interpretation of what exactly is covered by an insurance policy, or not covered, becomes of paramount importance to both the insurer and insured. Over time various rules and guidelines have been articulated by courts relating to what events will trigger insurance coverage, whether a policy covers the damages being claimed against an insured, what an insurer's duties are with respect to defense and indemnification of an insured, what rights and protections exist for an insured, and what guidelines are applicable for an insurance company, or its attorneys, when drafting a reservation of rights letter. Each of these topics will be discussed in greater detail below.

A. AN INSURANCE POLICY IS A CONTRACT AND INTERPRETED PURSUANT TO RULES OF CONTRACT LAW.

Courts have long recognized that in construing an insurance policy the primary function of a court is to determine and enforce the intentions of the parties as expressed in the insurance contract. Outboard Marine Corp. v. Liberty Mutual Insurance Co., 154 Ill. 2d 90, 607 N.E. 2d 1204 (Ill. 1992) and Bohner v. Ace American Insurance Co., 359 Ill. App. 3d 621, 834 N.E. 2d 625 (2<sup>nd</sup> Dist. 2005). In order to determine the intent of the parties to the insurance contract, and the meaning of the words used in the insurance policy, courts have long recognized that they must construe the insurance policy as a whole, taking into account the type of insurance involved, the risks that were agreed to be undertaken by the insurance company and the subject matter or property that is being insured. See Outboard Marine Corp., and Bohner, *supra*.

With the foregoing principles in mind, courts have stressed the need for focusing on the language used in an insurance policy as a means to determine the parties' intent. Thus courts presented with an insurance coverage/policy interpretation question, often focus on whether the language of the policy itself is ambiguous. The principle of ambiguity, in the context of insurance policy interpretation, has been addressed many times, by many courts. Two of the overriding principles controlling the question are as follows:

1. If the words contained in an insurance policy are "clear and unambiguous" a court is to afford those terms their plain, ordinary and popular meaning and apply them strictly as written. Outboard Marine Corp., *supra*. However, where policy language is susceptible to more than one reasonable interpretation, the language will be deemed to be ambiguous and will be construed against the insurer as the drafter of the policy language. See Travelers Insurance Co. v. Eljer Manufacturing Inc., 197 Ill. 2d 278, 757 N.E. 2d 481 (Ill. 2001) and Bohner, *supra*.

2. A court construing the insurance policy language is not to "... pervert the plain language of the policy in order to create an ambiguity where none exists". Courts are not to adopt an interpretation "... that is strained, forced, unnatural or unreasonable or one that leads to an absurd result". Travelers Insurance v. Eljer and Bohner, *supra*. In this context, where the insurance policy's language is unambiguous a court is to discern the party's intent directly from the policy language without resorting to any rules of construction. American Family Insurance Co. v. Martin, 312 Ill. App. 3d 829, 728 N.E. 2d 115 (2<sup>nd</sup> Dist. 2000). It is also well recognized in Illinois that the best indicator of the party's intent is derived from the language used in the

insurance policy. Courts have routinely stated that the parties' intentions "... must be enforced as written unless they are ambiguous or enforcement contravenes public policy". Wallis v. Country Mutual Insurance Company, 309 Ill. App. 3<sup>rd</sup> 566, 723 N.E. 2d 376 (2<sup>nd</sup> Dist. 2000).

The foregoing principles will serve as a framework for practitioners undertaking an evaluation of insurance coverage, and provide a context for the concepts that will be discussed below relating to the interpretation of coverage under an insurance contract.

## B. ACTIONS THAT TRIGGER COVERAGE

### 1. What Does The Policy Language Say?

As is apparent from the case law referred to in Section A above, the place to begin any inquiry as to whether an event triggers insurance coverage under a given policy, is to review the policy language itself. Typically, insurance policies will contain a provision which defines what events are covered pursuant to the policy. Thus some policies will contain a "coverage" section which provides that the insurance policy will pay sums in excess of the applicable deductible or self insured retention up to the limits of the policy, which the insured "shall become legally obligated to pay as damages as a result of claims first made against the insured during the policy period and reported to the company during the policy period". Similarly, other insurance policies will contain a provision identified as "insuring agreement" which provides that the insurance company "will pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which this insurance applies. We will have the right and duty to defend the insured against any 'suit' seeking those damages."

The foregoing alternative policy language provides a framework for the initial inquiry as to whether a given event triggers insurance coverage. Upon further examination of the above quoted language, it becomes apparent that there are terms included which require further analysis and definition. Thus in the first of the quoted language it is stated that the policy will provide coverage for "damages" as a result of "claims". In this instance, it is then necessary to analyze what the policy states are "claims" and "damages".

In reference to the first quoted policy language above, the insurance policy defines "claim" to mean a demand "received by any insured for money or services including the service of suit or institution of arbitration proceedings against the insured". Furthermore, that same policy defines "damages" as meaning "a monetary judgment or settlement, including any such

judgment or settlement for personal injury, but does not include fines or statutory penalties, or sanctions”. Consequently, in connection with the first quoted policy language, for an event to trigger insurance coverage there must be a demand for money or services, against the insured, during the policy period that does not involve a fine, statutory penalty or sanction.

In connection with the definition of “insuring agreement” quoted above, further inquiry would also be necessary to determine whether an event triggers coverage under that policy. Specifically the definition of “insuring agreement” states that the insurance company will be obligated to pay the sums that the insured becomes “legally obligated to pay” as “damages” because of ‘bodily injury’ or ‘property damage’ to which the insurance applies. Furthermore that policy language states that the insurance company has the right and duty “to defend the insured against any ‘suit’ seeking the defined damages. Based on this policy language, in order to determine whether an event triggers coverage, it is necessary to analyze the policy language defining “damages”, “bodily injury”, “property damage”, and “suit”.

The insurance policy quoted above for purposes of the “insuring agreement” contains a multi-paragraph definition of property damage, a multi-paragraph definition of “bodily injury”, a multi-part definition of “suit” and a multi-part definition of “damages”.

While it is difficult to generalize what “actions” or events will trigger insurance coverage, given the various types of policies written by insurance companies and the differing policy language, including endorsements, certain events typically form the basis of an insured’s request for coverage under a policy. The event most frequently thought of as triggering insurance coverage is a lawsuit brought by a third party against an insured for monetary damages. However, as indicated by the above quoted policy language, in the current commercial/business environment multiple additional events can occur that potentially trigger insurance coverage. An example of such an event includes formal or informal demands made by customers upon a manufacturer or supplier of goods for repair or replacement of the insured’s products that have failed while in use. Additionally, in a similar context an insured manufacturer or supplier of goods may receive a tender of defense and indemnity obligations from a sub-contractor or distributor of a product who has been sued by an end user of the product based upon a defect or deficiency in the product initially supplied by the insured.

In such situations as described above, the insured’s legal or insurance representative will need to review in detail both the applicable insurance policy issued to the insured, as well as the

actual language and scope of the demand being made upon the insured in order to determine whether one or more insurance policies issued to the insured have actually been triggered, thereby creating obligations on the part of the insurer and benefits due the insured.

### C. PRE-LITIGATION ISSUES

#### 1. Whether A Policy Covers The Damages Claimed.

The inquiry into whether an insurance policy covers the damages sought also requires a careful review of the applicable policy's language. Depending upon the type of risk being covered, the policy language may not only include a recitation of what items constitute "damages" but also a listing of what items do not constitute damages. Thus while an insurance policy may define "damages" to mean a monetary judgment or settlement, that same policy may define "damages" as not including "fines or statutory penalties, sanctions, the payment of legal fees, costs and expenses, punitive or exemplary damages, or amounts which are without legal recourse to the insured". Furthermore, some policies will define "damages" in terms of "property damage" and "bodily injury".

Typically a policy will define "bodily injury" to mean a physical injury, sickness or disease sustained by a person. On the other hand, property damage is typically defined as "physical injury to tangible property, including all resulting loss of use of that property". However, the inquiry as to whether an insurance policy covers the damages sought does not end with simply an analysis of the definition of bodily injury and/or property damage. On the contrary, the determination of whether claimed damages falls within the definition of the policy is only the first step of the analysis. Once it is determined that claimed damages fall within the policy definition of bodily injury or property damage, it is then necessary to determine whether those damages are removed from coverage pursuant to the exclusions contained in the policy, or any endorsements attached thereto. Typically, an insurance policy will contain a section setting forth exclusions to coverage which have the affect of eliminating coverage for claims which may fall within the defined scope of the policy. Thus although a claim may meet the definition of "bodily injury" or "property damage", many policies state that if the bodily injury or property damage is "expected or intended from the standpoint of the insured no coverage is afforded for such damages.

Along the same lines, although claimed damage may fall within the scope of bodily injury or property damage under a policy's definitions, many policies will exclude coverage for such damages where the insured's obligation to pay such damages has arisen by reason of an agreement in a contract or other written document to assume the liability for such sums. Such a situation may arise between a sub-contractor and a supplier of goods where a services agreement exists for the sub-contractor to undertake installation of products and in which the sub-contractor agrees to indemnify and hold harmless the supplier of the product for damages resulting from the negligence of the sub-contractor. In this scenario, it is not unusual for the supplier/indemnitee to make demand upon the sub-contractor/indemnitor to assume the supplier's defense and indemnity obligations. When the sub-contractor/indemnitor forwards the demand of the supplier/indemnitee to the sub-contractor's insurance carrier, the insurer may well state that the sub-contractor's indemnity obligation is excluded from coverage because it is an obligation that the sub-contractor/indemnitor voluntarily assumed in a contract or agreement.

Along the same lines, comprehensive general liability policies typically contain multiple exclusions that eliminate coverage for damages related to an insured's own products that have been distributed in the stream of commerce and for which damage claims have been submitted seeking the recall, repair or replacement of the insured's product.

In light of the foregoing, it is important for a practitioner assessing whether insurance coverage is available for claimed damages, to not confine a review of the policy language to the definitions of what is covered under the policy, but the inquiry must extend to other policy terms including exclusions and endorsements to the policy. Many insurance policies will contain endorsements added at the conclusion of the policy which have the affect of modifying or superseding certain of the exclusions contained in an insurance policy. Consequently, the practitioner must review the entire policy, including the definitions reflecting what damages/claims are covered, the exclusions setting forth what damages/claims are excluded from coverage, even though they fall within the defined parameters of covered claims and, finally, the practitioner must review the endorsements to the policy in order to determine whether the terms of those endorsements reinstate coverage for any of the damage claims that may be excluded by certain of the policy's terms.

Finally, in assessing whether coverage is available for claimed damages, it is important to determine whether the insured has provided all of the insurance policies in effect so that all of

the policy terms, from multiple layers of coverage, can be assessed to determine whether a damage claim is subject to coverage under one policy as opposed to another policy. On occasion, a corporate/business insured may have primary, excess and/or umbrella insurance coverage. In certain situations, an excess or umbrella insurance policy may contain “difference in condition” language which provides that claims which are not covered under the primary policy may be subject to coverage under an excess, master or umbrella policy which contains language which specifically provides that the policy will “drop down” and cover a particular category of claims that is not covered by the insured’s primary insurance. In such cases, it is important for the practitioner to work closely with the insured’s risk manager/insurance broker in order to be certain that all potentially applicable insurance policies have been provided to the practitioner for review and analysis.

## 2. Whether The Damages Occurred Within The Policy Period

Insurance policies typically fall into two categories relating to the timing of a covered claim: there are policies which are defined as “occurrence” policies and there are policies defined as “claims made” policies. “Occurrence” policies generally provide that the event which has given rise to a claim must have occurred within the scope of the time that the policy was in effect. On the other hand, “claims made” policies generally provide that the claim for which insurance coverage is sought must have been made during the period of time that the policy was in effect.

While it may appear a relatively simple matter to determine whether an event took place while the policy was in effect, for purposes of determining whether an “occurrence” took place within the policy period, situations can arise which significantly complicate this inquiry. For example, a manufacturer or supplier of a product may distribute the product following which that item may begin failing, with the failures extending over a period of several years. In such a situation, the question arises as to whether each of the failures constitutes a separate “occurrence” or whether the failures constitute a “serial failure” in which case all of the individual failures relate back to the date of the first failure in the series.

In order to begin the process of resolving this question, it is important to review the insurance policy’s definitions section to determine how the term “occurrence” is defined. Many policies will define “occurrence” to mean an accident, “including continuous or repeated exposure to substantially the same general harmful conditions”. While the above quoted

language regarding “occurrence” has often been construed in the context of cases involving the escape or migration of toxic or hazardous substances which may have been buried underground and escaped their containment, questions do arise as to whether such language is applicable to commodities which are mass marketed in the stream of commerce. Applying the foregoing definition of “occurrence” to the example of items which are mass marketed and have a failure history covering multiple policy periods, an argument exists that if the failure mechanism is the same for each of these items only one occurrence has taken place and that occurrence falls within the policy period in effect when the first item failed.

The foregoing inquiry regarding whether one or multiple occurrences has taken place is also of significance as it impacts whether one or multiple deductibles may be brought into play. This can become a significant consideration as if the mass marketed item/commodity has a value within the insured’s deductible, the potential exists that the insurer’s indemnity obligation may never be triggered as the damages related to the occurrences, on an individual basis, do not exceed the amount of the deductible. Alternatively, if all of the damages related to the multiple failures are aggregated into the first policy year in which a failure occurred, then it is likely that the indemnity obligation will be triggered and one deductible will be required from the insured.

Also of importance in the analysis of whether damage occurred within the policy period is the doctrine of “known loss” or “known risk”. These terms are often viewed synonymously and can be used by an insurance carrier to argue that a loss is not covered under an insurance policy, even though it occurred during the period of time that the policy was in effect. The Illinois Supreme Court has addressed the “known risk”/“known loss” doctrine in Outboard Marine Corporation v. Liberty Mutual Insurance Company, 154 Ill. 2d 90, 607 N.E. 2d 1204 (Ill. 1992). The Court in Outboard Marine Corporation stated that the principle underlying insurance coverage insurance is that the insurance guards against “contingent risks” which may or may not occur. Where an insured knows, or has reason to know, when it purchases an insurance policy that “there is a substantial probability that it will suffer or has already suffered a loss, the risk ceases to be contingent and becomes a probable or known loss”. Outboard Marine Corporation, at 1210.

The foregoing principle is applicable in the context of a loss which spans more than one policy period, as an insurer on a risk during a policy period that follows the initial period of the occurrence will argue that the risk or loss was known to the insured at the time that subsequent

insurance policies were purchased and, therefore, no coverage is afforded for any such loss following the policy on the risk at the time that the “occurrence” first took place. An insured responding to such an argument will need to argue that it was not aware of any risk or loss during the period of time preceding the issuance of the insurance policy and the risk remained a contingent risk, not one that had become an actual loss, at the time of the issuance of the policy.

D. INSURER’S DUTY TO DEFEND AND INDEMNIFY

1. Applicable Law

It is well recognized in Illinois that an insurer’s duty to defend its insured is significantly broader than its duty to indemnify an insured. See Stoneridge Development Company, Inc. v. Essex Insurance Co., 321 Ill. Dec. 114, 888 N.E. 2d 633 (2<sup>nd</sup> Dist. 2008), Outboard Marine Corporation, *supra*. An insurance carrier’s duty to defend arises when factual allegations contained in a complaint being liberally construed in the insured’s favor, even potentially fall within policy coverage. See Stoneridge Development Company, *supra*, and General Agents Insurance Company of America, Inc. v. Midwest Sporting Goods Company, 215 Ill. 2d 146, 828 N.E. 2d 1092 (Ill. 2005). Furthermore, if the complaint that has been brought against the insured contains several theories of recovery, and only one of the theories is potentially covered by insurance, the insurer still has an obligation to provide a defense to the insured. Stoneridge Development Co., Inc., *supra*, Midwest Sporting Goods Company, *supra* and Maryland Casualty Company v. Peppers, 64 Ill. 2d 187, 355 N.E. 2d 24 (Ill. 1976).

Unlike the duty to defend, an insurer’s duty to indemnify the insured arises only in the case where a judgment has been entered against the insured in an underlying claim and the insured’s activity giving rise to the resulting loss or the damage itself, actually (as opposed to potentially) fall within the insurance policy’s coverage. Outboard Marine Corporation, *supra* and Stoneridge Development Company, Inc., *supra*.

The Illinois Supreme Court has stated that the insurer’s duty to indemnify “will not be defined until the adjudication of the very action which [the insurer] should have defended”. See Outboard Marine Corporation, *supra* and Maryland Casualty Company v. Chicago & Northwestern Transportation Company (Ill. 1984). The Court explained, in Outboard Marine Corporation, that “... the question of whether the insurer has a duty to indemnify the insured for a particular liability is only ripe for consideration if the insured has already incurred liability in

the underlying claim against it. [citations omitted]. If so the duty to indemnify arises if the insured's activity and the resulting loss or damage *actually* fall within the policy's coverage". Outboard Marine Corporation.

The insurer's duty to defend the insured typically carries with it the right of the insurer to control the defense of the insured. This principle is designed to allow the insurer a means to protect its financial interest in the litigation's outcome and minimize an unwarranted liability exposure. Illinois Masonic Medical Center v. Turegum Insurance Company, 168 Ill. App. 3d 158, 522 N.E. 2d 611 (1<sup>st</sup> Dist. 1988).

The principal exception to the foregoing point arises in a situation where multiple theories of recovery have been advanced against an insured and one or more of those theories are potentially not covered under the insurance policy. In such a scenario the potential exists for a conflict of interest between the insurer and the insured, especially particularly in light of the attorney assigned by the insurance carrier having ethical obligations to both the insurer and insured. Where such a situation is presented the insurer must either defend the suit pursuant to a reservation of rights or seek a declaratory judgment that there is no coverage afforded for certain of the claims under the applicable insurance policy.

Additionally, where there is such a conflict of interest, the insurer must decline to defend the insured and, instead of participating in the defense, the insurer must pay for independent counsel for the insured. American Family Mutual Insurance Company v. W.H. McNaughton Builders, Inc., 363 Ill. App. 3d 505, 843 N.E. 2d 492 (2<sup>nd</sup> Dist. 2006) and Stoneridge Development Company, Inc., supra.

To summarize, when an insured is faced with a complaint that contains multiple theories of recovery and only one of those theories is potentially covered by its insurance policy, the insurer is obligated to provide a defense to all of the claims presented. While the insurer may defend the insured under a reservation of rights or seek a declaratory judgment for a finding that no coverage is afforded for multiple theories of recovery, the insurer cannot simply provide a defense without putting the insured on notice of the coverage issues and then, subsequently, seek to deny coverage for the claims potentially excluded from coverage. If the insurer fails to either reserve its rights or seek a declaratory judgment that there is no coverage, the insurer will be estopped from later raising policy defenses to coverage and is liable for the award of damages against the insured, as well as the costs of suit. Murphy v. Urso, 88 Ill. 2d 444, 430 N.E. 2d

1079 (Ill. 1981). Alternatively, if the insurer adequately informs the insured that the defense of the insured is being provided pursuant to a reservation of rights, and if the insured accepts the defense counsel provided by the insurance carrier, the insurer has not breached its duty to the insured and is not estopped from asserting policy defenses. Royal Insurance Company v. Process Design Associates, Inc., 221 Ill. App. 3d 966, 582 N.E. 2d 1234 (2<sup>nd</sup> Dist. 1991).

Of course, if the insured is informed of the coverage issues contemplated by the insurer and a conflict of interest is deemed to exist, the insured may reject the appointment of defense counsel by the insurance carrier and may insist upon retaining its own “independent counsel”. In such a situation, the insurance company no longer is allowed to control the defense of the insured and, rather is obligated to pay the costs of the insured’s independent counsel. Murphy v. Urso, *supra*. An insurance company’s refusal to provide a defense for its insured to a lawsuit is “unjustifiable unless it is clear from the face of the underlying complaint that the facts alleged do not fall potentially within the policy’s coverage”. Outboard Marine Corporation, *supra*.

## 2. Policy Language Relating To The Duty To Defend

With the foregoing principles of law in mind regarding an insurer’s duty to defend, the analysis shifts to the actual policy language regarding an insurer’s defense obligation under an insurance policy. As a threshold matter, not every insurance policy contains a duty to defend. Furthermore, in some circumstances, an insurance policy may contain a duty to defend which is only triggered after an insured has paid a “retained limit” or self insured retention. Thus certain insurance policies contain language stating that the insured has “... the obligation to defend any demand, claim or suit which may involve this coverage without respect to the amount of your retained limit and to settle such demand, claim or suit within your retained limit where appropriate. Your obligation continues until your retained limit has been exhausted by settlement or claim expenses or until we [the insurer] give you written permission to discontinue the defense of the demand, claim or suit”. Thus where such policy language is present it is the insured’s responsibility to pay all claim expenses, including attorneys’ fees and expert fees, until such time as the self-insured retention or “retained limit” has been exhausted by such payments. Following the exhaustion of the self-insured retention the insurance carrier’s defense obligation then takes effect and the insurance carrier is obligated to begin paying for the insured’s defense.

As noted previously, the potential exists for a conflict of interest to arise where some of the claims or theories of recovery advanced against an insured are potentially within coverage

while other theories or causes of action are likely not covered by a policy's terms. This scenario often arises where negligence causes of action are alleged against an insured along with claims of intentional conduct and/or claims seeking punitive damages. In such a situation cases have repeatedly indicated that a conflict of interest may arise which requires the insured to receive independent counsel and the insurer to relinquish control of the defense. However, when such a situation arises it is important to review the specific policy language regarding the defense obligation, and any additional policy language regarding punitive damages. Thus in The Village of Lombard v. Inter-Governmental Risk Management Agency, 288 Ill. App. 3d 1003, 681 N.E. 2d 88 (2<sup>nd</sup> Dist. 1997), the court found that the presence of claims for punitive damages in a complaint did not create a conflict of interest or a duty on the part of the insurer to pay for independent counsel, because of the policy's language.

The court in Village of Lombard, *supra* noted that the insurance policy at issue contained an exclusion entitled "no coverage-no defense" which provided that the insurer was not obligated to provide a defense or pay attorneys' fees "for any loss, claim proceeding, suit or any other legal or administrative action or part thereof to which this coverage document does not apply and/or for which there is no coverage or indemnification afforded except at the sole discretion of [the insurer]". Furthermore the insurance policy at issue in that case also contained a punitive damages exclusion which stated that "this coverage does not apply to punitive or exemplary damages. In addition, we will not pay defense costs nor shall we be obligated to provide a defense for claims or legal actions in any way requesting punitive or exemplary damages, except at our discretion". In light of the foregoing policy language, the Appellate Court in Village of Lombard v. Inter-Governmental Risk Management Agency, held that the insurer was under no contractual obligation to defend Lombard and its employees for the non-covered punitive damage claims. The court found that the plain language of the policy, as quoted above, limited the insurer's defense obligations to only those claims that fall within the scope of coverage. Consequently the court held that while the insurer must appoint defense counsel to represent Lombard on the covered compensatory claims, it owed no duty to provide counsel to defend the non-covered punitive claims.

Significantly, the court noted that it did not find any conflict of interest because the insurance company's appointed defense counsel had no obligation to defend the non-covered claims. On the contrary, the defense counsel appointed by the insurer only was obligated to

defend the insurer's and insured's interests as they relate to the compensatory damage claims while Lombard and its employees were free to retain independent counsel at their own expense, to defend their own interests as to the punitive damage claims. In this manner, the court concluded that the full interests of Lombard and its employees were protected.

Thus it is once again important to review with care the terms of the policy at issue in order to determine whether a duty to defend has actually been triggered, and if so what is the actual scope of that duty to defend.

#### E. INSURED'S RIGHTS AND PROTECTIONS

Courts have recognized various rights and protections for insureds in the context of coverage disputes with insurance carriers. As discussed previously, courts have noted that insurance policies are to be construed in such a manner as to give effect to the intent of the parties to the insurance policy. In order to achieve this goal of giving effect to the parties' intentions, courts look at the policy language and will afford the terms of the policy their plain, ordinary and popular meaning. However, if the words in an insurance policy are susceptible to more than one reasonable interpretation, they will be deemed ambiguous and, by operation of law, construed in favor of the insured and against the insurer which drafted the policy. Outboard Marine Corporation, supra and United States Fidelity and Guaranty Company v. Wilkin Insurance Company, 144 Ill. 2d 64, 578 N.E. 2d 926 (Ill. 1991) and Dora Township v. Indiana Insurance Company, 78 Ill. 2d 376, 400 N.E. 2d 921 (Ill. 1980). Thus the insured will have the right to seek interpretation of ambiguous policy language in its favor and against the insurance carrier as a result of the fact that the carrier drafted the policy language and, in most cases, presented the language to the insured with no room for negotiation.

Additionally, an insurer's action, or inaction, in the context of an insurance coverage dispute, can give rise to protections for an insured by operation of law. Thus the legal concepts of "waiver" and "estoppel" are relevant in the context of a coverage issue. With respect to "waiver", this legal doctrine consists of "the intentional relinquishment of a known right" and may be expressed or implied from the insurer's acts, words, conduct or knowledge. In the absence of a reservation of rights, an insurer is deemed to have waived all questions of policy coverage when it assumes an insured's defense. See Western Casualty & Surety Company v. Bruchu, 105 Ill. 2d 486, 475 N.E. 2d 872 (Ill. 1985) and Apex Mutual Insurance Company v. Christner, 99 Ill. App. 2d 153, 240 N.E. 2d 742 (1<sup>st</sup> Dist. 1968). Thus an insurer may waive a

policy defense by providing a defense to the insured when it knows, or in the exercise of ordinary diligence, could have known the facts in question which give rise to the defense. If the insurance company is fully advised of the facts bearing on its policy defense and does not then insist, by way of a reservation of rights letter or declaratory judgment, on a lack of coverage, it will be deemed to have waived the policy defense. Kenilworth Insurance Company v. McDougal, 20 Ill. App. 3d 615, 313 N.E. 2d 673 (1<sup>st</sup> Dist. 1974). Additionally, in the context of waiver, the Illinois Supreme Court has stated that since waiver is based upon the unilateral conduct of the insurer, prejudicial reliance by the insured is not required for the doctrine to be applicable. Western Casualty v. Bruchu, *supra*.

The companion doctrine of estoppel also provides rights and benefits to an insured in a coverage dispute with an insurer. Specifically, unlike the waiver doctrine, estoppel can be an involuntary relinquishment of rights by the insurer, although estoppel does require prejudicial reliance by the insured. Western Casualty v. Bruchu, *supra*. Under the estoppel doctrine an insurer may be estopped from asserting any policy defenses it may have if it does not properly reserve its rights under the insurance policy. Murphy v. Urso, *supra* and Maryland Casualty Co. v. Peppers, *supra*. Ordinarily, an insured will assert that it has been prejudiced by an insurer's timely and proper reservation of rights, on the ground that the insured has surrendered the right to control its defense and has completely relied on the insurance carrier for its defense of a lawsuit. American States Insurance Company v. National Cycle, Inc., 260 Ill. App. 3d 299, 631 N.E. 2d 1292 (1<sup>st</sup> Dist. 1994). However, prejudice will not be presumed from the mere entry of an appearance and assumption of the defense by an insurance carrier. On the contrary, the insured has the burden of establishing prejudicial reliance by clear, concise and unequivocal evidence. American States Insurance Company, *supra*. In those cases where estoppel is found to be applicable, the insurer is estopped from later raising policy defenses to coverage and becomes liable for any award against the insured as well as the costs of defending the suit. American States Insurance, *supra* and Murphy v. Urso, *supra*.

Finally, in addition to the waiver and estoppel principles set forth above, insureds in Illinois are also afforded statutory and common law protections based on bad faith insurance claims principles. From a statutory basis, insureds are afforded protections pursuant to 215 ILCS5/155. From a common law perspective, the Illinois Supreme Court has addressed the bad faith insurance claims issues in Cramer v. Insurance Exchange Agency, et al., 174 Ill. 2d 513,

675 N.E. 2d 897 (Ill. 1996) and the issue has also been discussed in Gaston v. Founders Insurance Company, 365 Ill. App. 3d 303, 847 N.E. 2d 523 (1<sup>st</sup> Dist. 2006). The foregoing cases discuss in detail the various forms that bad faith insurance claims can take, the various elements required to maintain such causes of action, and the context in which such causes of action are available. Both the statutory and common law principles governing bad faith insurance claims provide an important source of protection to insureds in connection with conduct undertaken by an insurance carrier relating to claims for insurance coverage.

F. DRAFTING A RESERVATION OF RIGHTS LETTER

As previously discussed, where an insurer believes that either a claim, in its entirety or in part, is not subject to coverage under an insurance policy, the insurer is obligated to either defend the claim pursuant to a reservation of rights, or file a declaratory judgment action seeking a determination that there is no insurance coverage for the disputed portion of the claim or the claim in its entirety. See Waste Management, Incorporated v. International Surplus Lines Insurance Company, 144 Ill. 2d 178, 579 N.E. 2d 322 (Ill. 1991) and Mobil Oil Corporation v. Maryland Casualty Company, 288 Ill. App. 3d 743, 681 N.E. 2d 552 (1<sup>st</sup> Dist. 1997).

A reservation of rights letter typically contains a section discussing the facts relevant to the claim and coverage issue presented, a section reciting the relevant policy terms and conditions which form a basis for questioning insurance coverage for the claim, and a section applying the policy terms to the facts setting forth a basis for why coverage is not, or may not, be afforded for the claim at issue. However, courts have provided additional requirements concerning what content must be contained within a reservation of rights letter.

Additionally, a reservation of rights letter must adequately inform the insured of the rights that the insurer intends to reserve. The letter must make specific reference to the policy defense(s) being asserted by the insurer and to the potential conflict of interest between the insurer and the insured. Mobil Oil Corporation, supra and Royal Insurance Company v. Process Design Associates, Inc., supra. If the insurer does not disclose the conflict of interest that may exist between the insurer and the insured, in the reservation of rights letter, the insurer will be estopped from raising coverage defenses. Doe v. Illinois State Medical Inter-Insurance Exchange, 234 Ill. App. 3d 129, 599 N.E. 2d 983 (1<sup>st</sup> Dist. 1992) and Stoneridge Development Company, Inc., supra. A proper reservation of rights letter sets forth sufficient information

regarding coverage issues and the potential conflict of interest that it allows the insured to decide whether to hire independent counsel in order to avoid a conflict of interest.

Furthermore, the reservation of rights letter must clearly inform the insured of what rights are actually being reserved. Mobil Oil Company, supra and Royal Insurance Company v. Process Design Associates, Inc., supra. A letter which simply provides "... bare notice of a reservation of rights is insufficient unless it makes specific reference to the policy defense which may be asserted and to the potential conflict of interest. Stoneridge Development Company, Inc. referring to Cowan v. Insurance Company of North America, 22 Ill. App. 3d 883, 318 N.E. 2d 315 (2<sup>nd</sup> Dist. 1974).

Finally, the timeliness of a reservation of rights letter also can become a factor. An insurer which seeks to reserve rights under an insurance policy is required to notify the insured "without delay" or "with reasonable promptness". A long delay in providing a reservation of rights to an insured is an element to be considered in determining the reasonableness of an insurer's conduct. American States Insurance Company v. National Cycle, Inc., supra.

Given the foregoing applicable law, it is important that when a reservation of rights letter is drafted, not only are the specific policy provisions at issue addressed, and the facts supportive of coverage defenses, but it is also critical that the letter be clear regarding the potential for a conflict of interest, so that the insured can make a proper determination whether it wishes to demand independent counsel. As discussed previously, the consequences of an inadequate reservation of rights letter can be dramatic, including the insurer being estopped from asserting coverage defenses and required to not only indemnify the insured for any judgment imposed upon it, but also the costs of defending the litigation against the insured.

The discussion contained herein was not intended to be all encompassing on the topic of interpreting coverage under the insurance contract, and should you have any questions regarding the points discussed in this presentation, or that were not addressed herein, please feel free to contact Howard L. Lieber at FISHER KANARIS, P.C.