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"CLAIMS MADE" AND "CLAIMS MADE AND REPORTED" POLICIES IN CANADA

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A. INTRODUCTION

This paper will discuss various coverage implications arising in the context of E&O claims. In particular, this paper will discuss the type of insurance coverage written for professional services liability as compared to commercial or personal lines policies. It will also address the scope of coverage available under an E&O policy and requirements on both parties to the contract at the binding stage. Thereafter the paper will discuss some practical aspects of claims investigation in the coverage context. What will be shown is that coverage for E&O claims is created on a very different basis than commercial or personal lines policies and that particular attention must be paid at the policy inception and claims investigation stages.

B. A DIFFERENT TYPE OF INSURANCE POLICY

1. ADVENT OF THE "CLAIMS MADE" POLICY

Commercial liability and personal lines policies are often referred to as "occurrence" based policies. That is, the trigger for coverage is an accident or untoward event causing damage or loss during the currency of the policy period. The timing of the claim being brought to recover the loss or damage is irrelevant. So long as the loss occurs during the policy period coverage, subject to policy provisions, will be available.

In contrast, the development of E&O insurance in Canada has been accompanied by the creation and industry-wide acceptance of the "claims made" policy. The claims made policy has a completely different trigger than an "occurrence" based policy. The trigger on a "claims made" policy is the initial reporting of a claim during the policy period. The malfeasance or loss or damage need not have occurred during the currency of the policy. So long as the claim was first reported by the insured during the policy period coverage may be available.

2. ADVANTAGE OF A "CLAIMS MADE" POLICY

The development of the claims made format was a result of a number of marketplace factors including the following:

a) desire of insurers to avoid "long tail" claims;

b) the availability of wider coverage for insureds; and

c) the ability to set limits of insurance suitable for the current claims environment.

By its nature an occurrence based policy can require an insurer to defend and indemnify an insured multiple years after the policy has expired and the insurer has gone off risk. Not so with a "claims made" policy. Once the policy expires the insurer can expect no further claims for that policy period.

The claims made policy provides insureds with immediate coverage for all past present and future claims made during the policy period provided that there is no "prior acts exclusion" and no retroactive date. Insurance need not have been in place when the wrongful act or damage occurred.

Given the "current" nature of claims made policies they allow insurers a better opportunity to set competitive premium and insurance limit levels. Naturally this ability benefits insureds as well.

3. THE "CLAIMS MADE AND REPORTED FORM"

As discussed above one of the key features of a "claims made" policy is that coverage is triggered by the reporting of a claim during the currency of the policy. The "insuring agreement" in a "claims made" policy will typically state in part that:

> "The Insurer shall pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as a result of *claims first made against the Insured during the policy period.*" (emphasis added)

The claims made form will also include a provision that notice of a claim will be given by the insured to the insurer "*immediately*" or "*as soon as practicable*". Accordingly, it is possible that an insurer will first receive notice of a claim first made on the policy after the policy has expired. This can occur when a claim is made against the insured on one of the last few days of the policy period and for various practical reasons such as holidays, illness or infirmity, the insured cannot provide notice of the claim to the insurer until after the policy lapses. Canadian Courts have considered this situation and determined that the failure to give immediate notice is tantamount to "imperfect compliance" rather than "non-compliance" with policy provisions. Accordingly, coverage has been deemed to remain available in spite of the reporting of the claim outside the policy period. In addition, it is open to insureds to argue that they should obtain "relief from forfeiture" when they do not strictly comply with reporting provisions in claims made forms because the compliance with timing of notice provisions does not go to the very root of the contract. Also, the ambiguity in terms such as "immediate" and "as soon as practicable" can lead a Court to provide an insured with relief from forfeiture in cases of late reporting.

Insurers addressed this situation by incorporating "condition precedent" language into their policies. This language made it a condition of coverage that the claims be reported within the policy period or the extended reporting period. By introducing this language, insurers effectively precluded insureds from obtaining relief from forfeiture for untimely reporting and firmly limited the timeframe during which a claim can be reported and covered.

The development of law on "claims made" policies and the insurer's response to same lead to the development of the "claims made and reported" form. Typical claims made and reported wording in an insuring agreement is as follows:

> "The Insurer shall pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as a result of *claims first made against the Insured and reported to the Insurer during the policy period*." (emphasis added)

This type of language was considered by the Ontario Court of Appeal in *Stuart v. Hutchins* (1998), 164 D.L.R. (4th) 67. In *Stuart* an insured realtor gave its insurer first notice of a December 7 claim on January 26. The policy had lapsed on December 31 and was not renewed. Nor was "extended claims reporting" coverage obtained. The Court held that as reporting of the claim during the policy period was a clear and unambiguous provision of the policy relief from forfeiture for late reporting could not be granted.

In order to ensure that claims made and reported forms do not contain any ambiguities that might entitle an insured to relief from forfeiture they often contain the "condition precedent" wording discussed above. Again, this type of wording makes the reporting of claims during the policy period a condition to coverage. If the claim is not reported during the policy period, regardless of the reason or other policy provisions, coverage will not be available. An example of "condition precedent" language incorporated into "claims made and reported" forms is as follows:

> "The Insured shall, *as a condition precedent to the availability of rights under this policy*, give written notice to the Insurer as soon as practicable *during the policy period or during the extended reporting period* (if applicable) of any claim made against the Insured." (emphasis added)

Condition precedent language such as the foregoing when combined with a reporting requirement in the insuring agreement will work to remove any doubt as to claims reporting obligations necessary to obtain coverage.

C. SCOPE OF COVERAGE AND BINDING PROCEDURES

This section of the paper will discuss the scope of coverage under a typical E&O policy. It will also discuss the good faith obligations on Insureds at the policy inception stage and potential repercussions for failing in this duty. Entailed in these discussions is determining what constitutes a "claim" in the E&O coverage context and the obligations on insureds and insurers in respect of pre-binding disclosure.

1. WHAT IS A "CLAIM" FOR COVERAGE PURPOSES?

Whereas CGL and personal lines policies afford coverage for bodily injury and property damage, E&O policies, by virtue of the people and activities they insure, cover a much wider ambit of claims. A typical definition of "claim" reads:

> "Claim means a demand, written or verbal, received by the Insured for monetary or non-monetary relief or remedial Professional Services involving this policy and shall include the service of suit or institution of arbitration proceedings against the Insured"

The definition of "claim" is obviously expansive in that it entails a demand for monetary or non-monetary relief. Accordingly, insureds would be well advised to give their insurer immediate notice of any demand made upon them for any matter whatsoever.

Naturally not all claims will result in coverage; the operative words in the above definition being "involving this policy". The "insuring agreement" in most policies will mandate what "involves" the policy. In most cases the policy will be involved when the claim pertains to a "wrongful act" rendered by the insured in the delivery of "professional services".

"Wrongful act" is usually defined as meaning:

> "any negligent or allegedly negligent act, error or omission in "professional services" rendered or that should have been rendered by the Insured or for which the Insured is responsible."

Based on the foregoing the availability of coverage requires a determination of whether the error or omission entailed the delivery of "professional services". Canadian courts

have grappled with this definition when a policy is silent as to same and have arrived at the following general definition:

> "A professional act or service is one arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labour or skill, and the labour or skill involved is predominantly mental or intellectual, rather than physical or manual."

Accordingly, a claim under an E&O policy must involve:

a) a monetary or non-monetary demand;

b) an allegation of a negligent act or omission; and

c) the insured's specialized skill set.

These requirements are incorporated into E&O policies to avoid the overlap of coverage afforded by insured's CGL policies. Examples of claims that would *not* be covered by an E&O policy are:

(i) the improper set-up of a ladder at a construction site by an engineer leading to another person's fall and injury; or

(ii) water on the floor of a dentist's office leading to another person's fall and injury.

Neither of these examples involve the application of the professional's specialized skill set and accordingly to not constitute "claims" or "wrongful acts" in the context of an E&O policy.

In addition to the foregoing, some E&O policies provide limited coverage for administrative hearings or tribunals. Coverage for these types of "claims" is often limited to legal fees expended by professionals in dealing with various governmental agencies such as human rights tribunals, workers' compensation hearings and disciplinary proceedings commenced by the insured's own professional association.

2. FAILURE TO DISCLOSE AND ITS RESULTS

By virtue of the fact that claims made policies provide coverage for previous wrongs of an insured, absent a "prior acts exclusion", insurers are vulnerable at the binding stage in cases where the insured committed a "wrongful act" but has yet to receive a written

or verbal notice or demand (*i.e.*, "claim") in that regard. For this reason insurers often require insureds to complete detailed insurance applications in order to determine if outstanding claims exist and possibly exclude them from coverage. Below we discuss an insured's obligations in respect of disclosure on applications, typical application forms and insurer's obligations to determine underwriting facts.

a) Insured's Duty to Disclose

The duty of good faith is a longstanding tenet of insurance law which holds parties to an insurance contract to a standard of utmost good faith in their dealing. It places a heavy burden on those seeking insurance coverage to make full and complete disclosure of all relevant information when applying for a policy. A prospective insured has an obligation at common law to communicate all relevant facts to the insurer. Should an insured fail in this regard, even inadvertently, the policy is void.

The duty to disclose extends only to the facts known to one party and not the other party. When information is disclosed it must be full and accurate but only in respect of matters relevant to the insurance and only to facts and not opinion. The obligation to disclose, therefore, necessarily depends upon the factual knowledge possessed by the prospective insured at the time of the contract.

b) Insurance Applications

In order to establish relevance of facts or circumstances which may lead to claims in the binding process insurers will require prospective insureds to complete an application form and include in the policy wordings a clause that incorporates the application and the information contained therein into the policy.

A typical question in an E&O insurance application regarding facts and circumstances follows:

> "Is the proposer aware of any facts or circumstances which may result in any claim of the kind covered by the proposed insurance against them, their predecessors in business, or any of the present or past partners or officers?
>
> If yes, state briefly the cause and nature of the facts and circumstances including the amount involved and names of the project and the potential claimant, the date when the facts or circumstances arose, the date the act giving rise to the potential claim was committed and the final disposition."

The insurance application will also contain a declaration for the proposer's execution:

> I acknowledge that Insurers will be relying on this Declaration, the answers given to the questions in the proposal and all information provided by me in deciding whether to issue a contract of insurance and, if so, the terms of such insurance and the premium charged.

The test for determining if a fact is relevant or material is an objective one in the sense that the fact must be such that a prudent insurer would take it into account in either deciding whether to accept the risk or in setting the premium. Accordingly, insureds must be wary of their disclosure obligations. Courts have found that the following circumstances should have led an insured to reasonably anticipate a claim and reported same on the application:

(i) the insured realized he had committed an act that might adversely affect the client such as missing a limitation period or failing to file a report or return by a specific date;

(ii) a client threatened to bring a suit if the insured did not cure problem;

(iii) a client had expressed dissatisfaction with a result and expressed that he believed the professional was responsible;

(iv) the insured had committed a fraud against a client;

(v) the insured was aware he had breached a professional conduct rule in his dealings with the client; and

(vi) an employee had complained he was improperly terminated and had his lawyer contact the professional.

The common law duty of disclosure however can be varied by the terms of an insurance application. While the fact of various questions or declarations in an application do not relieve the applicant from the duty to disclose, a question or declaration in an application may constitute a "waiver" of information by the insurer. This type of "waiver" most often occurs through the use of lists of questions in an application or the use of questions which limit disclosure. An example of a "waiver" of disclosure may be found in an application for motor vehicle insurance wherein the insured is asked if he had an impaired driving conviction in the prior three years. If the applicant had been

convicted of impaired driving four years ago it would not be open to insurers to void the policy for non-disclosure as the question posed by insurers set the parameters of material fact disclosure required.

c) Insurer's Obligations at Policy Inception

The prospective insured's disclosure obligations do not allow an insurer to sit idly by and thereafter seek to void a policy of insurance if facts which would have affected the underwriting process were readily available to it and for whatever reason the insurer did not take any action to obtain those facts. Such was the determination of the Supreme Court of Canada in *Coronation Insurance Co. v. Taku Air Transport Ltd.*, [1991] S.C.R. 622. *Taku* involved a small airline that had three accidents in its first year of coverage with the insurer. The insurer refused to renew the policy the following year but several years later again wrote a policy for the insured on the basis of the insured's disclosure in its insurance application that it had only one prior accident.

Following an accident in which five people were killed the insurer discovered the misrepresentation on the application and voided the policy.

The Supreme Court held that the voiding of the policy on the basis of this particular misrepresentation was inappropriate (the voiding was upheld on other grounds). The Court stated that at a minimum, the duty of utmost good faith at the policy binding stage, required the insurer to examine its own files. The Court also held that in a heavily regulated and monitored field such as aviation an insurer would be expected to undertake a reasonable search of public records on the carrier's accident history.

While not dispensing with or altering the insured's duty of disclosure at the application stage the Supreme Court ruled that an insurer cannot "bury its head in the sand" on information relevant to the risk and in good faith thereafter accept the premium and deny coverage.

D. PRACTICAL CONSIDERATIONS

The nature of claims made or claims made and reported forms of insurance requires that careful consideration be given to certain preliminary or threshold questions in the claims investigation process. Below we outline a few of these issues that must be determined at the outset of the presentation of a claim by an insured.

a) When and how was the claim made?

The claims investigator must ensure the date and manner in which the claim against the insured was made. The former is necessary to ensure the claim was first made during the policy period and the latter to ensure that the claim constitutes a "claim" as defined in the policy.

b) When was the insurer notified?

The scope of consideration of this issue will depend on whether the policy is claims made or claims made and reported. Particular attention must be paid to "claims reporting" or "notice" provisions in the policy.

c) Establish the date of the error or omission.

The purpose of this investigation is twofold. First, professional firms will often change their makeup including personnel and the legal entity pursuant to which the services in question were provided. Determining the date of the error or omission in conjunction with determining the specific identity of the entity that actually provided those services will allow the investigator to establish if the policy applies to a different or predecessor firm.

In respect of the date of the error or omission these types of policies will often contain "Retroactive Date" endorsements on the policy declaration page. The insuring agreement in the policy in such cases will state that coverage is available for errors or omissions that "happen during the policy period or on or after the Retroactive Date stated in the declarations". The Retroactive Date affords the insured with "prior acts" coverage.

d) Pending claims

Many E&O policies will afford insureds coverage for pending claims. These are "claims" (*i.e.*, demands) that may be made after the policy period but are reported by the insured to the insurer during the policy period as facts or circumstances that may reasonably give rise to a claim. In such cases insurers will often require the investigator to obtain details of the potential error or omission including the date, the specific nature and extent of the demand (usually property damage or bodily injury) that is expected to be made and how the insured became aware of the circumstances.

This kind of investigation has often been required in the context of B.C. "leaky condo" claims. Situations have arisen where insureds have delivered to insurers notice of

pending claims that entail numerous projects that were designed and constructed in the same fashion as one or more other projects that have been subject to water penetration. In circumstances such as this it is incumbent on insurers and investigators to review the "laundry list" provided by insureds to determine if the facts or circumstances reported by the insured can in fact reasonably give rise to a claim. In circumstances where there is no reasonable basis on which to conclude that a claim may arise notice of this determination must be afforded to the insured along with the basis for same.