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Risk Management Interest Group

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Chair's Corner — Reflections on Our Industry

by Stanley Oetken, CPCU, ARM

Stanley Oetken, CPCU, ARM, is senior vice president in Marsh's Alternative Risk Financing Unit in its Denver office, assisting clients using large deductible programs, captives, and risk retention groups in loss forecasting and cash flow analysis. During his tenure at Marsh, Oetken has been actively involved with clients in the oil and gas industry; construction project wrap-ups; electric and gas utilities; environmental remediation; and sports teams and venues. He earned a bachelor's degree in mathematics from Wake Forest University and a master's degree in insurance management from Boston University. Oetken is a member of the CPCU Society's Colorado Chapter.

As I think about my career in the insurance industry and what has transpired, several significant events come to mind. Some of these are:

- The liability crisis of 1986, which precipitated the Risk Retention Group (RRG) Act and the formation of RRGs since then.
- Hurricane Andrew in 1992, as our family was living in Fort Lauderdale, Fla., at the time and expected our home to be in its path. We dodged a bullet when it turned south.
- Sept. 11, 2001, of course, which had a dramatic effect on all our lives.
- New York Attorney General Eliot Spitzer and the effect he had on several industries.
- Now, the economic crisis that began last October and is still having an ongoing effect on all that we do.

As far as the industry itself is concerned, however, there are some signs of hope. One of these is an announcement by Lloyd's of an overall profit in 2008 of $2.78 billion. Although that is down from 2007's total profit of $5.64 billion, it is a positive result.

Although A.M. Best noted 57 downgrades of property-casualty insurers in 2008, up from 43 in 2007, this is still considerably better than the 97 downgrades in 2004. Upgrades totaled 59, returning to 2004 and 2005 levels after highs of 128 in 2006 and 87 in 2007.

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Chair's Corner — Reflections on Our Industry

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While everyone appreciates the savings that can be achieved in a soft insurance market, I believe that everyone also wants a profitable industry that will be able to provide security and stability over time. Based on my own experience in the brokerage business, we are seeing increased underwriting discipline to counter the drop in potential investment income compared to a year ago. Is this the beginnings of a hard market? I suppose that would depend on how long the investment returns remain erratic.

Possibly, 2009 may also be similar to 1993 and 2005, when the insurance market was hard in certain lines and less so in others. While there are indications that there is a general hardening in the reinsurance marketplace, it is still more pronounced in property lines than in casualty lines.

Another factor that may ultimately affect the property-casualty market is the issue of federal regulation. A recent report by McKinsey & Co. says that federal regulation may not be the best option for the U.S. economy or the property-casualty industry. While a systemic risk regulator may improve safety and soundness by providing additional oversight of state regulators, it could also lead to confusion, lack of accountability and a costly duplication of effort — inefficiency for which customers would pay. The report suggests a comprehensive stability regulator, which would involve a national regulator for solvency issues, pricing and products while state regulators would be limited to fair treatment of customers. The full report can be obtained by sending an e-mail to insurance@mckinsey.com.

In summary, the industry continues to survive, if not thrive, in these tough economic times. Compared to some industries, while the challenges continue to increase, they are not insurmountable. ■

THE

RISK MANAGEMENT INTEREST GROUP

PRESENTS

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Tuesday, Sept. 1, 2009 • 10:15 a.m.–12:15 p.m.

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Editor's Note

by Jane M. Damon, CPCU, MBA, CIC, CPIW

Jane M. Damon, CPCU, MBA, CIC, CPIW, is an assistant vice president and commercial account executive with Wachovia Insurance Services in Dallas, Texas. She earned a bachelor of business administration in management and master of business administration in strategic leadership from Amberton University. Damon has more than 20 years' experience in the insurance industry, and works on large complex accounts in the real estate, construction and technology fields. She has administered the two largest privately held construction projects (at the time) under a Contractor Controlled Insurance Program (CCIP) through a captive program. Damon joined Wachovia Insurance Services in October 2001.

Welcome to our June 2009 issue.

Jerome Trupin, CPCU, CLU, ChFC, one of our regular contributors, has written two articles for this issue: "Spear-Phishing" deals with employee fidelity and theft by third parties and "This and That — A Potpourri of Insurance Coverage Issues" shows the limitation imposed by a margin clause in property blanket policies.

Trupin has also written a letter to the editor based on an article about taking the proceeds from a homeowners loss and not rebuilding. The article was written by **George L. Head, CPCU, Ph.D., CSP, CLU, ARM, ALCM,** and published in our October 2008 newsletter issue.

As most of you know, George Head has retired, after spending 32 years at the Institutes. He was a regular contributor to our newsletters, and it was wonderful benefiting from his out-of-the-box thinking. Head's articles always stirred everyone's interest, prompted comments and made you think a little more. He will be missed. We all wish him well in his future endeavors.

Robert D. Chesler, J.D., Ph.D., and **Cindy Tzvi Sonenblick, J.D.,** write on coverage for potential corporate privacy exposures in "Privacy Liability — Are You Covered?" This article is Part 1 of 4 in a series originally published by Bloomberg Finance LP and reprinted with permission.

Thomas M. Bower, J.D., has provided an article on New York case law on "lost policies," which will be interesting even if you are not in New York.

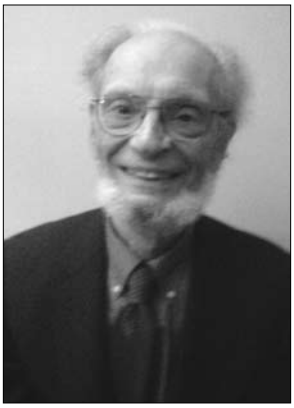
Fatigue in the workplace can have a major impact on a company's productivity and costs. **Kevin M. Quinley, CPCU, ARM, AIC,** has written a very interesting article on this subject.

Also included in this issue is an article that details the Society's new interest group member benefit. In January, every Society member became entitled to benefits from every interest group for no extra fee beyond the regular annual dues.

Please enjoy another wonderful issue provided by our authors. As always, please feel free to let us know your thoughts on the articles, what you would like to see, and what you like and what you don't like. If you would be interested in providing an article, please contact me at jane.damon@wachovia.com. We welcome all authors and commentaries. ■

Spear-Phishing

by Jerome Trupin, CPCU, CLU, ChFC



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Spear-phishing isn't the name of a sport for phonetically-challenged scuba divers; it's a refinement on the all-too-common Internet blight known as "phishing." A phisher casts a wide net; a spear-phisher sends a message directly to a specific recipient. (It's easy to get e-mail addresses of people in, for example, the finance department of a large corporation, either by bribing an employee for a list or searching for names on the Internet and then formatting their e-mail addresses using the firm's standard e-mail name-format.) An actual spear-phishing loss occurred as follows:

Late on a Friday afternoon, Sue Mark (name changed), an employee in the finance department of a large firm, received an e-mail, addressed directly to her, appearing to be from the firm's bank. The message said that there had been a number of unsuccessful attempts to log in to the firm's bank account and directed Sue to the bank's Web site.

The Web site appeared to be legitimate. It asked that she send a reply message containing the firm's bank account number and password. According to the message, this information was needed so the bank could be sure that she was someone in the firm rather than the person attempting to access the account. The message said that the bank would then change the password and let her know the new one. The Web site appeared identical to the bank's actual Web site. It was, of course, run by the spear-phisher. Sue took the bait, and by Monday morning the spear-phisher had withdrawn $650,000 from the firm's bank account.[1]

Could the firm collect for the $650,000 loss under its employee fidelity coverage? Is there any other crime coverage that might apply?

There are two basic types of employee fidelity coverage available today. The Insurance Services Office (ISO) and some other insurers provide what's known as "employee theft" coverage. Employee theft is, logically, a theft by an employee. Theft is defined as "unlawful taking to the deprivation of the insured." In order to trigger coverage, Sue's act would have to be unlawful and she would have to be the one who had done the "taking." Because her actions do not meet that standard, there's no coverage. Sending the account number and password was stupid, but probably not illegal. If stupid acts were illegal, we'd probably all be indicted at one time or another.

The other type of employee fidelity coverage is known as "employee dishonesty." The American Association of Insurance Services (AAIS) and the Surety & Fidelity Association of America (SFAA) make employee dishonesty forms available, as do some independent insurers; at one time ISO offered employee dishonesty coverage. The basic requirement under these forms is that the employee's act be dishonest, not necessarily unlawful. Employee dishonesty forms, however, contain what's referred to as a "dual trigger." The dual trigger requires that the employee manifest an intent to cause the insured to sustain loss and obtain financial benefit for the employee or another person whom the employee designates. The benefit must be something other than salaries, commissions, bonuses, promotions, profit sharing, etc. Since Sue didn't intend to cause a loss to her employer and since she didn't expect any financial benefit, there's no coverage under employee dishonesty coverage either.

It appears that Sue's employer would also be unsuccessful in seeking coverage under its employee fidelity insurance, whichever form (employee theft or employee

dishonesty) is used. Is there a coverage that might apply?

There is coverage available under an ISO coverage known as "Computer Fraud." The computer fraud insuring agreement reads as follows:

6. Computer Fraud

We will pay for loss of or damage to "money," "securities" and "other property" resulting directly from the use of any computer to fraudulently cause a transfer of that property from inside the "premises" or "banking premises":

a. To a person (other than a "messenger") outside those "premises;" or

b. To a place outside those "premises."[2]

This appears to be a coverage that would protect Sue's firm. We don't know exactly how the spear-phisher obtained the funds. Depending on the exact way that the spear-phisher communicated with the bank, coverage might be found under ISO Crime Funds Transfer Fraud coverage instead. It reads as follows:

7. Funds Transfer Fraud

We will pay for loss of "funds" resulting directly from a "fraudulent instruction" directing a financial institution to transfer, pay or deliver "funds" from your "transfer account." "Fraudulent instruction" means: An electronic, telegraphic, cable, teletype, telefacsimile or telephone instruction which purports to have been transmitted by you, but which was in fact fraudulently transmitted by someone else.[3]

Because it recognizes the possible overlap between these coverages, the ISO Computer Fraud coverage form excludes any claim that qualifies as Fund Transfer Fraud claim and the Fund Transfer Fraud coverage excludes any claim that qualifies as Computer Fraud. To avoid this overlap, some insurers combine the two coverages into one insuring agreement.

Spear-phishing may be the most exotic, but it's far from the only way that criminals can help themselves to a firm's bank account. A front page story by **John Markoff** in the Dec. 5, 2008, issue of *The New York Times* starts out: "Internet security is broken, and nobody seems to know quite how to fix it." The story goes on to point out that credit card thefts, bank fraud and other scams rob computer users of an estimated $100 billion a year. Amazingly, the author writes that "a Russian company that sells fake antivirus software that actually takes over a computer pays its illicit distributors as much as $5 million a year."[4]

The most common source of computer and fund transfer fraud losses are employees. The CFO of the American Cancer Society's Columbus, Ohio, office, who had wired $7 million from the Cancer Society's bank account to one in his name in an Austrian bank, was arrested just as he was boarding a plan to flee the country. An employee's thefts would be covered under fidelity coverage — another argument for high limits for that coverage. But the Internet has given criminals worldwide the opportunity to invade a firm's bank accounts. To protect against those losses, Computer Fraud and Fund Transfer Fraud coverages with high limits are vital for virtually every enterprise. ■

References

1. Based on a presentation by George N. Allport, Chubb Insurance, at the Westchester CPCU Chapter/Westchester Community College seminar on Nov. 21, 2008.
2. ISO Properties Inc., CR 00 20 05 06 Commercial Crime Coverage Form © 2005.
3. ISO Properties Inc., op. cit.
4. Markoff, John. "Thieves Winning Online War, Maybe Even in Your Computer." The New York Times: Dec. 5, 2008.

In case the term phishing is new to you, here's information about it from Wikipedia: "In the field of computer security, **phishing** alludes to baits used to "catch" financial information and passwords. It is the criminally fraudulent process of attempting to acquire sensitive information such as usernames, passwords and credit card details by masquerading as a trustworthy entity in an electronic communication. Communications purporting to be from popular social Web sites (YouTube, Facebook, MySpace), auction sites (eBay), online banks (Wells Fargo, Bank of America, Chase), online payment processors (PayPal), or IT Administrators (Yahoo, ISPs, corporate) are commonly used to lure the unsuspecting. Phishing is typically carried out by e-mail or instant messaging,[1] and it often directs users to enter details at a fake Web site whose URL and look and feel are almost identical to the legitimate one. Even when using SSL with strong cryptography for server authentication, it is practically impossible to detect that the Web site is fake. Phishing is an example of social engineering techniques used to fool users,[2] and exploits the poor usability of current Web security technologies.[3] Attempts to deal with the growing number of reported phishing incidents include legislation, user training, public awareness and technical security measures."

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2. Microsoft Corporation. "What is social engineering?" <http://www.microsoft.com/protect/yourself/phishing/engineering.mspx> Accessed on Aug. 22, 2007.
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This and That — A Potpourri of Insurance Coverage Issues

by Jerome Trupin, CPCU, CLU, ChFC

'Margin Clause' for Blanket Property Coverage

The latest ISO property coverage changes include the option for an insurance company to add a "margin clause" to property policies written on a blanket basis. The margin clause limits recovery to a specified percentage in excess of the value shown in the Statement of Values that the insured submitted. The percentage is set at policy issuance by negotiations between the insured (more realistically the insured's broker/agent) and the insurer. The full title of the endorsement is Limitation On Loss Settlement — Blanket Insurance (Margin Clause) CP 12 32 06 07. The ISO endorsement has been approved in most states.

It's a good-news/bad-news development. On the one hand, it confirms what I've always felt: The values shown in the Statement of Values are for rating purposes only; they do not set a limit on the amount of the insured's recovery. The bad news is that the margin clause limits the amount of recovery to a specified percentage of the individual limit per building shown in the Statement of Values. It is easy to say that insureds should insure to value, but no one really knows how much it would cost to rebuild a building — call three contractors and you'll get three, sometimes wildly different, estimates. And how do you cover the wild increases in value that can, for example, accompany a widespread disaster?

Another advantage of blanket insurance that may fall victim to the margin clause is the added insurance that blanketing insurance provides for debris removal expenses in the event of a total loss. The standard ISO form provides only $10,000 additional coverage for debris removal when the loss has otherwise exhausted the limit; as discussed below, this can fall very short of the mark.

Blanket insurance is not a freebie; a blanket policy is written at 90 percent coinsurance without the reduction in rate that using the 90 percent provision ordinarily calls for — in effect a 5 percent increase in rate. Blanket coverage is a valuable option for insureds; the margin clause can reduce the insured's protection.

Increased Debris Removal Limits

Until 1986 most property policies covered debris removal with no limit other than the total applicable policy limit. In response to the "pollution pandemonium" that struck the insurance industry in the early 1980s, a sublimit was applied to debris removal. Coverage for debris removal in the ISO property forms is now limited to an amount equal to 25 percent of the rest of the covered loss before applying the deductible. Recognizing that this was not sufficient in all cases, ISO added an additional coverage of $10,000 to supplement that limit; this additional coverage applies when the debris removal expenses exceed the 25 percent of loss limit or when, as noted above, the coverage limit is used up.

This is not adequate coverage. A relatively small loss can trigger a large debris removal bill. While pollution is excluded, the cost to remove polluted debris from covered property is not. Once the crew in white hazmat suits is turned loose, tracking the costs is like watching a taximeter on steroids.

In one loss, fire damaged piping insulation that cost about $15,000 to replace. The cost to clean up the debris from the damaged insulation, which contained asbestos, was more than $100,000.

Even when it doesn't involve hazardous materials, debris removal is expensive. It's estimated that ordinary debris removal can run about $10 to $15 per square foot. A typical 60-family, 6-story apartment building contains about 70,000 square feet of floor space; that's $700,000 to $1.05 million in estimated debris removal cost. ISO has a standard endorsement to provide additional debris removal coverage, Debris Removal Additional Insurance (CP 04 15 10 00). Most insureds need this coverage; brokers and agents should quote additional debris removal coverage when writing property insurance.

Debris removal coverage, provided by either the endorsement or the basic policy, does not apply to the cost to remove pollution from land or water; land and water are specifically excluded by the list of property-not-covered that's part of the policy. There is an additional coverage for the cost to extract pollutants from land or water when the release is caused by covered cause of loss during the policy period, but it's limited to $10,000 — some companies will increase the limit to as much as $100,000. Environmental impairment insurance is a better alternative for this exposure; it can provide broader perils and higher limits.

Limited Operations Coverage for Contractors

The commercial general liability (CGL) policy, like its predecessor the comprehensive general liability policy, covers all of an insured's operations not otherwise excluded, whether listed in the classifications section of the policy or not. On audit, a premium is charged for operations not listed in the policy at inception at the rate applicable to such operations. However, audits for smaller insureds are often far from thorough, are sometimes just self-audits (a form is sent to the insured) or are omitted entirely. As a result, higher-rated exposures are sometime undetected unless there is a claim.

To combat this problem, some insurers attach a "limited operations endorsement" (also known as a "classification endorsement") that restricts coverage to classifications of operations shown in the policy at inception or by specific endorsement. This destroys the all-encompassing nature of CGL policies.

I can appreciate the problems underwriters face, but the limited operations endorsement creates major difficulties for insureds, additional insureds and their insurance representatives. As a consultant, I strongly object to such endorsements, although I'll admit that I'm not always able to have it removed. It's particularly difficult to have a contractor that is doing work for my client have its policy changed — often there's no indication that the endorsement is included in the policy to which my client has been added as an additional insured.

It's argued that insureds can always add new operations by endorsement.[1] That sounds fine in theory; but we all know that in practice insureds and their insurance advisers are not in constant communication and that insureds have only the vaguest idea of what their policies cover. (The standard response from an insured when informed about a lack of coverage is always: "What do you mean I'm not covered?")

To further confuse insureds, the language used in the description of the operations section of the policy often differs from the classification wording. In one case, a contractor was hired to do interior demolition work. The declarations page described the insured's operations as "Interior Reno. Contractor." The classification page showed the classification as "Painting — interior buildings or structures." The insurer denied liability for a claim arising from interior demolition work. Arguably, that work would be encompassed by "Interior Reno. Work;" the insurer said that it was the classification wording that prevailed, not the description of the insured's business on the declarations page. The result was expensive litigation — the demolition operations caused a fire that did over $5 million in damage — that was ultimately settled to both parties dissatisfaction.

At a minimum, the policy itself, as well as all certificates of insurance covering such policies, should prominently state that the policy is subject to a limited operations endorsement and list the exact operations that are covered. It's not sufficient to show it in an endorsement buried in the huge pile of forms that comprise a commercial general liability policy. ■

Endnote

1. Boggs, Chris. "What Are the Coverage Gaps Created by the Limited Operations Endorsements? Sensationalizing the Non-Sensational!" MyNewMarkets.com. <http://www.mynewmarkets.com/article_view.php?id=96503>. Accessed Dec. 31, 2008.

Privacy Liability — Are You Covered?

Part 1 of 4 in a Series

by Robert D. Chesler, J.D., Ph.D., and Cindy Tzvi Sonenblick, J.D.

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Potential corporate privacy exposures are inherent in the way most corporations do business. Any executive traveling with a laptop computer containing personally identifiable data represents a potential privacy exposure for his corporation. Every retailer is subject to suit when individual customer credit card information appears on a receipt or is collected on a Web site.

While privacy concerns abound, companies are often slow to assess the nature and extent of their privacy exposures and realize the limited protections inherent in technological innovations and standard general liability insurance policies. This failure leaves many companies exposed to substantial penalties, as well as remedial and recovery costs when a privacy breach occurs.

Coverage for Privacy under CGL Policies

The standard general commercial liability (CGL) policy provides coverage for some privacy liabilities. This coverage lies in the section of the policy which states that the insurer is obligated to pay damages because of "personal injury" or "advertising injury." While CGL policy forms vary, "personal injury" is generally defined as "injury, other than 'bodily injury', arising out of one or more of the following offenses: false imprisonment, malicious prosecution, wrongful eviction, or slander or libel that tarnish a person's products or services or right of privacy." "Advertising injury" generally includes "injury arising out of one or more of the following offenses: slander or libel that tarnish a person's products or services or right of privacy, misappropriation of advertising styles or ideas, or copyright infringement."

The communications forming the basis of an "advertising injury" must be disseminated to the general public in either written or oral form. Similarly, there is a publication element to a "personal injury" offense, as the statement or action harming a person's character, reputation or position in the community must occur publicly.

Testing the Scope of 'Personal Injury' Coverage for Privacy Disputes

Companies and their insurers are currently litigating the "personal injury" provisions of a CGL policy in two arenas: blast faxes and data mining. Blast fax cases involve civil liability for unsolicited, mass dissemination of advertising material via fax machines. Data mining cases involve companies gathering supposedly secret customer information from their Web sites for the purpose of preparing marketing strategies. In both coverage litigations, the key issue has been the interpretation of the word 'publication.'

Privacy has two strands: secrecy and seclusion. Secrecy concerns the transmission of private information, while seclusion concerns the right to be left alone. Insurers argue that the use of the term 'publication' in the policy means that the coverage responds solely to secrecy liability, and not seclusion. Insurers also assert that 'publication' also requires an affirmative action by the alleged tortfeasor to make the private information available, as opposed, for example, to losing a laptop. As discussed below, courts are split on this issue.

Blast Fax Cases

Pursuant to the Telephone Consumer Protection Act (TCPA), 47 U.S.C. § 227, enacted in 2003, a company that sends out blast faxes is liable for damages of up to $500 per fax. Since companies may send out millions of unsolicited faxes, a blast fax bar has developed that seeks out recipients of blast faxes and then sues the companies that sent them. Those companies then seek insurance coverage. While some insurers have agreed to defend such cases, others have refused, leading to a large number of reported decisions. The courts have split on whether these claims are covered under a CGL policy, with the crucial issue being whether publication to a third party is necessary to trigger coverage under the policy's "advertising injury" provision.

Among the leading cases is *Resource Bankshares Corp. v. St. Paul Mercury Ins. Co.*, 407 F.3d 631 (4th Cir. 2005), in which the insured sought a declaration that its insurer had a duty to defend an underlying blast fax class action lawsuit alleging violation of the TCPA. Resource alleged coverage based upon two policy provisions — one dealing with coverage for "property damage" and the other

dealing with coverage for damages resulting from an "advertising injury offense." 407 F.3d at 634. St. Paul denied coverage for the litigation under both policy provisions.

The Fourth Circuit Court of Appeals held that the lawsuit alleged a violation of "seclusion" privacy, whereas the advertising injury coverage in the policy only protected "secrecy" privacy. The court noted that the policy provides coverage for damages resulting from "making known to any person or organization written or spoken material that violates a person's right of privacy" and that here, the unsolicited faxes did not contain any private information harmful to a third party. 407 F.3d at 634. Moreover, the court noted that to constitute an advertising injury offense, the harmful content must be made known to a third party. *See also Melrose Hotel Co. v. St. Paul Fire and Marine Ins. Co.*, 432 F. Supp.2d 488, 504 (E.D. Pa. 2006) ("[T]he clear and unambiguous ['making known' provision] . . . requires that the content contained in the covered material must violate a person's right of privacy and must be made known to a third party.")

However, in *Park Univ. Enterprises, Inc. v. Amer. Casualty Co. of Reading, PA*, 442 F.3d 1239 (10th Cir. 2006), the Tenth Circuit Court of Appeals issued a contrary holding, finding coverage under both the property damage and advertising injury parts of a CGL policy for claims stemming from the distribution of unsolicited blast faxes. With respect to the advertising injury provision, the court reasoned that the dual meaning of the word "privacy" created an ambiguity in the policy with respect to that term. The court stated that it was reasonable to construe "privacy" either to include the right to be left alone, or as the right to seclusion, noting that Congress contemplated such a broad view of privacy when enacting the TCPA. The court also embraced a broad construction of the term "publication" as the act of "bringing before the public" or "announcing, "which the court held would include the faxing of information to the plaintiff class. 442 F.3d at 1250.

Data Mining Cases

Data mining cases involve a variation on the same theme. In these cases, customers bring class actions asserting invasion of privacy. The insurers then deny coverage because of the lack of publication to a third party. In such cases, courts have held that publication by one person to another within the insured company is sufficient to trigger coverage. In a leading case, *Netscape Communications Corp. v. Federal Ins. Co.*, No. C 06-0198 JW, 2007 BL 134368 (N.D. Cal. 2007), the court held that information downloaded from users and transmitted to persons at Netscape and AOL satisfied the personal injury offense of "making known" information to any "person or organization," and did not require widespread dissemination. Similarly, in *Zurich Amer. Ins. Co. v. Fieldstone Mortgage Co.*, No. CCB-06-2055, 2007 BL 152416 (Dist. Ct. MD 2007), the court held that where a mortgage company improperly accessed and used individuals' credit information in violation of the Fair Credit Reporting Act to provide "pre-screened" offers, the claim was covered, since publication did not need to be to a third party.

Coverage for Privacy under Cyber Liability Policies

As demonstrated by the cases above, the publication requirement of the advertising injury provision of a CGL policy is problematic for many privacy claims. The insurance industry has responded to the flurry of privacy liability claims by crafting new insurance policies that provide very broad protection. Cyber liability policies can provide protection against liabilities related to privacy and computer system breaches of security, including liability arising from disclosures by vendors or service providers holding credit card information. These policies can be extended to cover notification costs required by state laws and costs of credit monitoring that must often be provided to credit card holders. Insurers have also added coverage for regulatory defense costs, fines and penalties arising from certain statutes.

A cyber liability policy generally will define "privacy liability" very broadly, in order to include claims for theft or misuse of personally identifiable non-public information on computer systems by a third party or an employee of the insured, or any claim arising out of a failure by the insured to comply with its own internal privacy policy. The inclusive privacy liability definitions in cyber liability policies are designed to avoid the issue of 'publication' and provide coverage for both the secrecy and seclusion strands. The policy generally provides broad coverage for both online and offline information, and for information on laptops and other media, even if lost or stolen offsite. The policy also covers claims alleging use of spyware, spam, or other intrusive technology. As to damages, the coverage includes fines and penalties, duty to notify costs, costs to remedy reported compliance deficiencies, and credit monitoring services for third parties at risk because of lost personal information.

Unlike traditional liability and property policies, no standard form cyber or privacy policy exists. Rather, a company can purchase a policy that only provides privacy coverage, or instead choose a policy that provides coverage for a variety of cyber risks, including intellectual property infringement, destruction of data, or disruption of computer service by hackers. A company can pick and choose among these coverages to customize a policy that fits its needs, combining coverage for risks traditionally separated into liability and property policies. We can only wait to see if the insurers live up to their promises concerning these new policies, or if policyholders will need to resort to litigation to enforce their rights. ■

New York Case Law on 'Lost' Policies — A Primer

by Thomas M. Bower, J.D.

Thomas M. Bower, J.D., is an AV®-rated sole practitioner in Briarcliff Manor, N.Y. He earned a bachelor's degree from Cornell University and a law degree from Columbia University. Since 1987, Bower's practice has concentrated on property and casualty insurance and reinsurance coverage issues. He functions principally as a "consulting attorney," providing clients with analysis, advice and representation concerning a wide array of coverage issues and helping insurers and MGAs develop appropriate language for new or updated products. Bower may be reached at tombower@thomasbower.com.

General Rules

New York's basic rules for "lost" policy cases are straightforward. As the party claiming under the policy, the insured bears the burden of proving the existence and terms of the insurance contract. When the policy itself cannot be found, the insured may prove its existence and terms through secondary evidence.

Before being permitted to introduce such secondary evidence, the insured must first satisfy two requirements:

- First, the insured must establish a reasonable explanation for why the policy is missing and that there was no bad faith or fraud surrounding its loss or destruction.
- Second, the insured must show it undertook a diligent, but unsuccessful, search for the policy.

See generally, Leitner, D.L., Simpson, R.W., & Bjorkman, J.M., 3 *Law & Practice of Insurance Coverage Litigation* §§ 40:1 *et seq*. (2005); 4 N.Y.Prac., Com. Litig. in N.Y. State Courts §§ 60:6, 60:34 (2nd ed); Ostrager, B.R., & Newman, T.R., *Handbook on Insurance Coverage Disputes* §§ 17:01 et seq. (11th ed. 2002).

Once those two threshold requirements are met, the insured may use any and all kinds of secondary evidence to prove the prior existence and terms of the policy circumstantially. In reported cases, such secondary evidence has included affidavits and testimony from witnesses; documents referring to the policy; accounting and other financial records (including those showing the payment of premium, loss or commission); minutes of meetings; records of third parties (e.g., brokers, agents, adjusters, and lawyers); evidence of a routine custom or practice; the insurer's own records; and certificates of insurance.

The insurer is always entitled to attack the *sufficiency* of such secondary evidence, but such an attack goes only to its *weight*, not its *admissibility*. Once such evidence is admitted, the trier of fact decides whether it satisfies the insured's burden of proving the existence and contents of the policy. The burden of proving any exclusions from coverage, or conditions or limitations on coverage, rests with the insurer. *See generally*, Leitner, D.L., Simpson, R.W., & Bjorkman, J.M., 3 *Law & Practice of Insurance Coverage Litigation* §§ 40:1 et seq. (2005); 4 N.Y.Prac., Com. Litig. in N.Y. State Courts §§ 60:6, 60:34 (2nd ed); Ostrager, B.R., & Newman, T.R., *Handbook on Insurance Coverage Disputes* §§ 17:01 et seq. (11th ed. 2002).

Applicable Evidentiary Standard

Once past the basic rules outlined above, questions become thornier. For example:

- What evidentiary standard must an insured satisfy to prove the existence and terms of the alleged insurance? That is, can an insured prove the existence and terms of such insurance by a mere preponderance of the evidence, or must it make some heavier showing?
- Whatever the evidentiary standard is, how much secondary evidence does it take to satisfy it?

In some older cases, courts required insureds to prove the existence and terms of lost or missing insurance policies by evidence that was "clear and convincing," "clear, satisfactory, and convincing," or words of similar import. *Boyce Thompson Inst. for Plant Research, Inc. v. Ins. Co. of North America*, 751 F.Supp. 1137 (S.D.N.Y. 1990); *State of New York v. Union Fork & Hoe Co.*, 1992 WL 107363 (U.S.D.C., N.D.N.Y., May 8, 1992) [noting that a "clear and convincing" standard would apply at trial, but applying an even more stringent "beyond factual dispute" standard, because the insured was moving for summary judgment]. A "clear and convincing" standard "is satisfied when the party bearing the burden of proof has established that it is ***highly probable*** that what he or she has claimed is actually what happened." *Home Ins. Co. of Indiana v. Karantonis*, 156 A.D.2d 844, 845, 550 N.Y.S.2d 77, 79 (3rd Dep't. 1989) [emphasis added]. This standard is "more exacting

than the standard of preponderance of the evidence, but less exacting than the standard of proof beyond a reasonable doubt." *Maryland Cas. Co. v. W.R. Grace & Co.*, 1995 WL 562179 (S.D.N.Y., September 20, 1995).

More recent decisions have required an insured to prove the existence and terms of a lost or missing insurance policy by a mere preponderance of the evidence. For example, *Goldfields American Corp. v. Aetna Cas. & Sur. Co.*, 173 Misc.2d 901, 661 N.Y.S.2d 948 (Sup.Ct., N.Y.Co., 1997). *Goldfields* is the only decision by a New York State court I have found on this issue. It has been followed by federal courts in New York. *Employers Inc. of Wausau v. Duplan Corp.*, 1999 WL 777976 (U.S.D.C., S.D.N.Y., September 30, 1999); *Burt Rigid Box Inc. v. Travelers Property Cas. Corp.*, 126 F.Supp.2d 596 (W.D.N.Y., 2001), *aff'd in part, rev'd in part*, 302 F.3d 83 (2nd Cir. 2002) [trial court followed *Goldfields*, *supra*; 2nd Cir. did not decide issue, but affirmed on basis that insured had satisfied even the higher "clear and convincing" standard].

The preponderance-of-the-evidence standard is much less exacting than the "clear and convincing" standard. To satisfy a preponderance-of-the-evidence standard, an insured need prove only that its version of the facts is more likely than not. Courts applying the lower preponderance-of-the-evidence standard have given two reasons for doing so:

(a) The heavier "clear and convincing" standard should be required only to prove the existence and contents of documents evidencing an interest in land or decedents' estates, or when required by statute, or when important civil rights are at stake, but not in an ordinary contract action.

(b) Requiring proof by "clear and convincing" evidence would encourage insurers to discard their records of older policies, to make such proof that much more difficult.[1]

How Much Evidence Is Enough?

As to how much evidence it takes to satisfy either the "clear and convincing" or "preponderance" standards, there is no clear rule: The answer always depends on the specific secondary evidence offered, how persuasive the trier of fact finds it to be in the circumstances of the particular case, and the procedural posture in which the question arises. Although the reported decisions are necessarily fact-specific, a few examples are illustrative:

- In *Boyce Thompson Inst. for Plant Research, Inc. v. Ins. Co. of North America*, 751 F.Supp. 1137 (S.D. N.Y. 1990), the insured presented an affidavit from a broker, plus accounting ledger entries showing the insured had made payments to that broker and received payments from INA. The court held that was not enough to satisfy the "clear and convincing" standard.

- In *Goldfields American Corp. v. Aetna Cas. & Sur. Co.*, 173 Misc.2d 901, 661 N.Y.S.2d 948 (Sup.Ct., N.Y.Co., 1997), the court held that check stubs from settlement payments, plus invoices from premium audits, were enough to raise an issue of fact as to whether a policy had existed, and therefore to defeat an insurer's motion for summary judgment.

- In *Employers Ins. Co. of Wausau v. Duplan Corp.*, 1999 WL 777976 (U.S.D.C., S.D.N.Y., September 30, 1999), a broker's uncorroborated, one-page "Confirmation" of coverage was sufficient to raise a question of fact and defeat an insurer's motion for summary judgment, even though the "Confirmation" did not identify the insured. The court said that, under a "preponderance" standard, a reasonable jury could infer from the "Confirmation" that coverage had existed during the stated coverage period. The court even said a reasonable jury could infer from the "Confirmation" that coverage had existed in an ***earlier*** coverage period, as to which ***no*** evidence of coverage had been offered!

- In *State of New York v. Blank*, 820 F.Supp. 697 (N.D.N.Y. 1993), *vacated on other grounds*, 27 F.3d 783 (2nd Cir. 1994), the insured moved for summary judgment, offering an affidavit from its broker, a copy of an alleged dec page, and a specimen policy of the same general type. The court held this was enough to establish a prima facie case for coverage. The insurer submitted no contradictory evidence, so the court granted summary judgment for the insured.

A close reading of these and other cases leads to three general conclusions:

(1) It does not take very much evidence to make out a prima facie case for coverage under a mere "preponderance" standard.

(2) Courts are particularly impressed if the insured offers multiple items of secondary evidence from separate sources, and those items corroborate one another.

(3) Under a "preponderance" standard, once an insured offers secondary evidence sufficient to make a prima facie showing of coverage, the carrier should not just sit back and criticize the weight, credibility, or persuasiveness of that evidence, or point to gaps in the insured's proof. The carrier also cannot rely on speculation, surmise, or its own unsupported contentions about what the insured's evidence means. Rather, whether at trial or on a motion for summary judgment, the carrier should come forward with whatever evidence it can to contradict the insured's evidence. If it does not do so, the carrier will probably lose. ■

Endnote

1. The insurer in *Goldfields* had apparently done exactly that.

Letter to the Editor

Dear Editor,

The article written by **George L. Head, CPCU, Ph.D., CSP, CLU, ARM, ALCM,** in the October 2008 issue of the Risk Management Interest Group newsletter poses interesting ethical issues; but in two of the cases, the insurance industry has solved the problem.

The first two dilemmas are handled by current versions of the HO policy. Standard ISO HO forms state that there's no requirement that the home be rebuilt at the same site; they do limit recovery to the amount it would have cost to rebuild it at its original site. Here's the wording from ISO form HO 03 10 00:

> (3) The necessary amount actually spent to repair or replace the damaged building. If the building is rebuilt at a new premises, the cost described in (2) above is limited to the cost which would have been incurred if the building had been built at the original premises.

The ISO Commercial Property forms have similar provisions.

I think that's the way it should be. There may be some forms that don't grant that permission. If so, I think they're wrong and that ethically they should permit the insured to rebuild at another location to satisfy the requirement of the replacement cost provision.

As to the third dilemma, I sympathize with the widow, but I don't see that it's within the adjuster's prerogative to flout his/her duty to abide by the policy.

Another point: The article appears to equate ACV with depreciated historical cost — "Because of its age, her home's actual cash value (depreciated historical cost) was essentially zero." That is not the correct approach.

ACV is based on current cost with a deduction for physical depreciation, not straight-line percentage depreciation based on original cost. A well-maintained structure seldom has an ACV less than 85 percent of its current replacement cost. If the widow's house has not been well-maintained and needed substantial repairs to make it habitable, it might have a low, but I doubt a zero, ACV; but if the widow rebuilds at any location, she'll still be entitled to replacement cost. (ACV is more complicated than just "Replacement Cost minus Depreciation," but this isn't the place to discuss Broad Evidence Rule, Market Value laws, etc.)

I have a thought about another possible ethical issue: Let's say that in inspecting the premises to evaluate the widow's loss, the adjuster notices that the stairs are a trip hazard, the furnace is a fire hazard, there is unrepaired water damage from a leaking roof, doors and windows, etc. Should he report this to the insurance company? If he does, he knows that the company will either cancel the widow's insurance or raise her premium. She can barely afford the coverage now. What should he do?

I'm sad to hear that George will not be writing any more insurance articles. His writings were always thought provoking. He has taken early retirement and is studying theology. We all wish George the best.

Jerome Trupin, CPCU, CLU, ChFC
Trupin Insurance Services
Insurance Consulting & Education

New Interest Group Member Benefit

by CPCU Society Staff

Beginning Jan. 1, 2009, *every* Society member became entitled to benefits from every interest group for no extra fee beyond the regular annual dues, including access to their information and publications, and being able to participate in their educational programs and functions.

An Interest Group Selection Survey was e-mailed to members beginning mid-November. By responding to the survey, members could identify any of the existing 14 interest groups as being in their primary area of career interest or specialization. If you did not respond to the survey and want to take full advantage of this new member benefit, go to the newly designed interest group area of the Society's Web site to learn more about each of the interest groups and indicate your primary area of career interest. You will also see options to receive your interest group newsletters.

Currently, there are 14 interest groups: Agent & Broker; Claims; Consulting, Litigation & Expert Witness; Excess/Surplus/Specialty Lines; Information Technology; International Insurance; Leadership & Managerial Excellence (former Total Quality); Loss Control; Personal Lines; Regulatory & Legislative; Reinsurance; Risk Management; Senior Resource; and Underwriting.

As part of the Interest Group Selection Survey, members also were asked to express their interest in the following proposed new interest groups: Actuarial & Statistical; Administration & Operations; Client Services; Education, Training & Development; Finance & Accounting; Human Resources; Mergers & Acquisitions; New Designees/Young CPCUs; Nonprofits & Public Entities; Research; Sales & Marketing; and The Executive Suite.

Members who missed the Survey may update their selections on the Society's Web site or by calling the Member Resource Center at (800) 832-CPCU, option 4. Members can also order printed newsletters for nonprimary interest groups at an additional charge. ■

The **Agent & Broker Interest Group** promotes discussion of agency/brokerage issues related to production, marketing, management and effective business practices.

The **Claims Interest Group** promotes discussion of enhancing skills, increasing consumer understanding and identifying best claims settlement tools.

The **Consulting, Litigation, & Expert Witness Interest Group** promotes discussion of professional practice guidelines and excellent practice management techniques.

The **Excess/Surplus/Specialty Lines Interest Group** promotes discussion of the changes and subtleties of the specialty and non-admitted insurance marketplace.

The **Information Technology Interest Group** promotes discussion of the insurance industry's increasing use of technology and what's new in the technology sector.

The **International Insurance Interest Group** promotes discussion of the emerging business practices of today's global risk management and insurance communities.

The **Leadership & Managerial Excellence Interest Group** promotes discussion of applying the practices of continuous improvement and total quality to insurance services.

The **Loss Control Interest Group** promotes discussion of innovative techniques, applications and legislation relating to loss control issues.

The **Personal Lines Interest Group** promotes discussion of personal risk management, underwriting and marketing tools and practices.

The **Regulatory & Legislative Interest Group** promotes discussion of the rapidly changing federal and state regulatory insurance arena.

The **Reinsurance Interest Group** promotes discussion of the critical issues facing reinsurers in today's challenging global marketplace.

The **Risk Management Interest Group** promotes discussion of risk management for all CPCUs, whether or not a risk manager.

The **Senior Resource Interest Group** promotes discussion of issues meaningful to CPCUs who are retired (or planning to retire) to encourage a spirit of fellowship and community.

The **Underwriting Interest Group** promotes discussion of improving the underwriting process via sound risk selection theory and practice.

Loss Control Means Waking Up to the Perils of Fatigue!

by Kevin M. Quinley, CPCU, ARM, AIC

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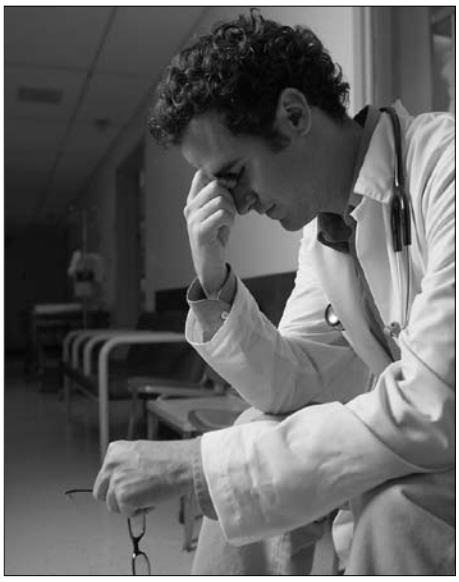
Editor's note: This article first appeared in the April 2009 issue of the CPCU Society's Loss Control Interest Group newsletter.

Did you get enough sleep last night? Are you feeling droopy from working on a late-night project? Maybe you caught the red-eye from L.A. and are starting to feel groggy. Join the club, but beware.

Some of the most spectacular accidents of the last century have been caused by human fatigue. This includes the oil spill of the *Exxon Valdez,* the fatal navigational error of KAL Flight 007, the Union Carbide gas leak at Bhopal, India, and the Three Mile Island nuclear disaster. Less heralded are other accidents that have employee fatigue as a causative factor.

The National Highway Safety Council estimates that thousands of accidents per year are due to trucker and driver fatigue. Medical residents in training pull 36-hour shifts and are prone to fatigue-induced judgment errors. Stockbrokers rise in the middle of the night to juggle huge sums of money on foreign markets. Some lawyers are so burned out by the billable hour treadmill that they are looking at alternative careers.

In isolation, these developments may not seem serious. The consequences of mind-numbing fatigue, however, can cause bodily injury, property damage and business blunders with a high price tag. Underlying seemingly disparate losses is a common thread of human fatigue, stretched taut by downsizing, re-engineering, technological advances and the pressure of global competition.



Companies ignoring these factors can find themselves facing grave safety and loss control risks. There is an increasing amount of case law holding employers liable when their employees' fatigue injures or kills others. Personal injury lawyers are bringing the science of sleep into courtrooms. Lawyer publications such as *Trial* magazine contain articles on suing companies who let workers burn candles at both ends. Courts increasingly say that corporate fatigue management is the business of an organization. Companies ignoring this will receive painful reminders in the form of jury awards and high settlements.

Aside from the loss control consequences, accident and health costs loom as well. Fatigued workers are sicker workers, spawning absenteeism and excessive sick days while inflating the tab for a company's employee benefits program.

While there is ample evidence that human fatigue is a factor which loss control professionals should address, there is scant practical advice on exactly how risk managers can go about this task. Therefore, let's examine some hands-on steps that loss control managers can take in addressing this growing problem.

- **Analyze your operations for chronic fatigue potential.**
  Assess work patterns within your own organization for chronic fatigue potential, especially those who:
  - Work lots of overtime.
  - Work back-to-back shifts.
  - Do shift-work, especially the midnight to 8 a.m. "graveyard" shift.

Not surprisingly, studies show a direct correlation between volume of work hours and the odds of chronic fatigue. Further, night-shift workers whose circadian rhythms are disrupted are much more prone to error.

- **Monitor your organization's corporate culture.**
  See if it subtly or blatantly incentivizes employees to burn candles at both ends. For example, some law firms offer cash bonuses for billings above a certain yearly threshold. In other businesses, bosses monitor whose cars are still in the company parking lot at 7 p.m. and on weekends. Those who fail to log Herculean hours are not promoted because they are not considered "team players" who are willing to pay the price.

  Diagnose objectively your organization's corporate culture. Are long hours viewed as signs of employee loyalty? Are people who work a nine-to-five shift ostracized or passed over for promotions? Do top executives set the tone by not taking all of their vacation time or haunting the office on holidays? These questions offer a starting point for your diagnosis phase.

- **Provide Employee Assistance Programs (EAPs) to all employees.**
  Studies have shown that EAPs help workers address shift-work problems effectively. Your company may be too small to have an in-house EAP. Nevertheless, there are many firms which offer counseling assistance to workers with a wide variety of problems. These problems impact safety.

- **Work with the human resources (HR) department.**
  Fashion a joint safety strategy with HR to manage and prevent corporate fatigue. An effective plan to manage corporate fatigue must involve the human resources (or personnel) department. This helps avoid friction and turf battles over who should be the architect of the plan.

- **Assess staffing and workload levels.**
  Not to overlook the obvious, but are staffing levels realistic within the organization? Are there a sufficient number of people to realistically do the work? Conscious decisions to under-staff to trim overhead may create a climate where chronic fatigue takes root, inviting accidents, injuries and property damage.

- **Undertake a causation analysis.**
  A causation analysis of your organization's past losses to assess the role played by human fatigue takes time, but it is time well spent. Study the gamut of past losses for your organization, particularly workers compensation, fleet auto, property loss, accident and health. Was fatigue a factor? There may be a root cause of many seemingly unrelated losses.

- **Sensitize upper management to the perils of chronic fatigue among workers.**
  This may be the most daunting challenge. For example, in some states the marathon hours of medical residents have come under fire. The medical establishment, though, has resisted efforts to curb residents' hours, partially on the macho ethic that, "We were tough enough to do it, so the new doctors should take it as well."

Until you can demonstrate empirically to top management that fatigue is a causative factor in losses, it will be tough to draw attention to the phenomenon as a loss control issue. If you can make the case, however, and demonstrate that fatigue hurts the organization financially, you speak a language that top executives understand.

Expect skepticism at first. Like an alcoholic denying that he has a drinking problem, many organizations deny that they have a fatigue risk within their workforce. Inwardly, they may concede that one exists but rationalize it as a cost of doing business. Others might think that addressing the problem is tantamount to coddling employees.

Progressive, forward-thinking loss control professionals, though, will analyze the role of fatigue, not only as a clue in unraveling past loss trends, but in averting future losses which can cause financial hemorrhage.

Get some rest and tackle the problem! ■

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