

Annual Insurance Law Report

Developments in Insurance Case Law 2010

FOCUS: California

A summary prepared by Gordon & Rees LLP of the holdings, alphabetized by topic, of the cases published in 2010 applying California law, as well as select cases from other jurisdictions, which address the rights and duties of the insurance industry.



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Abstention

A trial court may abstain from adjudicating a suit that seeks equitable remedies if granting the relief would require a trial court to assume or interfere with the functions of an administrative agency. *Arce v. Kaiser Found. Health Plan, Inc.*, 181 Cal.App.4th 471 (2010).

Abuse of Discretion

The decision to grant or deny a motion for new trial or remittitur rests in the sound discretion of the trial judge; that exercise of discretion can be set aside only upon a clear showing of abuse. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

Accident

An accident does not occur when the insured performs a deliberate act unless some additional unexpected, independent, and unforeseen happening occurs that produces the damage. *Fire Ins. Exch. v. Super. Ct.*, 181 Cal.App.4th 388 (2010).

An accident does not occur in circumstances where the insured committed an intentional act based on a mistaken belief in his or her legal right to engage in the particular conduct. *Fire Ins. Exch. v. Super. Ct.*, 181 Cal.App.4th 388 (2010).

Where the insured intended all of the acts that resulted in the victim's injury, the event may not be deemed an accident merely because the insured did not intend to cause injury. *Fire Ins. Exch. v. Super. Ct.*, 181 Cal.App.4th 388 (2010).

An injury-producing event is not an "accident" within the coverage language of a general liability policy when the acts, the manner in which they were done, and the objective accomplished occurred as intended by the actor. *L.A. Checker Cab Cooperative, Inc. v. First Specialty Insurance Co.*, 186 Cal.App.4th 767 (2010). *Not citable. Review granted.*

An insured's unreasonable belief in the need for self-defense does not turn the resulting purposeful and intentional act of assault and battery into an "accident" within the coverage clause of a general liability policy. *L.A. Checker Cab Cooperative, Inc. v. First Specialty Insurance Co.*, 186 Cal.App.4th 767 (2010). *Not citable. Review granted.*

The term "accident" in a general liability policy's coverage clause refers to the injury-producing acts of the insured, not those of the injured party. *L.A. Checker Cab Cooperative, Inc. v. First Specialty Insurance Co.*, 186 Cal.App.4th 767 (2010). *Not citable. Review granted.*

The term "accident" refers to the event causing damage, not an earlier event creating the potential for future injury. *L.A. Checker Cab Cooperative, Inc. v. First Specialty Insurance Co.*, 186 Cal.App.4th 767 (2010). *Not citable. Review granted.*

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Accidental Direct Physical Loss

“Direct physical loss” “contemplates an actual change in insured property then in a satisfactory state, occasioned by accident or other fortuitous event directly upon the property causing it to become unsatisfactory for future use or requiring that repairs be made.” There must not be intervening persons, conditions, or agencies. An “accident” is one that is unintended and unexpected by the insured. *MRI Healthcare Center of Glendale, Inc. v. State Farm Gen. Ins. Co.*, 187 Cal.App.4th 766 (2010).

In order for an insured to recover under a business policy which provides for loss due to “accidental direct physical loss,” the insured must show it sustained either an “accidental direct physical loss” of its property or a loss of business income due to the “necessary suspension” of its operations caused by “accidental direct physical loss” to its property. *MRI Healthcare Center of Glendale, Inc. v. State Farm Gen. Ins. Co.*, 187 Cal.App.4th 766 (2010).

There is no “accidental direct physical loss” to an insured’s MRI (magnetic resonance imaging) machine when the insured deliberately “ramped down” (demagnetized) the machine and knew of the high probability the MRI would not ramp back up. *MRI Healthcare Center of Glendale, Inc. v. State Farm Gen. Ins. Co.*, 187 Cal.App.4th 766 (2010).

Advertising Injury

Plaintiff must show it was engaged in “advertising” during the policy period to establish a duty to defend for an “advertising injury.” “Advertising” is defined as “widespread promotional activities usually directed to the public at large,” other than “solicitation.” *Hyundai Motor Am. v. Nat’l Union Fire Ins. Co.*, 600 F.3d 1092 (9th Cir. 2010).

The California Supreme Court has specified three required elements to establish “advertising injury”: (1) the insured must be engaged in “advertising” during the policy period when the alleged “advertising injury” occurred; (2) the allegations in the complaint must create a potential for liability under one of the covered offenses; and (3) a causal connection must exist between the alleged injury and the “advertising.” *Hyundai Motor Am. v. Nat’l Union Fire Ins. Co.*, 600 F.3d 1092 (9th Cir. 2010).

Patent infringement of a method of advertising could constitute an “advertising injury” where the underlying complaint alleges the method was a misappropriation of an advertising idea. *Hyundai Motor Am. v. Nat’l Union Fire Ins. Co.*, 600 F.3d 1092 (9th Cir. 2010).

A nonconformity exclusion that bars coverage for advertising injury “arising out of the failure of goods, products or services to conform with any statement of quality or performance made in [the insured’s] advertisements” precludes coverage for third party claims predicated on allegations that the insured’s advertising misrepresented the quality or price of the insured’s own product. *Total Call Int’l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

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A nonconformity exclusion that bars coverage for advertising injury “arising out of the failure of goods, products or services to conform with any statement of quality or performance made in [the insured’s] advertisements” is not ambiguous and applies to claims against the insured by both consumers and competitors. *Total Call Int’l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

A provision for “advertising injury” that provides coverage for injuries arising out of an “oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person’s or organization’s goods, products or services” provides coverage for product disparagement, trade libel and defamation. *Total Call Int’l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

Where there was no alleged injurious falsehood specifically referring to the derogated person or product, the torts of product disparagement, trade libel and defamation do not fall within the scope of a policy’s coverage for advertising injury. *Total Call Int’l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

An insurance policy provision that defines “advertising injury” to include “oral or written publication of material that violates a person’s right of privacy” contemplates the right to be free from disclosure of personal or confidential information, not the right to be free from unwanted intrusion. *State Farm Gen. Ins. Co. v. JT’s Frames, Inc.*, 181 Cal.App.4th 429 (2010).

Applying the “last antecedent rule” of policy construction, to come within a policy provision defining “advertising injury” to include “oral or written publication of material that violates a person’s right of privacy,” the “material” at issue must contain personal or confidential information, the disclosure of which violates the victim’s right to secrecy. *State Farm Gen. Ins. Co. v. JT’s Frames, Inc.*, 181 Cal.App.4th 429 (2010).

A policy provision that defines “advertising injury” to include “oral or written publication of material that violates a person’s right of privacy” must be construed in the context of the policy’s coverage of advertising injury as a whole, including other definitions of advertising injury. *State Farm Gen. Ins. Co. v. JT’s Frames, Inc.*, 181 Cal.App.4th 429 (2010).

Advice of Counsel

While an insured is entitled to withhold privileged information during the insurer’s investigation of a claim, withholding such information may adversely affect the insured. The legislature did not intend to circumvent an insured’s obligations to perform conditions precedent by the enactment of sanctioned privileges. *Abdelhamid v. Fire Ins. Exchange*, 182 Cal.App.4th 990 (2010).

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Anti-Collusive Provisions

An insurer has a legitimate interest in protecting itself from sham or collusive claims, and thus, clear and unambiguous policy provisions excluding coverage for claims made “by or in connection with any business enterprise [other than the insured itself] ... which is directly or indirectly controlled, operated, or managed” by the insured will be upheld. [*Carolina Cas. Ins. Co. v. L.M. Ross Law Group LLP*, 184 Cal.App.4th 196 \(2010\).](#)

Appeals & Writs: Standard of Review

Whether policy language is ambiguous is a question of law that is reviewed *de novo*. [*Legacy Vulcan Corp. v. Super. Court*, 185 Cal.App.4th 677 \(2010\).](#)

Assignment

Insurance Code section 11580 provides an injured plaintiff with the right to bring a direct action against a defendant's insurer which does not defend its insured once the plaintiff obtains a judgment against the defendant. [*Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 \(2010\).](#)

Attorneys' Fees

Insurer did not violate Unfair Competition Law, Bus.& Prof. §§ 17200 *et seq.*, when it sought to recoup its payout from the third-party tortfeasor's insurer without making insured whole unless and until the insured sued the third-party tortfeasor. [*Chandler v. State Farm Mutual Auto. Ins. Co.*, 598 F.3d 1115 \(9th Cir. 2010\).](#)

To determine the percentage of the legal fees attributable to contract recovery, the trial court should determine the total number of hours an attorney spent on the case and then determine the total number of hours spent exclusively on the contract recovery. Hours spent working on issues jointly related to both the tort and contract should be apportioned, with some hours assigned to the contract and some to the tort. This latter figure, added to the hours spent on the contract alone, when divided by the total number of hours worked, provides the appropriate percentage. [*Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 \(2010\).](#)

A prevailing party seeking an award of attorney's fees in an ERISA action must establish that the rate sought is in line with the fees that private attorneys of an ability and reputation comparable to that of prevailing counsel charge their paying clients for legal work of similar complexity. [*Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 \(2010\).](#)

A prevailing party in an ERISA action could not recover attorney's fees for time her counsel spent preparing materials that were stricken from the record as improper or inadmissible. [*Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 \(2010\).](#)

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Once a prevailing party in an ERISA action establishes entitlement to attorney fees, the court must determine a reasonable fee amount by multiplying the number of hours reasonably expended on the litigation by a reasonable hourly rate. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

A prevailing party in an ERISA action may recover attorney's fees for work performed by her attorney related to an administrative review following court-ordered remand to the claim administrator. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

Where a prevailing party in an ERISA action was awarded attorney's fees, and the court found certain hours constituted "block billing," those hours were reduced by 20%. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

Generally, when an insurer's breach of contract places the insured in a situation that makes it necessary to incur expense to protect its interest, such costs and expenses, including attorney's fees, should be treated as the legal consequences of the original wrongful act and may be recovered as damages. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Auto Insurance: Minimum Liability Limits

Minimum limits for insurance coverage are specified in Vehicle Code section 16056, subdivision (a), and require not less than \$15,000 liability coverage for bodily injury to or death of one person in any one accident. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

The insurer and the named insured are empowered to provide in the insurance policy that permissive users will be provided only with the minimum statutory coverage; however, because a reduced coverage provision is a limitation or partial exclusion on coverage it is subjected to the closest possible scrutiny. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

Automobile Exclusion

Employee is an "insured" and automobile exclusion applies when employee is driving a vehicle to work that is required to perform job. *Sprinkles v. Associated Indem. Corp.*, 188 Cal.App.4th 69 (2010).

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Brandt Fees

To determine the percentage of the legal fees attributable to contract recovery, the trial court should determine the total number of hours an attorney spent on the case and then determine the total number of hours spent exclusively on the contract recovery. Hours spent working on issues jointly related to both the tort and contract should be apportioned, with some hours assigned to the contract and some to the tort. This latter figure, added to the hours spent on the contract alone, when divided by the total number of hours worked, provides the appropriate percentage. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Breach of the Implied Covenant of Good Faith and Fair Dealing

Damages are awarded to compensate the insured for losses caused by the insurer's refusal to pay. Penalties, on the other hand, are assessed to punish the insurer for its bad faith. The fact that both require the same finding of bad faith does not render this distinction irrelevant, nor does it render redundant awarding statutory damages along with assessing statutory penalties. In sum, statutory damages under former La. Rev. Stat. Ann. § 22:1220(A) may be awarded concurrent with statutory penalties under former La. Rev. Stat. Ann. § 22:658(B)(1). *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

A breach of the implied covenant of good faith and fair dealing involves something beyond breach of the contractual duty itself and it has been held that bad faith implies unfair dealing rather than mistaken judgment. *Nieto v. Blue Shield of California Life and Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

An insurer's bad judgment or negligence is insufficient to establish bad faith; instead, the insurer must engage in a conscious and deliberate act, which unfairly frustrates the agreed common purposes and disappoints the reasonable expectations of the other party thereby depriving that party of the benefits of the agreement. *Nieto v. Blue Shield of California Life and Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

Unreasonable delay in paying policy benefits or paying less than the amount due is actionable withholding of benefits which may constitute a breach of contract as well as bad faith giving rise to damages in tort. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

An insurer's failure to acknowledge the insured's right to independent counsel and delay in paying policy benefits gives rise to causes of action for breach of contract and bad faith as a breach of the duty to defend. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

When an insured agrees to an insurer's settlement of a third party claim, the insured waives any right to maintain a bad faith action against the insurer based on the settlement, unless the insured's agreement to the settlement was procured by coercion, duress, fraud or some other improper means. *Essex Ins. Co. v. Heck*, 186 Cal.App.4th 1513 (2010).

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The genuine dispute doctrine does not apply to an insurer's failure to settle in third party cases. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Where a single insurer insures the risk, the insurer must receive a settlement offer within policy limits to be liable in bad faith for failure to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Where multiple insurers insure the risk, an insurer must receive a settlement offer within the combined policy limits of all the insurers on the risk to be liable in bad faith for failure to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

An excess judgment against an insured is not necessary to establish bad faith for refusal to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

On a motion for summary judgment, in a state law disability insurance benefits action, evidence that insurer's experts had financial incentive to provide opinions favorable to the insurer, and experts' opinion were not reasonable interpretations of the evidence sufficed to raise a material question as to bias. *Bravo v. The U. S. Life Ins. Co. in the City of N. Y.*, 701 F.Supp. 2d 1145 (E.D. Cal. 2010).

On a motion for summary judgment, in a state law disability insurance benefits action, evidence that the insurer unreasonably ignored the limits imposed by a treating physician and afforded too little weight to subjective reports raises a material question as to whether insurer's conclusion that insured was not disabled was reasonable. *Bravo v. The U. S. Life Ins. Co. in the City of N. Y.*, 701 F.Supp. 2d 1145 (E.D. Cal. 2010).

On a motion for summary judgment, in a state law disability insurance benefits action, where insured presents substantial evidence of disability, insurer's motion for summary judgment of breach of contract claim will be denied. *Bravo v. The U. S. Life Ins. Co. in the City of N. Y.*, 701 F.Supp. 2d 1145 (E.D. Cal. 2010).

There can be no breach of the implied covenant of good faith and fair dealing where there is no coverage under the policy. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

An insured alleging breach of the duty of good faith must show both that the insurer acted unreasonably in investigating, evaluating or processing the claim and that it either knew or was conscious of the fact that it acted unreasonably. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

An insurer's failure to pay a claim is not unreasonable when the claim's validity is "fairly debatable." *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

An insurer's reasonable but incorrect policy interpretation does not, by itself, constitute bad faith. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

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An insurer does not commit bad faith simply by asserting a policy defense that turns out to be invalid or unfounded. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Business Interruption Coverage

Losses for business interruption cannot be based on conjecture or speculation. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

Decreased and lost anticipated patronage resulting from incomplete property may be covered under a business interruption policy coverage as “loss resulting directly from necessary interruption of business whether total or partial.” *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Loss resulting from decreased and lost anticipated patronage following collapse and delay of hotel expansion is not covered because the damage was to property that was not yet contributing to insured's business income and not covered under the policy. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

In the context of contingent business interruption loss coverage, the ordinary meaning of “contributing property” is that the property is presently in operation or production and adding to the Insured's business when the loss occurs. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

If an enterprise spent substantial amounts of money building on-site signage to attract customers to its premises to purchase goods that created a documented increase in customers and the signage is subsequently destroyed by a covered peril, then although the production facility itself has not been impacted, the insured should nonetheless be entitled to coverage if the policy provides for interruption of its “business.” *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

In lay terms, there is simply no question that the term “business” in a business interruption policy is not limited to the “operation” or “ability to use” one's premises, as contrasted with a broader definition that also includes the ability to sell the services available or the goods produced. One would not be able to stay in “business” if one's production facility was not impaired, but there was no ability to sell any items produced. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

California Business & Professions Code Section 17200: Unfair Competition Law

Since the only remedy available in a private action under California's unfair competition law is restitution and restitution is not a penalty, Civil Code section 3345 is not applicable to a private action under the unfair competition law. *Clark v. Super. Ct.*, 50 Cal. 4th 605 (2010).

Class action “pick off” cases apply to unfair competition claims under California Business & Professions Code section 17200, despite the injury-in-fact requirement. The pick off cases presuppose injury-in-fact at the time the lawsuit is filed. *Wallace v. GEICO Gen. Ins. Co.*, 183 Cal.App.4th 1390 (2010).

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California Civil Code Section 354.4

Parent company whose German subsidiaries issued insurance policies to Armenian Genocide victims was an “insurer” as defined by California Civil Code section 354.4, and thus a proper defendant in a suit brought pursuant to that statute. *Movsesian v. Victoria Versicherung AG*, 2010 U.S. App. LEXIS 25225 (9th Cir. 2010).

California Civil Code section 354.4, governing pursuit of insurance claims under policies issued to Armenian Genocide victims, does not define “insurer” for purposes of limiting potential classes of defendants, but rather to limit the types of claims that may be brought. *Movsesian v. Victoria Versicherung AG*, 2010 U.S. App. LEXIS 25225 (9th Cir. 2010).

California Civil Code Section 2860

An insured is entitled to independent counsel under Civil Code section 2860(c) subject to the insurer’s right to exercise its right to require that the counsel selected by the insured possess certain minimum qualifications. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

Under Civil Code section 2860(c), the insurer’s obligation to pay fees to the independent counsel selected by the insured is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

Issues regarding an insurer’s duty to defend must be resolved before arbitration of a dispute over fees charged by independent counsel. A premature determination that an insurer is entitled to binding arbitration under section 2860(c) may prejudice the insured’s bad faith and breach of contract claim. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

Civil Code section 2860(c) requires binding arbitration of all contested issues concerning the amount of attorney fees owed independent counsel. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

California Civil Code Section 3345

Civil Code section 3345 applies in actions brought by, on behalf of, or for the benefit of senior citizens or disabled persons to redress unfair or deceptive acts or practices or unfair methods of competition. *Clark v. Super. Ct.*, 50 Cal. 4th 605 (2010).

Subdivision (b) of Civil Code section 3345 allows for a recovery of up to three times the amount of a monetary award whenever a trier of fact is authorized by a statute to impose a fine, or a civil penalty or other penalty, or any other remedy the purpose or effect of which is to punish or deter, if the trier of fact finds any of the factors identified in the statute existed. *Clark v. Super. Ct.*, 50 Cal. 4th 605 (2010).

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Civil Code section 3345 authorizes the trebling of a remedy only when it is in the nature of a penalty. *Clark v. Super. Ct.*, 50 Cal. 4th 605 (2010).

Since the only remedy available in a private action under California's unfair competition law is restitution and restitution is not a penalty, Civil Code section 3345 is not applicable to a private action under the unfair competition law. *Clark v. Super. Ct.*, 50 Cal. 4th 605 (2010).

California Health and Safety Code Section 1374.72

Codified in California Health and Safety Code § 1374.72, the Mental Health Parity Act obligates health plans to provide coverage for the diagnosis and treatment of mental illnesses. The statute specifically defines and includes autism in these mental illnesses. *Arce v. Kaiser Found. Health Plan, Inc.*, 181 Cal.App.4th 471 (2010).

California Insurance Code Section 332

California Insurance Code § 332 does not require a health care service plan to disclose how an insured could structure coverage so as to lower the insured's monthly health care premiums. *Levine v. Blue Shield of Cal.*, 189 Cal.App.4th 1117 (2010).

California Insurance Code Section 11580

Insurance Code section 11580 provides an injured plaintiff with the right to bring a direct action against a defendant's insurer which does not defend its insured once the plaintiff obtains a judgment against the defendant. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

California Insurance Code Section 12340.11

A preliminary report shall not be construed as, nor constitute, a representation as to the condition of title to real property, but it shall constitute a statement of the terms and conditions upon which the issuer is willing to issue its title policy, if such offer is accepted. *Lee v. Fidelity Nat'l Title Ins. Co.*, 188 Cal.App.4th 583 (2010).

California Insurance Guarantee Association

CIGA has the authority to stipulate and enter a binding settlement of a claim where its liability is uncertain. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

Section 1063.2, subdivision (b), broadly authorizes CIGA to investigate claims with the object of paying covered claims and denying noncovered claims. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

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It is a reasonable construction of section 1063.2, subdivision (b) that CIGA has the statutory authority to investigate and assess its probable liability, factually and legally, for a presented claim and to accept a settlement offer it determines is reasonable. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

CIGA must pay covered claims, which are obligations of an insolvent insurer. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

Covered claims does not include any claim to the extent it is covered by any other insurance. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

Where an insured has overlapping insurance policies and one insurer becomes insolvent, the other insurer, even if only a secondary or excess insurer, is responsible for paying the claim. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

CIGA is an insurer of last resort and does not assume responsibility for claims where there is any other insurance available. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

CIGA need not reimburse a permissibly self-insured employer for benefits paid to an employee for cumulative injury if the employer's liability is based in part on a period of time when the employer was self-insured and chose not to buy excess insurance for the particular risk. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

California Insurance Guarantee Association's Timely "Covered Claims"

The willingness of an out-of-state liquidator to extend the time for filing an insolvent insurer claim is not binding on a local liquidator such as CIGA, whose time limit for "covered claims" is strictly enforced. *HCM Healthcare, Inc. v. Cal. Ins. Guarantee Ass'n*, 187 Cal.App.4th 1317 (2010).

Claims in Excess of Limits: Multiple Claimants

Arizona law rejects the "first in time, first in right" rule as applied to multiple claims to a single insurance policy when no factual basis exists upon which a meaningful temporal priority can be established. *McReynolds v. Am. Commerce Ins. Co.*, 235 P.3d 278 (Ariz. 2010).

The prompt, good faith filing of an interpleader as to all known claimants with payment of the policy limits into the court and the continued provision of a defense for the insured as to each pending claim, acts as a safe harbor for an insurer against a bad faith claim for failure to properly manage the policy limits (or give equal consideration to settlement offers) when multiple claimants are involved and the expected claims are in excess of the applicable policy limits. *McReynolds v. Am. Commerce Ins. Co.*, 235 P.3d 278 (Ariz. 2010).

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Claims Handling

The insurer's offer to consider additional information provided by the insured alone does not reflect any continuing evaluation by the insurer, and thus, does not constitute a re-opening of the insurer's obligations and duties under the policy. *Abdelhamid v. Fire Ins. Exchange*, 182 Cal.App.4th 990 (2010).

Class Actions

Though individual claims against brokers may not be suitable for adjudication within the class action framework, the existence of individual claims against other parties, such as brokers, does not necessarily defeat the availability of a class action against the company under a statute aimed at protecting reasonable consumers from deceptive business practices. *Yokoyama v. Midland Nat'l Life Ins. Co.*, 594 F.3d 1087 (9th Cir. 2010).

A class-action defendant is not permitted to avoid a class suit by "picking off" the representative plaintiffs by remedying the plaintiff's individual injuries after suit is filed. *Wallace v. GEICO Gen. Ins. Co.*, 183 Cal.App.4th 1390 (2010).

Class action "pick off" cases apply to unfair competition claims under California Business & Professions Code section 17200, despite the injury-in-fact requirement. The pick off cases presuppose injury-in-fact at the time the lawsuit is filed. *Wallace v. GEICO Gen. Ins. Co.*, 183 Cal.App.4th 1390 (2010).

Conditions Precedent

Insured must perform conditions precedent before recovering under an insurance policy. In other words, an insurer is entitled to deny coverage where the insured fails to perform conditions precedent. *Abdelhamid v. Fire Ins. Exch.*, 182 Cal.App.4th 990 (2010).

Contract Damages

In determining whether a CGL policy covers a particular situation involving damage, the proper inquiry is whether an occurrence has caused property damage, not whether the ultimate remedy for that claims lies in contract or in tort. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

An assumption of liability in a contract exclusion does not encompass any contract, regardless of its nature. This exclusion applies only to the assumption of another's liability, such as an agreement to indemnify or hold another harmless. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Contract Interpretation

The Louisiana Civil Code provides that a contract should be interpreted to effect the common intent of the parties, and an insurance policy must be construed according to the entirety of its terms and conditions as set forth in the policy. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

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Louisiana has established rules of analysis for interpreting a policy that contains potentially ambiguous language: The words of a contract must be given their generally prevailing meaning. When the words of a contract are clear and explicit and lead to no absurd consequences, no further interpretation may be made in search of the parties' intent. If the policy wording at issue is clear and unambiguously expresses the parties' intent, the insurance contract must be enforced as written. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

Louisiana has established rules of analysis for interpreting a policy that contains potentially ambiguous language: Where, however, an insurance policy includes ambiguous provisions, the ambiguity must be resolved by construing the policy as a whole; one policy provision is not to be construed separately at the expense of disregarding other policy provisions. Words susceptible of different meanings must be interpreted as having the meaning that best conforms to the object of the contract. A provision susceptible of different meanings must be interpreted with a meaning that renders it effective and not with one that renders it ineffective. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

Louisiana has established rules of analysis for interpreting a policy that contains potentially ambiguous language: Ambiguity may be resolved through the use of the reasonable-expectations doctrine--i.e., by ascertaining how a reasonable insurance policy purchaser would construe the clause at the time the insurance contract was entered. The court should construe the policy to fulfill the reasonable expectations of the parties in light of the customs and usages of the industry. A doubtful provision must be interpreted in light of the nature of the contract, equity, usages, the conduct of the parties before and after the formation of the contract, and of other contracts of a like nature between the same parties. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

Louisiana recognizes two levels of ambiguity. If an ambiguity is perceived, then various tools of construction are applied that do not initially include construing the term against the drafter. If after applying the other general rules of construction an ambiguity remains, the ambiguous contractual provision is to be construed against the drafter, or, as originating in the insurance context, in favor of the insured. Further, that last principle applies only if equivocal provisions seek to narrow an insurer's obligation, and only where an ambiguous policy provision is susceptible to two or more reasonable interpretations. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

A court's interpretation of an insurance policy is a three part test: (1) is the policy, as it would be construed by a layperson, ambiguous (if not, the inquiry ends); (2) if ambiguous, is a finding of coverage under the policy consistent with the objectively reasonable expectations of the insured; (3) if still ambiguous after application of the reasonable expectation test, a court takes a final step in the interpretation analysis, construing the ambiguous language against the insurer, and in favor of coverage. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

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A conclusion that a policy is ambiguous does not provide a path to an absolute contractual entitlement to coverage, and a court may not rewrite a policy to bind an insurer to cover a risk which it did not contemplate covering, and for which it was not paid to provide coverage. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

The test is not whether a policy could be written better, from a customer service perspective after the fact, but instead whether, as written, it is ambiguous in the first instance. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

In interpreting a word in an insurance policy, including a word in an exclusion, a court may consult and consider definitions found in a common dictionary, provided the court does not disregard the policy's context, and maintains an eye on the fundamental goal of deciding how a layperson policyholder might reasonably interpret the exclusion's language. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

Generally, absent special or technical language, if the meaning a layperson would ascribe to the language of a contract of insurance is clear and unambiguous, a court will apply that meaning. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

Insurance contracts are contracts to which the ordinary rules of contract interpretation apply. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

The rules of contract interpretation require courts to look first to the language of the contract in order to ascertain its plain meaning or the meaning a layperson would ordinarily attach to it. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

It is the mutual intention of the parties at the time the contract is formed that governs interpretation. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

Interpretation of an insurance policy is a question of law. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

A court may not rewrite a policy to bind the insurer to a risk that it did not contemplate and for which it has not been paid. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

The purpose of the resolution of uncertainty in favor of the insured is to protect his or her reasonable expectation of coverage. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

The rule that uncertainty should be resolved in favor of the insured in order to protect the insured's reasonable expectation of coverage is applicable only when the policy language is found to be unclear. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

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A policy provision is ambiguous only when it is capable of two or more constructions, both of which are reasonable. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

An insurance policy is not rendered ambiguous or uncertain because of a strained or grammatically incorrect reading of the policy's terms. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

Although provisions, conditions and exceptions that tend to limit liability are strictly construed against the insurer, strict construction does not mean strained construction. Even when resolving uncertainties and ambiguities against the insurer, the policy must be given a reasonable interpretation and the words used are to be given their common, ordinary and customary meaning. *Am. Int'l Underwriters Ins. Co. v. Am. Guarantee and Liab. Ins. Co.*, 181 Cal.App.4th 616 (2010).

While insurance contracts have special features, they are still contracts subject to the ordinary rules of contract interpretation. The fundamental goal of contract interpretation is to give effect to the parties' mutual intentions, which, if possible, should be inferred solely from the written terms of the policy. If that language is clear and explicit, it governs. *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal.App.4th 1466 (2010).

Policy provisions are ambiguous only if they are capable of two or more reasonable constructions. Courts will not adopt a strained or absurd interpretation to create an ambiguity where none exists. *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal.App.4th 1466 (2010).

The fundamental rule of contract interpretation is that a contract should be construed to give effect to the mutual intention of the contracting parties at the time the contract was formed. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

The mutual intention of the contracting parties at the time the contract was formed is to be inferred, if possible, solely from the written provisions of the contract. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

The clear and explicit meaning of the written provisions, interpreted in their ordinary and popular sense, unless used by the parties in a technical sense or a special meaning is given to them by usage, controls judicial interpretation. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

In an insurance policy, coverage provisions are interpreted broadly so as to afford the greatest possible protection to the insured, whereas exclusionary clauses are interpreted narrowly. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

A policy provision will be considered ambiguous when it is capable of two or more constructions, both of which are reasonable. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

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If there is ambiguity, it is resolved by interpreting the ambiguous provisions in the sense the insurer believed the insured understood them when the contract was made, which means the court must first attempt to determine whether coverage is consistent with the insured's objectively reasonable expectations. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

In determining whether coverage is consistent with the insured's objectively reasonable expectations, the court must interpret the language in the context of the policy as a whole, and in the circumstances of the case. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

If the ambiguity cannot be resolved, it is construed against the party who caused it to exist. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

The interpretation of an insurance policy corresponds to the interpretation of contracts generally. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

The parties' mutual intention when they form the contract governs interpretation; the fundamental goal of contractual interpretation is to give effect to the mutual intention of the parties. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

If possible, courts infer intent solely from the written provisions of the insurance policy. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

If the policy language is clear and explicit, it governs. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

When interpreting a policy provision, courts must give its terms their ordinary and popular sense, unless used by the parties in a technical sense or a special meaning is given to them by usage. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

Courts must interpret terms in context and give effect to every part of the policy with each clause helping to interpret the other. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

A policy provision will be considered ambiguous when it is capable of two or more constructions, both of which are reasonable. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

Language in a contract must be interpreted as a whole, and in the circumstances of the case, and cannot be found to be ambiguous in the abstract. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

Whether policy language is ambiguous is a question of law that is reviewed *de novo*. *Legacy Vulcan Corp. v. Super. Court*, 185 Cal.App.4th 677 (2010).

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An insurance policy is interpreted using the same rules of interpretation applicable to other contracts. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The goal of policy interpretation is to give effect to the mutual intention of the contracting parties at the time the contract was formed. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The intention of the parties is determined solely from the written contract if possible but the circumstances under which the contract was made and the matter to which it relates may also be considered. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

In interpreting an insurance policy, the contract as a whole must be considered and its language interpreted in context so as to give effect to each provision, rather than interpret contractual language in isolation. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Words of an insurance policy are to be interpreted in accordance with their ordinary and popular sense, unless the words are used in a technical sense or a special meaning is given to them by usage. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Any limitation on coverage otherwise available under a policy must be stated understandably in words that are part of the working vocabulary of the average layperson. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

If contractual language is clear and explicit and does not involve an absurdity, the plain meaning governs. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Contract interpretation, including the resolution of any ambiguity, is solely a judicial function, unless the interpretation turns on the credibility of extrinsic evidence. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The terms “self-insured retention” and “retained limit” are not sufficient to convey to an unsophisticated insured an understanding of what an insurance expert or attorney might believe to be the essence of a self-insured retention. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Ordinary rules of contract interpretation apply to insurance policies. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

Under statutory rules of contract interpretation, the mutual intention of the parties at the time the contract is formed governs. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

In the insurance context, the court generally resolves ambiguities in favor of coverage. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

Courts typically interpret the coverage clauses of insurance policies broadly, protecting the objectively reasonable expectations of the insured. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

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Because the insurer writes the policy, it is held responsible for ambiguous language, which is therefore construed in favor of coverage. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

When the facts are undisputed, as they are deemed to be when ruling on a demurrer, the interpretation of a contract, including whether an insurance policy is ambiguous or whether an exclusion or limitation is sufficiently conspicuous, plain, and clear, is a question of law. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

To the extent a insured's understanding of a policy is contrary to the policy's explicit language, then the insured's subjective intent is not relevant. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

When the facts are undisputed, as they are deemed to be when ruling on a demurrer, the interpretation of a contract, including whether an insurance policy is ambiguous or whether an exclusion or limitation is sufficiently conspicuous, plain, and clear, is a question of law. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

Parol evidence is admissible to interpret an insurance policy if relevant to prove a meaning to which the language of the instrument is reasonable susceptible. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

Although parol evidence is admissible to determine whether the terms of a contract are ambiguous, it is not admissible if it contradicts a clear and explicit policy provision. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

The determination whether to admit parol evidence involves a two step process. First, the court provisionally receives all credible evidence concerning the parties intentions to determine ambiguity, i.e., whether the language is reasonably susceptible to the interpretation urged by a party. If, in light of the extrinsic evidence, the court finds that the language is reasonably susceptible, the evidence is admitted to the second step – contract interpretation. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

The test of whether parol evidence is admissible to construe and ambiguity is not whether the language appears to the court unambiguous, but whether the evidence presented is relevant to prove a meaning to which the language is reasonably susceptible. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

When determining whether a particular policy provides a potential for coverage courts are guided by the principle that interpretation of an insurance policy is a question of law. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

While insurance contracts have special features, they are still contracts to which ordinary rules of contractual interpretation apply. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

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The fundamental goal of contractual interpretation is to give effect to the mutual intention of the parties. Such intent is to be inferred, if possible, solely from the written provisions of the contract. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

If contractual language is clear and explicit it governs. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

A policy provision will be considered ambiguous if it is capable of two or more constructions both of which are reasonable. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

The fact that a term is not defined in a policy does not make it ambiguous. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

Language in a contract must be construed in the context of that instrument as a whole, and in the circumstances of the case, and cannot be found to be ambiguous in the abstract. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

If an asserted ambiguity is not eliminated by the language and context of the policy, courts invoke the principle that ambiguities are generally construed against the party who caused the uncertainty to exist (i.e., the insurer) in order to protect the insured's reasonable expectation of coverage. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

When construing an insurance policy, the court must resolve ambiguities in coverage clauses most broadly in favor of coverage, and we concomitantly must narrowly construe exclusions and limitations on coverage. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

Interpretation of an insurance policy seeks to give effect to the mutual intent of the parties. *S.B.C.C., Inc. v. St. Paul Fire and Marine Ins. Co.*, 186 Cal.App.4th 383 (2010).

Policy terms will be considered ambiguous if they are capable of two or more constructions, both of which are reasonable. But language in a contract must be interpreted as a whole, and in the circumstances of the case, and cannot be found to be ambiguous in the abstract. *S.B.C.C., Inc. v. St. Paul Fire and Marine Ins. Co.*, 186 Cal. App.4th 383 (2010).

Courts will not strain to create an ambiguity where none exists. *S.B.C.C., Inc. v. St. Paul Fire and Marine Ins. Co.*, 186 Cal.App.4th 383 (2010).

An ambiguity may be construed against an insurer only if the insured had an objectively reasonable expectation there would be coverage under the policy consistent with the ambiguity. In determining whether an ambiguity exists, a court should consider not only the face of the contract but also any extrinsic evidence that supports a reasonable interpretation, consistent with the objectively reasonable expectations of the insured. *Clarendon Am. Ins. Co. v. N. Am. Capacity Ins. Co.*, 186 Cal.App.4th 556 (2010).

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An ambiguity may be construed against an insurer only if the insured had an objectively reasonable expectation there would be coverage under the policy consistent with the ambiguity. In determining whether an ambiguity exists, a court should consider not only the face of the contract but also any extrinsic evidence that supports a reasonable interpretation, consistent with the objectively reasonable expectations of the insured. *Clarendon Am. Ins. Co. v. N. Am. Capacity Ins. Co.*, 186 Cal.App.4th 556 (2010).

In the absence of a definition of a term in the policy, the court will look to its “ordinary and popular sense.” *Clarendon Am. Ins. Co. v. N. Am. Capacity Ins. Co.*, 186 Cal.App.4th 556 (2010).

If an “ordinary reading” of a policy provision is unambiguous, then any reasonable expectation of coverage would be precluded from consideration. If there is an ambiguity, the court will look to the “ordinary reading” of words in the insurance policy that are to be interpreted according to the plain meaning which a layman would ordinarily attach to the words. *Lee v. Fidelity Nat’l Title Ins. Co.*, 188 Cal.App.4th 583 (2010).

When presented with extrinsic evidence the judge first considers the offered evidence and, if he or she finds that the contract language is reasonably susceptible to the interpretation asserted by its proponent, the evidence is admissible to determine the meaning intended by the parties. If the asserted interpretation is unreasonable or the offered evidence is not persuasive, then the judge bars admission of the extrinsic evidence. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Courts interpret a contract ‘so that every part is given effect, and each section of an agreement must be read in relation to each other to bring harmony, if possible, between all parts of the writing.’” *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

A court’s reading of one provision of a contract must not render a related provision meaningless. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

The specific provisions of a contract qualify the meaning of a general provision. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Arizona law requires courts eschew technical jargon or commercial customs that are both unexplained and unincorporated in the terms of the insurance policy itself and in fact contrary to a commonly held view of the term in dispute. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Interpretation of an insurance contract is a question of law, reviewed de novo. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

When a contract contains a specific provision that appears to conflict with a general provision, the usual interpretive rule is that the specific provision controls. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

When contract provisions appear to contradict each other, courts try to harmonize all parts of the contract by a reasonable interpretation in view of the entire instrument. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

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In determining whether a CGL policy covers a particular situation involving damage, the proper inquiry is whether an occurrence has caused property damage, not whether the ultimate remedy for that claims lies in contract or in tort. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Contract Interpretation: Ambiguity

A court's interpretation of an insurance policy is a three part test: (1) is the policy, as it would be construed by a layperson, ambiguous (if not, the inquiry ends); (2) if ambiguous, is a finding of coverage under the policy consistent with the objectively reasonable expectations of the insured; (3) if still ambiguous after application of the reasonable expectation test, a court takes a final step in the interpretation analysis, construing the ambiguous language against the insurer, and in favor of coverage. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

A conclusion that a policy is ambiguous does not provide a path to an absolute contractual entitlement to coverage, and a court may not rewrite a policy to bind an insurer to cover a risk which it did not contemplate covering, and for which it was not paid to provide coverage. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

The test is not whether a policy could be written better, but instead whether, as written, it is ambiguous in the first instance. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

In interpreting a word in an insurance policy, including a word in an exclusion, a court may consult and consider definitions found in a common dictionary, provided the court does not disregard the policy's context, and maintains an eye on the fundamental goal of deciding how a layperson policyholder might reasonably interpret the exclusion's language. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

A policy provision will be considered ambiguous when it is capable of two or more constructions, both of which are reasonable. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

If there is ambiguity, it is resolved by interpreting the ambiguous provisions in the sense the insurer believed the insured understood them when the contract was made, which means the court must first attempt to determine whether coverage is consistent with the insured's objectively reasonable expectations. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

If an ambiguity cannot be resolved, it is construed against the party who caused it to exist. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

The fundamental rule of contract interpretation is that a contract should be construed to give effect to the mutual intention of the contracting parties at the time the contract was formed. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

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The mutual intention of the contracting parties at the time the contract was formed is to be inferred, if possible, solely from the written provisions of the contract. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

The clear and explicit meaning of the written provisions, interpreted in their ordinary and popular sense, unless used by the parties in a technical sense or a special meaning is given to them by usage, controls judicial interpretation. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

In an insurance policy, coverage provisions are interpreted broadly so as to afford the greatest possible protection to the insured, whereas exclusionary clauses are interpreted narrowly. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

Policy language is ambiguous if it is susceptible of more than one reasonable interpretation in the context of the policy as a whole. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Whether policy language is ambiguous is a question of law that is reviewed *de novo*. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Any ambiguity must be resolved in a manner consistent with the objectively reasonable expectations of the insured in light of the nature and kind of risks covered by the policy. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Any provision that limits coverage reasonably expected by the insured under the policy terms must be conspicuous, plain and clear to be effective. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The terms “self-insured retention” and “retained limit” are not sufficient to convey to an unsophisticated insured an understanding of what an insurance expert or attorney might believe to be the essence of a self-insured retention. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Policy terms will be considered ambiguous if they are capable of two or more constructions, both of which are reasonable. But language in a contract must be interpreted as a whole, and in the circumstances of the case, and cannot be found to be ambiguous in the abstract. *S.B.C.C., Inc. v. St. Paul Fire and Marine Ins. Co.*, 186 Cal.App.4th 383 (2010).

Courts will not strain to create an ambiguity where none exists. *S.B.C.C., Inc. v. St. Paul Fire and Marine Ins. Co.*, 186 Cal.App.4th 383 (2010).

An ambiguity may be construed against an insurer only if the insured had an objectively reasonable expectation there would be coverage under the policy consistent with the insured’s interpretation. In determining whether an ambiguity exists, a court should consider not only the face of the contract but also any extrinsic evidence that supports a reasonable interpretation, consistent with the objectively reasonable expectations of the insured. *Clarendon Am. Ins. Co. v. N. Am. Capacity Ins. Co.*, 186 Cal.App.4th 556 (2010).

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If an “ordinary reading” of a policy provision is unambiguous, then any reasonable expectation of coverage would be precluded from consideration. If there is an ambiguity, the court will look to the “ordinary reading” of words in the insurance policy that are to be interpreted according to the plain meaning which a layman would ordinarily attach to the words. *Lee v. Fidelity Nat’l Title Ins. Co.*, 188 Cal.App.4th 583 (2010).

When presented with extrinsic evidence, the judge first considers the offered evidence and, if he or she finds that the contract language is reasonably susceptible to the interpretation asserted by its proponent, the evidence is admissible to determine the meaning intended by the parties. If the asserted interpretation is unreasonable or the offered evidence is not persuasive, then the judge bars admission of the extrinsic evidence. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Courts interpret a contract “so that every part is given effect, and each section of an agreement must be read in relation to each other to bring harmony, if possible, between all parts of the writing.” *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

A court’s reading of one provision of a contract must not render a related provision meaningless. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

The specific provisions of a contract qualify the meaning of a general provision. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Arizona law requires courts eschew technical jargon or commercial customs that are both unexplained and unincorporated in the terms of the insurance policy itself and in fact contrary to a commonly held view of the term in dispute. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Interpretation of an insurance contract is a question of law, reviewed de novo. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

When a contract contains a specific provision that appears to conflict with a general provision, the usual interpretive rule is that the specific provision controls. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

When contract provisions appear to contradict each other, courts try to harmonize all parts of the contract by a reasonable interpretation in view of the entire instrument. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

Contract Interpretation: Reasonable Expectations of Insured

Any ambiguity must be resolved in a manner consistent with the objectively reasonable expectations of the insured in light of the nature and kind of risks covered by the policy. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Any provision that limits coverage reasonably expected by the insured under the policy terms must be conspicuous, plain and clear to be effective. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

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Absent language to the contrary, an insured has no reasonable expectation an excess insurer will defend until primary insurance is exhausted. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Contractual Limitations Provisions

An insurer is required to provide notice of all contractual limitations provisions to any claimant. *Superior Dispatch, Inc. v. Ins. Corp. of N. Y.*, 181 Cal.App.4th 175 (2010).

Although an insured is represented by counsel, an insurer is still required to give notice of all contractual limitations provisions. *Superior Dispatch, Inc. v. Ins. Corp. of N. Y.*, 181 Cal.App.4th 175 (2010).

Costs

Allocation of costs between codefendants is not appropriate unless it can be demonstrated that the issues involved were separable between the codefendants. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Attorney meal expenses are a recoverable cost. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Generally, when an insurer's breach of contract places the insured in a situation that makes it necessary to incur expense to protect its interest, such costs and expenses, including attorney's fees, should be treated as the legal consequences of the original wrongful act and may be recovered as damages. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Cumis Counsel

An insured is entitled to independent counsel under Civil Code section 2860(c) subject to the insurer's right to exercise its right to require that the counsel selected by the insured possess certain minimum qualifications. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

Under Civil Code section 2860(c), the insurer's obligation to pay fees to the independent counsel selected by the insured is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

Cumis Counsel Arbitration

Issues regarding an insurer's duty to defend must be resolved before arbitration of a dispute over fees charged by independent counsel. A premature determination that an insurer is entitled to binding arbitration under section 2860(c) may prejudice the insured's bad faith and breach of contract claim. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

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Civil Code section 2860(c) requires binding arbitration of all contested issues concerning the amount of attorney fees owed independent counsel. *Intergulf Dev. LLC v. Super. Ct.*, 183 Cal.App.4th 16 (2010).

Declaratory Relief Actions: Prejudice to insured

An insured is prejudiced by concurrent litigation of a declaratory relief action and third party actions where: (1) the insurer will join forces with the plaintiffs in the underlying action as a means to defeat coverage; (2) the insured will be compelled to fight a two front war, doing battle with the plaintiffs in the third party litigation while at the same time devoting its money and its human resources to litigating coverage issues with its carriers; and (3) the insured may be collaterally estopped from relitigating any adverse factual findings in the third party action notwithstanding that any fact found in the insured's favor could not be used to its advantage. *United Enter., Inc. v. Super. Ct.*, 183 Cal.App.4th 1004 (2010).

Demurrer

In the context of a demurrer, the absence of a duty to defend may be established when the allegations in the third party complaint disclose no basis for policy coverage, and the insured's complaint alleges no extrinsic facts that raise a possibility of coverage. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

When an insurance policy is attacked as ambiguous solely on the basis of the policy's language, the challenge presents a question of law properly resolved on demurrer. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

Duty

An insurer is not a fiduciary, and owes no obligation to consider the interests of its insured above its own. *Village Northridge Homeowners Ass'n v. State Farm Fire & Cas. Co.*, 50 Cal. 4th 913 (2010).

There is no special duty in the relationship between an insurer and a potential insured. The relationship between an insurer and a prospective insured is not a fiduciary relationship. An insurer does not owe a purchaser of insurance any special duty in negotiating the price of an insurance contract. *Levine v. Blue Shield of Cal.*, 189 Cal. App.4th 1117 (2010).

The amount of money that an insurer is willing to accept in exchange for coverage is not information that implicates the special relationship between an insurer and its insured, because it does not relate to coverage or the processing of claims. *Levine v. Blue Shield of Cal.*, 189 Cal.App.4th 1117 (2010).

An insurer has no special common law duties as to a purchaser of insurance concerning the calculation of premiums, whether the insured is a potential insured or an insured. *Levine v. Blue Shield of Cal.*, 189 Cal.App.4th 1117 (2010).

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Duty to Defend

The Ninth Circuit court applied a “contextual reasonableness” analysis to determine whether a patent infringement constituted an “advertising injury.” The test was whether the patent at issue “involves any process or invention which could reasonably be considered an ‘advertising idea’.” *Hyundai Motor Am. v. Nat’l Union Fire Ins. Co.*, 600 F.3d 1092 (9th Cir. 2010).

The California Supreme Court has specified three required elements to establish a duty to defend for an “advertising injury”: (1) the insured was engaged in “advertising” during the policy period when the alleged “advertising injury” occurred; (2) the allegations in the complaint created a potential for liability under one of the covered offenses (i.e., misappropriation of advertising ideas); and (3) a causal connection existed between the alleged injury and the “advertising.” *Hyundai Motor Am. v. Nat’l Union Fire Ins. Co.*, 600 F.3d 1092 (9th Cir. 2010).

An insurer’s duty is not measured by the technical legal cause of action pleaded in the underlying complaint, but by the potential for liability as revealed by the facts alleged in the complaint or otherwise known to the insurer. *Hudson Ins. Co. v. Colony Ins. Co.*, 624 F.3d 1264 (9th Cir. 2010).

An insurer’s duty to defend is triggered when the facts alleged in the complaint or otherwise known to the insurer raises the potential for coverage, even if the underlying claimant declines to assert the claim. *Hudson Ins. Co. v. Colony Ins. Co.*, 624 F.3d 1264 (9th Cir. 2010).

An insurer’s duty to defend is triggered when the facts alleged in the complaint or otherwise known to the insurer raises the potential for coverage, unless the underlying claimant “unambiguously disclaims or concedes” an essential element of the cause of action. *Hudson Ins. Co. v. Colony Ins. Co.*, 624 F.3d 1264 (9th Cir. 2010).

Subcontractor’s defense obligation arose when developer cross-complained against subcontractor and tendered defense. The obligation is independent of a finding of negligence on the part of the subcontractor. *UDC-Universal Dev., L.P. v. CH2M Hill*, 181 Cal.App.4th 10 (2010).

It is firmly established that the duty to defend is broader than the obligation to indemnify. The former arises whenever an insurer ascertains facts that give rise to the possibility or the potential of liability to indemnify. Unlike the duty to indemnify which arises only when the insured’s underlying liability is established, the duty to defend must be assessed at the very outset of the case. *Total Call Int’l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

When a suit against an insured alleged a claim that potentially or even possibly could subject the insured to liability for covered damages, an insurer must defend unless and until the insurer can demonstrate, by reference to undisputed facts, that the claim cannot be covered. *Total Call Int’l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

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The absence of a duty to defend is established when the insurer shows that the underlying claim could not come within the policy coverage by virtue of the scope of the insuring clause or the breadth of an exclusion. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

The determination of whether the insurer owes a duty to defend usually is made in the first instance by comparing the allegations of the complain with the terms of the policy. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

Facts extrinsic to the complaint also trigger the duty to defend when they reveal a possibility that the claim may be covered by the policy. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

The fact that the third party complaint mentions an element of a covered claim does not trigger the duty to defend when the facts known to the insurer, viewed as a whole, establish that no such claim is potentially asserted. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

In the context of a demurrer, the absence of a duty to defend may be established when the allegations in the third party complaint disclose no basis for policy coverage, and the insured's complaint alleges no extrinsic facts that raise a possibility of coverage. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

Insurance Code section 11580 provides an injured plaintiff with the right to bring a direct action against a defendant's insurer which does not defend its insured once the plaintiff obtains a judgment against the defendant. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

Where more than one insurer has a duty to defend an insured, each insurer's duty is separate and independent from the others. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

An insurer that has allegedly breached its duty to defend may demonstrate that its insured suffered no damages from its alleged breach by demonstrating that its insured received a full and complete defense, notwithstanding its breach. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

A liability insurer has a duty to defend its insured against third party claims that are potentially within the scope of the insured's policy, and also has a duty to defend any noncovered claims that are asserted in the same action. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

An insurer that has breached its duty to defend under a policy may be bound by a stipulated judgment agreed to by its insured without its consent, notwithstanding a "no action" clause in the policy. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

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It is well-settled that, in the absence of policy language to the contrary, an excess insurer has no duty to defend unless underlying primary insurance is exhausted. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

One of the reasons excess insurers generally have no duty to defend until underlying primary insurance is exhausted, absent language to the contrary, is that the greater premium charged for primary insurance reflects the risk that the defense obligation falls on the primary insurer. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Absent language to the contrary, an insured has no reasonable expectation an excess insurer will defend until primary insurance is exhausted. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The general rule limiting the duty of excess insurers to defend only when primary insurance is exhausted does not apply to insurers that provide umbrella coverage subject to a self-insured retention absent clear language providing the defense obligation, as well as the indemnity obligation, is subject to the retention. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The ordinary rules applicable to the duty to defend, including application of the duty to potentially covered claims, apply to the duty to defend of an umbrella insurer in the absence of policy language to the contrary. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

A provision affording defense coverage for claims for which underlying insurance provides no coverage provides umbrella coverage. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Where an umbrella policy does not state that the duty to defend is subject to a retained limit, even if the indemnity obligation is so limited, the defense obligation applies without regard to exhaustion or satisfaction of the retained limit amount. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Whether an insurer has a duty to defend depends on a comparison between the allegations of the complaint and the terms of the policy. If any facts stated or fairly inferable in the complaint, or otherwise known or discovered by the insurer, suggest a claim potentially covered by the policy, the insurer's duty to defend arises and is not extinguished until the insurer negates all facts suggesting potential coverage. *S.B.C.C., Inc. v. St. Paul Fire & Marine Ins. Co.*, 186 Cal.App.4th 383 (2010).

If, as a matter of law, neither the complaint nor the known extrinsic facts indicate any basis for potential coverage, the duty to defend does not arise. *S.B.C.C., Inc. v. St. Paul Fire & Marine Ins. Co.*, 186 Cal.App.4th 383 (2010).

An insurer's duty to defend "suits" encompasses pre-litigation proceedings under the Calderon Act (Civil Code section 1375 *et seq.*), where "suit" is defined in the policy to mean "a civil proceeding in which damages because of 'bodily injury,' 'property damage' or 'personal and advertising injury' to which this insurance applies are alleged." *Clarendon Am. Ins. Co. v. StarNet Ins. Co.*, 186 Cal.App.4th 1397.

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Extending the duty to defend to the Calderon Process is consistent with a hypothetical insured's reasonable expectations. *Clarendon Am. Ins. Co. v. StarNet Ins. Co.*, 186 Cal.App.4th 1397 (2010).

There is no duty to defend where complaint and matters judicially noticed do not support coverage. *Sprinkles v. Associated Indem. Corp.*, 188 Cal.App.4th 69 (2010).

Duty to Indemnify

Evidence not presented in the underlying action may be used by the insured to establish the insurer's duty to indemnify where the coverage issue was not determined in the underlying action. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Efficient Proximate Cause

An "efficient proximate cause" analysis comes into play when excluded and covered perils interact to cause a loss. Coverage is found where the "predominating" cause is the covered peril. *MRI Healthcare Center of Glendale, Inc. v. State Farm Gen. Ins. Co.*, 187 Cal.App.4th 766 (2010).

Equitable Contribution

If an insurer has not paid more than its fair share, it cannot recover any sums in an equitable contribution action, even against an insurer who has paid nothing. *Scottsdale Ins. Co. v. Century Surety Co.*, 182 Cal.App.4th 1023 (2010).

In an equitable contribution action, an insurer is only entitled to recover sums paid in excess of its fair share. Practically speaking, this requires an insurer to introduce evidence of any allocation agreements made with other insurers in defending the claim. *Scottsdale Ins. Co. v. Century Surety Co.*, 182 Cal.App.4th 1023 (2010).

An insurer is entitled to offsets for expenses attributable to other claims only if the claims in the underlying action can be apportioned and do not arise out of a common core of facts. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Equitable Estoppel

On appeal, an insurer is not estopped from asserting defenses to coverage that were raised in a dispositive motion. A valid claim of equitable estoppel consists of (1) a representation or concealment of material facts, (2) made with knowledge, actual or virtual, of the facts (3) to a party ignorant, actually and permissibly, of the truth (4) with the intention, actual or virtual, that the ignorant party act on it, and (5) that party was induced to act on it. *Advanced Network, Inc. v. Peerless Ins. Co.*, 190 Cal.App.4th 1054 (2010).

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Equitable Subrogation

California district court relied on New York court's holding and reasoning for the rule that an equitable subrogee (i.e., plaintiffs' insurer) need not delay seeking recovery from a third-party tortfeasor until the insured has exhausted her efforts to collect there from. *Chandler v. State Farm Mutual Auto. Ins. Co.*, 598 F.3d 1115 (9th Cir. 2010).

Equitable subrogation permits a party who has been required to satisfy a loss created by a third party's wrongful act to step into the shoes of the loser and pursue recovery from the responsible wrongdoer. *Essex Ins. Co. v. Heck*, 186 Cal.App.4th 1513 (2010).

In the insurance context, the doctrine of equitable subrogation permits the paying insurer to be placed in the shoes of the insured and to pursue recovery from third parties responsible to the insured for the loss for which the insurer was liable and paid. *Essex Ins. Co. v. Heck*, 186 Cal.App.4th 1513 (2010).

The elements to an insurer's cause of action based on equitable subrogation are: 1) the insured has suffered a loss for which the party to be charged is liable, either because the latter is a wrongdoer whose act or omission caused the loss or because he is legally responsible to the insured for the loss caused by the wrongdoer; 2) the insurer, in whole or in part, has compensated the insured for the same loss for which the party to be charged is liable; 3) the insured has an existing, assignable cause of action against the party to be charged, which action the insured could have asserted for his own benefit had he not been compensated for his loss by the insurer; 4) the insurer has suffered damages caused by the act or omission upon which the liability of the party charged depends; 5) justice requires that the loss should be entirely shifted from the insurer to the party to be charged; and 6) the insurer's damages are in a stated sum, usually the amount it has paid to its insured, assuming payment was not voluntary and was reasonable. *Essex Ins. Co. v. Heck*, 186 Cal.App.4th 1513 (2010).

ERISA

In considering a motion for summary judgment, the district court must decide whether there are genuine issues of material fact, not whether there was a substantial or ample evidence to support the administrator's plan decision. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

If the plan administrator has left contested facts unresolved, the district court's review under Rule 56(c) should be limited to determining whether any of the facts in dispute are material. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

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ERISA: Standard of Review

A challenge to the denial of benefits under an ERISA plan is reviewed de novo unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

Under the de novo review standard, there must be a determination whether plaintiff is entitled to benefits under the terms of the policy without deference to either party's interpretation. If de novo review applies, no further preliminary analytical steps are required. The court simply proceeds to evaluate whether the plan administrator correctly or incorrectly denied benefits. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

Where there was a sufficiently developed record before the plan administrator the court should not review documents not submitted to the plan administrator prior to its decision. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

New evidence may be considered under certain circumstances in the discretion of the district court to enable the full exercise of informed and independent judgment. The district court should exercise its discretion, however, only when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review of the benefit decision. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

Estoppel

Where facts are imputed to an insurer, the insurer may be estopped from denying them. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Where an insurer has actual knowledge that answers in an application were false, the insurer may be estopped from arguing it was defrauded. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Excess Insurance

The distinction between excess and primary insurers is significant because different rules govern the obligations of excess and primary insurers. Defense obligations of excess insurers arise only when primary insurance coverage is exhausted. *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal.App.4th 1466 (2010).

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Exclusions

A nonconformity exclusion that bars coverage for advertising injury “arising out of the failure of goods, products or services to conform with any statement of quality or performance made in [the insured’s] advertisements” precludes coverage for third party claims predicated on allegations that the insured’s advertising misrepresented the quality or price of the insured’s own product. *Total Call Int’l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

A nonconformity exclusion that bars coverage for advertising injury “arising out of the failure of goods, products or services to conform with any statement of quality or performance made in [the insured’s] advertisements” is not ambiguous and applies to claims against the insured by both consumers and competitors. *Total Call Int’l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

An insurer is required to provide notice of all contractual limitations provisions to any claimant. *Superior Dispatch, Inc. v. Ins. Corp. of N. Y.*, 181 Cal.App.4th 175 (2010).

Although an insured is represented by counsel, an insurer is still required to give notice of all contractual limitations provisions. *Superior Dispatch, Inc. v. Ins. Corp. of N. Y.*, 181 Cal.App.4th 175 (2010).

In general, provisions relating to exclusions from coverage must be “conspicuous,” that is “placed and printed so they will attract the reader’s attention”; and must be “plain and clear” — i.e., stated precisely and understandably, in words that are part of the working vocabulary of the average layperson. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

It is the insurer’s burden to make its coverage exclusions and limitations conspicuous, plain and clear. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

A coverage limitation is conspicuous when it is positioned and printed in a form which adequately attracts the reader’s attention to the limitation. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

Placement of the lesser coverage limits within the insuring agreement, in combination with the multiple emphasized references to coverage limitations on the face page, table of contents, and liability provision if the Policy, conspicuously advises the insured that the coverage for a permissive user of the insured vehicle are not coextensive with his or her own, and explicitly tells the policyholder what those limits are. *Dominguez v. Financial Indem. Co.*, 183 Cal.App.4th 388 (2010).

In determining conspicuousness, a court must look to how a coverage-limiting provision actually has been positioned and printed within the policy at issue. Thus, to be enforceable, a policy provision limiting coverage otherwise reasonably expected under the policy must be so drafted that a reasonable purchaser of insurance would have both noticed it and understood it. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

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Coverage may be limited by a valid endorsement. But to be enforceable, any provisions that takes away or limits coverage reasonably expected by an insured, must be conspicuous, plain, and clear. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

Rating factors are defined as any factor including discounts, used by an insurer which establishes or affects the rates, premiums, or charges assessed for a policy of automobile insurance. *Mackay v. Super. Ct.*, 188 Cal.App.4th 1427 (2010).

The issue is not whether a particular factor (such as age or gender) is, standing alone, to be called a “rating factor” or an “underwriting guideline.” Instead the issue is whether it is submitted to the DOI as a factor affecting the rates to be charged. *Mackay v. Super. Ct.*, 188 Cal.App.4th 1427 (2010).

Federal Rules of Civil Procedure, Rule 12(b)(1)

Insurer’s motion to dismiss under FRCP Rule 12(b)(1) for lack of standing and ripeness was granted where insurer sought to recoup its payout from third-party tortfeasor’s insurer without making insured whole unless and until the insured sued the third-party tortfeasor. *Chandler v. State Farm Mut. Auto. Ins. Co.*, 598 F.3d 1115 (9th Cir. 2010).

Fiduciary Duty

An insurer is not a fiduciary, and owes no obligation to consider the interests of its insured above its own. *Village Northridge Homeowners Ass’n v. State Farm Fire & Cas. Co.*, 50 Cal. 4th 913 (2010).

There is no special duty in the relationship between an insurer and a potential insured. The relationship between an insurer and a prospective insured is not a fiduciary relationship. An insurer does not owe a purchaser of insurance any special duty in negotiating the price of an insurance contract. *Levine v. Blue Shield of Cal.*, 189 Cal. App.4th 1117 (2010).

The amount of money that an insurer is willing to accept in exchange for coverage is not information that implicates the special relationship between an insurer and its insured, because it does not relate to coverage or the processing of claims. *Levine v. Blue Shield of Cal.*, 189 Cal.App.4th 1117 (2010).

An insurer has no special common law duties as to a purchaser of insurance concerning the calculation of premiums, whether the insured is a potential insured or an insured. *Levine v. Blue Shield of Cal.*, 189 Cal.App.4th 1117 (2010).

Fraud in the Inducement, Rescission Based On

If a party knows what he or she is signing, but the party’s consent is induced by fraud, mutual assent is present, but the contract is voidable. The party seeking to void must rescind under statutory and common law. *Village Northridge Homeowners Ass’n v. State Farm Fire & Casualty Co.*, 50 Cal. 4th 913 (2010).

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Fraudulent Concealment

The elements of a cause of action for fraud based on concealment are: (1) the defendant must have concealed or suppressed a material fact, (2) the defendant must have been under a duty to disclose the fact to the plaintiff, (3) the defendant must have intentionally concealed or suppressed the fact with the intent to defraud the plaintiff, (4) the plaintiff must have been unaware of the fact and would not have acted as he did if he had known of the concealed or suppressed fact, and (5) as a result of the concealment or suppression of the fact, the plaintiff must have sustained damage. *Levine v. Blue Shield of Cal.*, 189 Cal.App.4th 1117 (2010).

Genuine Dispute Doctrine

The genuine dispute doctrine does not apply to an insurer's failure to settle in third party cases. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Where a single insurer insures the risk, the insurer must receive a settlement offer within policy limits to be liable in bad faith for failure to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Where multiple insurers insure the risk, an insurer must receive a settlement offer within the combined policy limits of all the insurers on the risk to be liable in bad faith for failure to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

An excess judgment against an insured is not necessary to establish bad faith for refusal to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Good Faith & Fair Dealing

The language in former La. Rev. Stat. Ann. § 22:1220(A) is mandatory: Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach. Further, former La. Rev. Stat. Ann. § 22:658 does not provide for a similar recovery of statutory damages based on the insurer's breach. *Consolidated Companies, Inc. v. Lexington Ins. Co.*, 16 F.3d 422 (5th Cir. 2010).

The Hummell Test

When determining whether to award attorney's fees to a prevailing party in an ERISA action, the five-factor Hummel test applies, and while no single factor is necessarily decisive, the factors should be construed in favor of protecting prevailing plan participants. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

The five-factor Hummel test applies to determining whether attorney's fees should be awarded to a prevailing party in an ERISA case, and no single factor is necessarily decisive, but where a defendant can pay any fees awarded, a prevailing plaintiff should receive attorney's fees based on this factor alone. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

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Implied Waiver

California courts will find waiver when a party's acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished. *Essex Ins. Co. v. Heck*, 186 Cal.App.4th 1513 (2010).

Insolvent Insurer

CIGA must pay covered claims, which are obligations of an insolvent insurer. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

Covered claims does not include any claim to the extent it is covered by any other insurance. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

Where an insured has overlapping insurance policies and one insurer becomes insolvent, the other insurer, even if only a secondary or excess insurer, is responsible for paying the claim. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

CIGA is an insurer of last resort and does not assume responsibility for claims where there is any other insurance available. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

CIGA need not reimburse a permissibly self-insured employer for benefits paid to an employee for cumulative injury if the employer's liability is based in part on a period of time when the employer was self-insured and chose not to buy excess insurance for the particular risk. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

Insured Defined

If an employee's activity is not purely personal, it is related to the conduct of the business, and the employee is an "insured" under the policy. *Sprinkles v. Associated Indem. Corp.*, 188 Cal.App.4th 69 (2010).

Insurer

Parent company whose German subsidiaries issued insurance policies to Armenian Genocide victims was an "insurer" as defined by California Civil Code section 354.4, and thus a proper defendant in a suit brought pursuant to that statute. *Movsesian v. Victoria Versicherung AG*, 2010 U.S. App. LEXIS 25225 (9th Cir. 2010).

California Civil Code section 354.4, governing pursuit of insurance claims under policies issued to Armenian Genocide victims, does not define "insurer" for purposes of limiting potential classes of defendants, but rather to limit the types of claims that may be brought. *Movsesian v. Victoria Versicherung AG*, 2010 U.S. App. LEXIS 25225 (9th Cir. 2010).

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Intentional Acts

Normally, an intentional acts exclusion referring to “an” insured excludes coverage for any insured where one insured acts with intent. *Minkler v. Safeco Ins. Co.*, 49 Cal.4th 315 (2010).

An intentional act of construction was not an accident even if the insured’s acted under a mistaken belief that they had the legal right to build on an easement. *Fire Ins. Exch. v. Super. Ct.*, 181 Cal.App.4th 388 (2010).

An accident does not occur when the insured performs a deliberate act unless some additional, unexpected, independent, and unforeseen happening occurs that produces the damage. *Fire Ins. Exch. v. Super. Ct.*, 181 Cal.App.4th 388 (2010).

An accident does not occur in circumstances where the insured committed an act based on a mistaken belief in their legal right to engage in particular conduct. *Fire Ins. Exch. v. Super. Ct.*, 181 Cal.App.4th 388 (2010).

Where the insured intended all of the acts that resulted in the victim’s injury, the event may not be deemed an accident merely because the insured did not intend to cause injury. *Fire Ins. Exch. v. Super. Ct.*, 181 Cal.App.4th 388 (2010).

An injury-producing event is not an “accident” within the coverage language of a general liability policy when the acts, the manner in which they were done, and the objective accomplished occurred as intended by the actor. *L.A. Checker Cab Cooperative, Inc. v. First Specialty Insurance Co.*, 186 Cal.App.4th 767 (2010). *Not citable. Review granted.*

An insured’s unreasonable belief in the need for self-defense does not turn the resulting purposeful and intentional act of assault and battery into an “accident” within the coverage clause of a general liability policy. *L.A. Checker Cab Cooperative, Inc. v. First Specialty Insurance Co.*, 186 Cal.App.4th 767 (2010). *Not citable. Review granted.*

The term “accident” in a general liability policy’s coverage clause refers to the injury-producing acts of the insured, not those of the injured party. *L.A. Checker Cab Cooperative, Inc. v. First Specialty Insurance Co.*, 186 Cal. App. 4th 767 (2010). *Not citable. Review granted.*

The term “accident” refers to the event causing damage, not an earlier event creating the potential for future injury. *L.A. Checker Cab Cooperative, Inc. v. First Specialty Insurance Co.*, 186 Cal.App.4th 767 (2010). *Not citable. Review granted.*

The intentional-injury exclusion bars coverage of injury caused when the insured intentionally acts wrongfully with a purpose to injure. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

The intentional-act exclusion must be construed narrowly so that the exclusion for intentional acts does not totally eliminate the coverage for intentional torts. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

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Coverage of a claim for false imprisonment would not be barred by an intentional-act exclusion if the insured intended to confine an individual and was later found to have acted wrongfully. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

There is an absolute prohibition of coverage when an insured acts wrongfully and with a purpose to inflict injury. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

Intentional Conduct

A severability-of-interests clause referring to “this insurance” renders an intentional acts exclusion ambiguous. *Minkler v. Safeco Ins. Co.*, 49 Cal.4th 315 (2010).

Transmission of thousands of unsolicited faxes over several years does not constitute “property damage” under an insurance policy that requires property damage to be caused by “an accident,” because an accident requires unintentional acts or conduct, and repeated transmission of faxes is not unintentional. *State Farm Gen. Ins. Co. v. JT’s Frames, Inc.*, 181 Cal.App.4th 429 (2010).

Intervention

An insurer has a right to intervene when it admits coverage. *Gray v. Begley*, 182 Cal.App.4th 1509 (2010).

An insurer has no right to intervene when it denies coverage and refuses to provide a defense, having lost its right to control the litigation. *Gray v. Begley*, 182 Cal.App.4th 1509 (2010).

An insurer that provides a defense under a reservation of rights has a sufficient interest in the litigation to intervene when the insured reaches a settlement without the participation of the defending insurer. *Gray v. Begley*, 182 Cal.App.4th 1509 (2010).

Known Loss

Known loss provision does not apply where, parties could reasonably conclude settlement problems that caused homeowners to complain prior to the policy periods had been fully resolved. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Legal Obligation to Pay Damages

A “legal obligation to pay” means any obligation enforceable by law, including, for example, an obligation created by statute, contract or the common law. Once created, the obligation exists prior to and even in the absence of a suit to enforce it or a court order compelling performance. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

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Coverage for sums an insured becomes 'legally obligated to pay as damages' may be triggered even in the absence of a civil lawsuit against the insured or a court order requiring the insured to make payment. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

The meaning of "damages" is far broader than sums that a court orders to be paid. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Limiting

Coverage may be limited by a valid endorsement. But to be enforceable, any provisions that takes away or limits coverage reasonably expected by an insured, must be conspicuous, plain, and clear. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

Rating factors are defined as any factor including discounts, used by an insurer which establishes or affects the rates, premiums, or charges assessed for a policy of automobile insurance. *Mackay v. Super. Ct.*, 188 Cal.App.4th 1427 (2010).

The issue is not whether a particular factor (such as age or gender) is, standing alone, to be called a "rating factor" or an "underwriting guideline." Instead the issue is whether it is submitted to the DOI as a factor affecting the rates to be charged. *Mackay v. Super. Ct.*, 188 Cal.App.4th 1427 (2010).

Loss of Use

"Loss of use" is not the same as "loss of property" for purposes of insurance coverage. "Loss of use" is determined with reference to the rental value of similar property which the insured can hire for use during the period when the insured is deprived of the use of its own property. The conversion of property is the taking or deprivation of property, and damages recovered in an action for conversion are not for loss of use but for the value of the property itself, and are not covered. *Advanced Network, Inc. v. Peerless Ins. Co.*, 190 Cal.App.4th 1054 (2010).

"Made-Whole" Doctrine

The "made-whole" doctrine is a common law exception to the insurer's right to subrogation, which precludes an insurer from recovering any third-party funds unless and until the insured has been made whole for the loss. *Chandler v. State Farm Mutual Auto. Ins. Co.*, 598 F.3d 1115 (9th Cir. 2010).

Materiality

In order for a misrepresentation to serve as a complete defense in an action on a policy the insurer must show that the misrepresentation was material. *Superior Dispatch, Inc. v. Ins. Corp. of N. Y.*, 181 Cal.App.4th 175 (2010).

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Where arson is suspected, questions regarding the insured's financial and business affairs are material to the insurer's investigation of claim. *Abdelhamid v. Fire Ins. Exchange*, 182 Cal.App.4th 990 (2010).

Statutes governing the relationship between an insurer and its insured require that each party to a contract of insurance communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material and as to which he makes no warranty, and which the other has not the means of ascertaining. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Neglect to communicate that which a party knows, and ought to communicate, is concealment. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Concealment, whether intentional or unintentional, entitles the injured party to rescind an insurance contract. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

If a false representation is material, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Mental Health Parity Act

Codified in California Health and Safety Code § 1374.72, the Mental Health Parity Act obligates health plans to provide coverage for the diagnosis and treatment of mental illnesses. The statute specifically defines and includes autism in these mental illnesses. *Arce v. Kaiser Found. Health Plan, Inc.*, 181 Cal.App.4th 471 (2010).

Misappropriation of Ideas

A patent infringement of a method of advertising could constitute an "advertising injury" where the underlying complaint alleges the method was a misappropriation of advertising ideas. *Hyundai Motor Am. v. Nat'l Union Fire Ins. Co.*, 600 F.3d 1092 (9th Cir. 2010).

Misrepresentation

Governing law permits an insurer to rescind a policy when the insured has misrepresented or concealed material information in connection with obtaining insurance. *Nieto v. Blue Shield of Cal. Life & Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

Insurance Code provides a statutory framework that imposes heavy burdens of disclosure upon both parties to a contract of insurance, and any material misrepresentation or the failure, whether intentional or unintentional, to provide requested information permits rescission of the policy by the injured party. *Nieto v. Blue Shield of Cal. Life & Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

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An insurance company has the unquestioned right to select those whom it will insure and to rely upon him who would be insured for such information as it desires as a basis for its determination to the end that a wise discrimination may be exercised in selecting its risks. *Nieto v. Blue Shield of Cal. Life & Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

In order for a misrepresentation to serve as a complete defense in an action on a policy the insurer must show that the misrepresentation was material. *Superior Dispatch, Inc. v. Ins. Corp. of N. Y.*, 181 Cal.App.4th 175 (2010).

Neglect to communicate that which a party knows, and ought to communicate, is concealment. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Concealment, whether intentional or unintentional, entitles the injured party to rescind an insurance contract. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

If a false representation is material, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Motion to Dismiss

Insurer's motion to dismiss under FRCP Rule 12(b)(1) for lack of standing and ripeness was granted where insurer sought to recoup its payout from third-party tortfeasor's insurer without making insured whole unless and until the insured sued the third-party tortfeasor. *Chandler v. State Farm Mutual Auto. Ins. Co.*, 598 F.3d 1115 (9th Cir. 2010).

Multiple Insurers

Where more than one insurer has a duty to defend an insured, each insurer's duty is separate and independent from the others. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

Nonconformity Exclusion

A nonconformity exclusion that bars coverage for advertising injury "arising out of the failure of goods, products or services to conform with any statement of quality or performance made in [the insured's] advertisements" precludes coverage for third party claims predicated on allegations that the insured's advertising misrepresented the quality or price of the insured's own product. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

A nonconformity exclusion that bars coverage for advertising injury "arising out of the failure of goods, products or services to conform with any statement of quality or performance made in [the insured's] advertisements" is not ambiguous and applies to claims against the insured by both consumers and competitors. *Total Call Int'l, Inc. v. Peerless Ins. Co.*, 181 Cal.App.4th 161 (2010).

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Occurrence

The time of occurrence of an accident within the meaning of an insurance policy is the time the complaining party was damaged, not the time the wrongful act was committed. *Penn. Gen. Ins. Co. v. Safety Indem. Co.*, 185 Cal.App. 4th 1515 (2010).

The ordinary trigger of coverage would focus on when damage was inflicted, not on when the causal acts were committed. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

The term “occurrence” has been interpreted to refer to the underlying cause of injury, rather than the injury itself, in the context of determining how to apply a policy’s “per occurrence limits.” *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

For purposes of determining whether there was coverage within the policy period, it is well established that the relevant “occurrence” or “accident” is not when the wrongful act was committed but when the complaining party was actually damaged.” *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

The appropriate focus for an “occurrence” is on when the damages caused by the negligent causal acts of the insured first commenced, and not on when the insured completed its work. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

If negligent supervision is a remote antecedent cause of injury, it is not an “occurrence” within the meaning of a general liability policy. *L.A. Checker Cab Coop., Inc. v. First Specialty Ins. Co.*, 186 Cal.App.4th 767 (2010). *Not citable. Review granted.*

Other Insurance

An “other insurance” provision necessarily presupposes the existence of coverage under the policy at the same level as some “other insurance.” *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Negligent Misrepresentation

Among the fundamental elements of the tort of negligent misrepresentation is that the defendant has made a misrepresentation. The “misrepresentation” element of the tort of negligent misrepresentation may be established by showing the suppression of a fact by one bound to disclose it. *Levine v. Blue Shield of Cal.*, 189 Cal.App.4th 1117 (2010).

Parol Evidence

Parol evidence is admissible to interpret an insurance policy if relevant to prove a meaning to which the language of the instrument is reasonable susceptible. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

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Although parol evidence is admissible to determine whether the terms of a contract are ambiguous, it is not admissible if it contradicts a clear and explicit policy provision. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

The determination whether to admit parol evidence involves a two step process. First, the court provisionally receives all credible evidence concerning the parties intentions to determine ambiguity, i.e., whether the language is reasonably susceptible to the interpretation urged by a party. If, in light of the extrinsic evidence, the court finds that the language is reasonably susceptible, the evidence is admitted to the second step – contract interpretation. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

The test of whether parol evidence is admissible to construe and ambiguity is not whether the language appears to the court unambiguous, but whether the evidence presented is relevant to prove a meaning to which the language is reasonably susceptible. *Hervey v. Mercury Casualty Co.*, 185 Cal.App.4th 954 (2010).

Patent Infringement

The Ninth Circuit court applied a “contextual reasonableness” analysis to determine whether a patent infringement constituted an “advertising injury.” The test was whether the patent at issue “involves any process or invention which could reasonably be considered an ‘advertising idea’.” *Hyundai Motor Am. v. Nat’l Union Fire Ins. Co.*, 600 F.3d 1092 (9th Cir. 2010).

A patent infringement of a method of advertising could constitute an “advertising injury” where the underlying complaint alleges the method was a misappropriation of advertising ideas. *Hyundai Motor Am. v. Nat’l Union Fire Ins. Co.*, 600 F.3d 1092 (9th Cir. 2010).

Plan Administrator

In considering a motion for summary judgment, the district court must decide whether there are genuine issues of material fact, not whether there was a substantial or ample evidence to support the administrator’s plan decision. *Orea v. FS San Francisco Employment, Inc.’s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

If the plan administrator has left contested facts unresolved, the district court’s review under Rule 56(c) should be limited to determining whether any of the facts in dispute are material. *Orea v. FS San Francisco Employment, Inc.’s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

Where there was a sufficiently developed record before the plan administrator the court should not review documents not submitted to the plan administrator prior to its decision. *Orea v. FS San Francisco Employment, Inc.’s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

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Policy Application

Statutes governing the relationship between an insurer and its insured require that each party to a contract of insurance communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material and as to which he makes no warranty, and which the other has not the means of ascertaining. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Neglect to communicate that which a party knows, and ought to communicate, is concealment. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Concealment, whether intentional or unintentional, entitles the injured party to rescind an insurance contract. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

If a false representation is material, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Prejudgment Interest

Prejudgment interest may be applicable to bad faith damages if the bad faith damages are certain. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Awarding prejudgment interest to an ERISA plaintiff is a question of fairness that lies within the court's discretion, however when calculating the rate of prejudgment interest to be awarded, the court should award the Treasury bill rate prescribed by 28 U.S.C. § 1961, unless it finds, based on substantial evidence, that the equities require a different rate. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

Where plaintiff sought prejudgment interest at a rate of 10% because she suffered financial hardship as a result of losing her long term disability benefits, court held that most, if not all, ERISA plan participants suffer financial setbacks when their benefits are terminated, and held the equities did not warrant departing from the Treasury bill rate. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

Prevailing Party (ERISA)

A prevailing party in an ERISA action need not obtain a judgment on the merits, but rather, must show that she obtained a judicially sanctioned, material change in the legal relationship between the parties. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

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Where a plaintiff's long term disability benefits were reinstated following a court-ordered remand to the claim administrator, the plaintiff was a prevailing party under ERISA because she achieved a material, judicially-sanctioned change in her relationship with the claim administrator. *Langston v. N. Am. Asset Dev. Corp. Group Disability Plan*, 2010 U.S. Dist. LEXIS 12507 (2010).

Primary v. Excess Insurance

Primary insurance provides coverage immediately upon the occurrence of a loss or an event giving rise to liability, while excess insurance provides coverage only upon the exhaustion of specified primary insurance. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Insurance policies sometimes include both excess and umbrella insurance. Umbrella insurance provides coverage for claims that are not covered by the underlying primary insurance. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

An umbrella insurer "drops down" to provide primary coverage when it provides coverage for claims not covered by underlying insurance. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

It is well-settled that, in the absence of policy language to the contrary, an excess insurer has no duty to defend unless underlying primary insurance is exhausted. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

One of the reasons excess insurers generally have no duty to defend until underlying primary insurance is exhausted, absent language to the contrary, is that the greater premium charged for primary insurance reflects the risk that the defense obligation falls on the primary insurer. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Absent language to the contrary, an insured has no reasonable expectation an excess insurer will defend until primary insurance is exhausted. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The general rule limiting the duty of excess insurers to defend only when primary insurance is exhausted does not apply to insurers that provide umbrella coverage subject to a self-insured retention absent clear language providing the defense obligation, as well as the indemnity obligation, is subject to the retention. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Products-Completed Operations Hazard

The purpose of the products-completed operations hazard coverage is to insure against the risk that the product or work, if defective, may cause bodily injury or damage to property of others after it leaves the insured's hands. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

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The only reasonable interpretation of the “products completed operations hazard” use of the disjunctive conjunction “or” in excluding all bodily injury or property damage ‘arising out of “your product” or “your work” makes clear that the “hazard” to be excluded is that arising from products once out of the insured’s possession, or from the insured’s work once completed. *Baker v. Nat’l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

The test is not whether a policy could be written better, from a customer service perspective, after the fact, but instead whether, as written, it is ambiguous in the first instance.” *Baker v. Nat’l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

“Products-completed operations hazard” coverage is ordinarily conditioned on damage occurring during the policy period, as long as the work was completed before the damage occurred, and is not conditioned on when the work was completed. *Penn. Gen. Ins. Co. v. Am. Safety Indem. Co.*, 185 Cal.App.4th 1515 (2010).

Property Damage

A “fax blaster’s” unauthorized use of the injured party’s fax machines and toners could constitute “property damage.” *State Farm Gen. Ins. Co. v. JT’s Frames, Inc.*, 181 Cal.App.4th 429 (2010).

Transmission of thousands of unsolicited faxes over several years does not constitute “property damage” under an insurance policy that requires property damage to be caused by “an accident,” because an accident requires unintentional acts or conduct, and repeated transmission of faxes is not unintentional. *State Farm Gen. Ins. Co. v. JT’s Frames, Inc.*, 181 Cal.App.4th 429 (2010).

Property Damage Exclusion

Property Damage exclusion does not bar coverage of damage to non-defective property resulting from faulty workmanship. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Generally, when an insurer’s breach of contract places the insured in a situation that makes it necessary to incur expense to protect its interest, such costs and expenses, including attorney’s fees, should be treated as the legal consequences of the original wrongful act and may be recovered as damages. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Property Insurance

The fundamental principle of a property insurance contract is to indemnify the owner against loss, that is to place the insured in the same position in which he or she would have been if nothing had occurred. This represents the reasonable expectations of the parties in light of the customs and usages of the industry, and the policy should be construed in accordance with them. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F. 3d 422 (5th Cir. 2010).

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Public Policy Against Insuring Willful Conduct

Insurance contracts must be construed consistent with the public policy that forbids contracts indemnifying a person against loss resulting from his own willful wrongdoing. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

The public policy against insuring against one's own wrongdoing is designed to prevent an insured from acting wrongfully with the security of knowing that his insurance company will pay the piper for the damages. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

Punitive Damages

Actual damages, even nominal damages, are an absolute predicate for an award of punitive damages. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

Civil Code section 3294, subdivision (a) provides: "In an action for the breach of an obligation not arising from contract, where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud, or malice, the plaintiff, in addition to the actual damages, may recover damages for the sake of example and by way of punishing the defendant." *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

The clear and convincing standard in proving oppression, fraud, or malice require that the evidence be so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

Civil Code section 3294 defines "malice" as "conduct which is intended by the defendant to cause injury to the plaintiff or despicable conduct which is carried on by the defendant with a willful and conscious disregard of the rights or safety of others." *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

"Oppression" means despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

"Fraud" means an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

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There are three guideposts for courts reviewing punitive damages: (1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases. Of the three guideposts, the most important is the degree of reprehensibility of the defendant's conduct. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

Reprehensibility factors relevant in review of a punitive damage award include whether (1) the harm caused was physical as opposed to economic; (2) the tortious conduct evinced an indifference to or a reckless disregard of the health or safety of others; (3) the target of the conduct had financial vulnerability; (4) the conduct involved repeated actions or was an isolated incident; and (5) the harm was the result of intentional malice, trickery, or deceit, or mere accident. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

Whether an award of punitive damages is constitutionally excessive is reviewed de novo and involves an independent assessment of the reprehensibility of the defendant's conduct, the relationship between the award and the harm done to the plaintiff, and the relationship between the award and civil penalties authorized for comparable conduct. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

Ratemaking

While Insurance Code section 1860.3 subjects the entirety of the business of insurance to the laws governing business generally, and Insurance Code sections 1860.2 and 1860.3 taken together provides that the statutes in the ratemaking chapter of the Insurance Code may be enforced by the laws governing business generally (if applicable), nonetheless, Insurance Code section 1860.1 exempts from other California laws acts done and actions taken pursuant to the ratemaking authority conferred by the ratemaking chapter, including the charging of a preapproved rate. *Mackay v. Superior Ct.*, 188 Cal.App.4th 1427 (2010).

If Insurance Code section 1860.1 has any meaning whatsoever (which under the accepted rules of statutory construction it must), the section must bar claims based upon an insurer's charging a rate that has been approved by the commissioner pursuant to the ratemaking chapter. *Mackay v. Superior Ct.*, 188 Cal.App.4th 1427 (2010).

Insurance Code Section 1860.1 does not protect insurer conduct not taken pursuant to the authority conferred by the ratemaking chapter, such as where the underlying conduct was not the charging of an approved rate. *Mackay v. Superior Ct.*, 188 Cal.App.4th 1427 (2010).

Ratemaking Procedures and Challenges

The Insurance Code provides that all rates must be approved by the commissioner prior to use, and provides a system for a consumer to seek a hearing prior to approval and judicial review of the approval. *Mackay v. Super. Ct.*, 188 Cal.App.4th 1427 (2010).

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The Insurance Code provides a procedure whereby a consumer can bring an administrative proceeding before the commissioner to challenge a rate subsequent to its approval, and may seek judicial review of the commissioner's decision. *Mackay v. Super. Ct.*, 188 Cal.App.4th 1427 (2010).

Historically, sections 1860.1 and 1860.2 of the Insurance Code have been interpreted to provide exclusive original jurisdiction over issues related to ratemaking to the commissioner. *Mackay v. Super. Ct.*, 188 Cal.App.4th 1427 (2010).

Reasonable Expectations of the Insured

Under California law, if the terms and conditions of a policy are ambiguous, then coverage comports to the reasonable expectations of the insured. *Minkler v. Safeco Ins. Co.*, 49 Cal.4th 315 (2010).

A court's interpretation of an insurance policy is a three part test: (1) is the policy, as it would be construed by a layperson, ambiguous (if not, the inquiry ends); (2) if ambiguous, is a finding of coverage under the policy consistent with the objectively reasonable expectations of the insured; (3) if still ambiguous after application of the reasonable expectation test, a court takes a final step in the interpretation analysis, construing the ambiguous language against the insurer, and in favor of coverage. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

A conclusion that a policy is ambiguous does not provide a path to an absolute contractual entitlement to coverage, and a court may not rewrite a policy to bind an insurer to cover a risk which it did not contemplate covering, and for which it was not paid to provide coverage. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

The test is not whether a policy could be written better, from a customer service perspective after the fact, but instead whether, as written, it is ambiguous in the first instance. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

In interpreting a word in an insurance policy, including a word in an exclusion, a court may consult and consider definitions found in a common dictionary, provided the court does not disregard the policy's context, and maintains an eye on the fundamental goal of deciding how a layperson policyholder might reasonably interpret the exclusion's language. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

The fundamental rule of contract interpretation is that a contract should be construed to give effect to the mutual intention of the contracting parties at the time the contract was formed. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

The mutual intention of the contracting parties at the time the contract was formed is to be inferred, if possible, solely from the written provisions of the contract. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

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The clear and explicit meaning of the written provisions, interpreted in their ordinary and popular sense, unless used by the parties in a technical sense or a special meaning is given to them by usage, controls judicial interpretation. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

In an insurance policy, coverage provisions are interpreted broadly so as to afford the greatest possible protection to the insured, whereas exclusionary clauses are interpreted narrowly. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

An ambiguity may be construed against an insurer only if the insured had an objectively reasonable expectation there would be coverage under the policy consistent with the ambiguity. In determining whether an ambiguity exists, a court should consider not only the face of the contract but also any extrinsic evidence that supports a reasonable interpretation, consistent with the objectively reasonable expectations of the insured. *Clarendon Am. Ins. Co. v. N. Am. Capacity Ins. Co.*, 186 Cal.App.4th 556 (2010).

If an “ordinary reading” of a policy provision is unambiguous, then any reasonable expectation of coverage would be precluded from consideration. If there is an ambiguity, the court will look to the “ordinary reading” of words in the insurance policy that are to be interpreted according to the plain meaning which a layman would ordinarily attach to the words. *Lee v. Fidelity Nat’l Title Ins. Co.*, 188 Cal.App.4th 583 (2010).

When presented with extrinsic evidence the judge first considers the offered evidence and, if he or she finds that the contract language is reasonably susceptible to the interpretation asserted by its proponent, the evidence is admissible to determine the meaning intended by the parties. If the asserted interpretation is unreasonable or the offered evidence is not persuasive, then the judge bars admission of the extrinsic evidence. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Courts interpret a contract ‘so that every part is given effect, and each section of an agreement must be read in relation to each other to bring harmony, if possible, between all parts of the writing.’” *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

A court’s reading of one provision of a contract must not render a related provision meaningless. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

The specific provisions of a contract qualify the meaning of a general provision. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Arizona law requires courts eschew technical jargon or commercial customs that are both unexplained and unincorporated in the terms of the insurance policy itself and in fact contrary to a commonly held view of the term in dispute. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Interpretation of an insurance contract is a question of law, reviewed de novo. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

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When a contract contains a specific provision that appears to conflict with a general provision, the usual interpretive rule is that the specific provision controls. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

When contract provisions appear to contradict each other, courts try to harmonize all parts of the contract by a reasonable interpretation in view of the entire instrument. *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504 (Ariz. 2010).

Release

An insurer may include a provision in release agreements requiring insured's to waive Civil Code section 1542 claims, or those unknown to them at the time of settlement and release. *Village Northridge Homeowners Ass'n v. State Farm Fire & Cas. Co.*, 50 Cal. 4th 913 (2010).

Remittitur

When a damage award is merely excessive or so large as to appear contrary to right reason, remittitur is the appropriate remedy. When the district court deems a jury award excessive it may remit the award rather than order a new trial, so long as the award does not result from passion or prejudice on the part of the jury. Although the Seventh Amendment prohibits remittitur without offering the plaintiffs a new trial, there is an exception for situations where it is apparent as a matter of law that certain identifiable sums included in the verdict should not have been there. *Consol. Companies, Inc. v. Lexington Ins. Co.*, 616 F.3d 422 (5th Cir. 2010).

Rescission

Generally, rescission requires that the aggrieved party provide the other party to the agreement with prompt notice, and to restore all consideration received. *Village Northridge Homeowners Ass'n v. State Farm Fire & Cas. Co.*, 50 Cal. 4th 913 (2010).

Governing law permits an insurer to rescind a policy when the insured has misrepresented or concealed material information in connection with obtaining insurance. *Nieto v. Blue Shield of Cal. Life & Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

Insurance Code provides a statutory framework that imposes heavy burdens of disclosure upon both parties to a contract of insurance, and any material misrepresentation or the failure, whether intentional or unintentional, to provide requested information permits rescission of the policy by the injured party. *Nieto v. Blue Shield of Cal. Life & Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

An insurance company has the unquestioned right to select those whom it will insure and to rely upon him who would be insured for such information as it desires as a basis for its determination to the end that a wise discrimination may be exercised in selecting its risks. *Nieto v. Blue Shield of Cal. Life & Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

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The insured's failure to disclose his diagnosis and thereby correct misstatements in an application clearly constitute a breach of duty and provides a basis for rescission. *Nieto v. Blue Shield of Cal. Life & Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

Right of Privacy

The "right of privacy" can be either the right to keep personal information confidential or secret, or the right to seclusion or to be free from unwanted intrusions. *State Farm Gen. Ins. Co. v. JT's Frames, Inc.*, 181 Cal.App.4th 429 (2010).

Ripeness, Lack Of

Insurer's motion to dismiss under FRCP Rule 12(b)(1) for lack of standing and ripeness was granted where insurer sought to recoup its payout from third-party tortfeasor's insurer without making insured whole unless and until the insured sued the third-party tortfeasor. *Chandler v. State Farm Mutual Auto. Ins. Co.*, 598 F.3d 1115 (9th Cir. 2010).

Summary Judgment

A genuine issue of fact is one that could reasonably be resolved, based on the factual record, in favor of either party. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

A dispute is "material" only if it could affect the outcome of the suit under the governing law. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

In considering a motion for summary judgment, the district court must decide whether there are genuine issues of material fact, not whether there was a substantial or ample evidence to support the administrator's plan decision. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

If the plan administrator has left contested facts unresolved, the district court's review under Rule 56(c) should be limited to determining whether any of the facts in dispute are material. *Orea v. FS San Francisco Employment, Inc.'s Long Term Disability Plan*, 2010 U.S. Dist. LEXIS 20564 (N.D. Cal. 2010).

Self-Insured Retention

The insured may purchase other insurance to cover the SIR unless the policy clearly requires the insured itself, not other insurers, to pay this amount. *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal.App.4th 1466 (2010).

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A codefendant's payment may satisfy the SIR. "Where the insured and another defendant are jointly and severally liable for the injury or damage, an SIR under the insured's liability policy may be satisfied by payments made by the other defendant or its liability insurer... unless the policy clearly provides otherwise. *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal.App.4th 1466 (2010).

Unlike a deductible which generally relates only to damages, an SIR also applies to defense costs and settlement of any claim. *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal.App.4th 1466 (2010).

It is well recognized that self-insurance retentions are the equivalent to primary liability insurance, and that policies which are subject to self-insured retentions are 'excess policies' which have no duty to indemnify until the self-insured retention is exhausted. *Forecast Homes, Inc. v. Steadfast Ins. Co.*, 181 Cal.App.4th 1466 (2010).

A "self-insured retention" or "retained limit" generally refers to the amount of loss or liability the insured agrees to bear before coverage can arise under the policy. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

A true "self-insured retention" expressly limits the duty to indemnify to liability in excess of a specified amount and limits the duty to defend until the insured has actually paid that specified amount but there is no general rule that applies to self-insured retentions without regard to the particular provisions of the policy. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

"Self-insurance" is not insurance and affords the insured no protection at all. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

While there are ordinarily differences between a deductible and a "self-insured retention" or "retained limit," those terms can reasonably connote to the insured no more than what is expressly stated in the policy. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The terms "self-insured retention" and "retained limit" are not sufficient to convey to an unsophisticated insured an understanding of what an insurance expert or attorney might believe to be the essence of a self-insured retention. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Where a self-insured retention is ambiguous as to its terms, because it did not define a term as used within, the court will look to the ordinary and popular sense of the term and the reasonable expectations of the insured. *Clarendon Am. Ins. Co. v. N. Am. Capacity Ins. Co.*, 186 Cal.App.4th 556 (2010).

Settlement

The key factor in determining whether an insurer is bound by a settlement reached without its participation is whether the insurer provided a defense, not whether it denied coverage. *Gray v. Begley*, 182 Cal.App.4th 1509 (2010).

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In deciding whether or not to settle a claim, the insurer must take into account the interests of the insured, and when there is a great risk of recovery beyond the policy limits, a good faith consideration of the insured's interests may require the insurer to settle the claim within the policy limits. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

An unreasonable refusal to settle may subject the insurer to liability for the entire amount of the judgment rendered against the insured, including any portion in excess of the policy limits. *Risely v. Interinsurance Exch. of the Auto. Club*, 183 Cal.App.4th 196 (2010).

Settlement and Release

A settling insured who claims that the insurer misrepresented policy limits in the settlement agreement must rescind under Civil Code sections 1688 to 1693 before it may sue for fraud damages. *Village Northridge Homeowners Ass'n v. State Farm Fire & Cas. Co.*, 50 Cal. 4th 913 (2010).

To allow an insured to settle with its insurer and sign a release, keep the money, and then sue its insurer for alleged fraud without rescinding the release would violate the terms of the bargain and frustrate the purposes of the statutory rescission scheme under Civil Code sections 1688-1693. *Village Northridge Homeowners Ass'n v. State Farm Fire & Cas. Co.*, 50 Cal. 4th 913 (2010).

An award based on an executed stipulation may be reopened and rescinded if the stipulation has been entered into through inadvertence, excusable neglect, fraud, mistake of fact or law, where the facts stipulated have changed or there has been a change in the underlying conditions that could not have been anticipated, or where special circumstances exist rendering it unjust to enforce the stipulation. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

When parties knowingly take the risk of unsettled law and their settlement agreement reflects such basis for their settlement, there is no good cause to reopen. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

Settlement: Refuse to Settle

The genuine dispute doctrine does not apply to an insurer's failure to settle in third party cases. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Where a single insurer insures the risk, the insurer must receive a settlement offer within policy limits to be liable in bad faith for failure to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Where multiple insurers insure the risk, an insurer must receive a settlement offer within the combined policy limits of all the insurers on the risk to be liable in bad faith for failure to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

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An excess judgment against an insured is not necessary to establish bad faith for refusal to settle. *Howard v. Am. Nat'l Fire Ins. Co.*, 187 Cal.App.4th 498 (2010).

Severability

A severability-of-interests clause referring to “this insurance” renders an intentional acts exclusion ambiguous. *Minkler v. Safeco Ins. Co.*, 49 Cal.4th 315 (2010).

Slogan Infringement

A slogan is defined as a “brief attention-getting phrase used in advertising or promotion.” *Hudson Ins. Co. v. Colony Ins. Co.*, 624 F.3d 1264 (9th Cir. 2010).

Standard of Review

On review of a decision by the Workers’ Compensation Appeals Board, questions of statutory interpretation are reviewed de novo. *Fireman’s Fund Ins. Co. v. Workers’ Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

The interpretation of an insurance contract is an issue of law, which is reviewed de novo under well-settled rules of contract law. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

Whether an award of punitive damages is constitutionally excessive is reviewed de novo and involves an independent assessment of the reprehensibility of the defendant’s conduct, the relationship between the award and the harm done to the plaintiff, and the relationship between the award and civil penalties authorized for comparable conduct. *Amerigraphics Inc. v. Mercury Cas. Co.*, 182 Cal.App.4th 1538 (2010).

The Court of Appeal need not defer to the trial court and is not bound by the reasons for the summary judgment ruling of the trial court. The Court of Appeal reviews the ruling of the trial court, not its rationale. *S.B.C.C., Inc. v. St. Paul Fire & Marine Ins. Co.*, 186 Cal.App.4th 383 (2010).

Standing

Insurer’s motion to dismiss under FRCP Rule 12(b)(1) for lack of standing and ripeness was granted where insurer sought to recoup its payout from third-party tortfeasor’s insurer without making insured whole unless and until the insured sued the third-party tortfeasor. *Chandler v. State Farm Mutual Auto. Ins. Co.*, 598 F.3d 1115 (9th Cir. 2010).

Statutory Interpretation

Objective reasonable-person standard used in Hawaii’s Deceptive Practices Act does not require showing of individualized reliance on deceptive practices. Instead, an objective “reasonable person” standard is the test. *Yokoyama v. Midland Nat'l Life Ins. Co.*, 594 F.3d 1087 (9th Cir. 2010).

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When a particular class of things modifies general words, those general words are construed as applying only to things of the same nature of class as those enumerated. The canon presumes that if the Legislature intends a general word to be used in its unrestricted sense, it does not also offer as examples peculiar things or classes of things since those descriptions then would be surplusage. *Clark v. Super. Ct.*, 50 Cal. 4th 605 (2010).

If a statute contains a list of specified items followed by more general words, the general words are limited to those items that are similar to those specifically listed. *Clark v. Super. Ct.*, 50 Cal. 4th 605 (2010).

When construing statutes, the goal is to ascertain the intent of the enacting legislative body so the construction which best effectuates the purpose of the law is adopted. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

If the statutory language is ambiguous and susceptible of differing constructions, it may be reasonably inferred that the legislators intended an interpretation producing practical and workable results rather than one resulting in mischief or absurdity. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

It is a fundamental tenet of statutory construction that the statute must be given a reasonable construction conforming to legislative intent. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

Unless expressly provided, statutes should not be interpreted to alter the common law and should be construed to avoid conflict with common law rules. A statute will be construed in light of common law decisions, unless its language clearly and unequivocally discloses an intention to depart from, alter, or abrogate the common law rule concerning the particular subject matter. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

There is a presumption that a statute does not, by implication, repeal the common law. Repeal by implication is recognized only where there is no rationale basis for harmonizing two potentially conflicting laws. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

When interpreting a statute, the court must ascertain the intent of the Legislature so as to effectuate the purpose of the law. Both the legislative history of the statute and the wider historical circumstances of its enactment may be considered in ascertaining the legislative intent. *City of Laguna Beach v. Cal. Ins. Guarantee Ass'n*, 182 Cal.App.4th 711 (2010).

It is a longstanding rule of statutory construction that the Legislature's omission of a term in a list of terms indicates that the Legislature did not intend to include the omitted term. *Blankenship v. Allstate Ins. Co.*, 186 Cal.App.4th 87 (2010).

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The Legislature is deemed to be aware of judicial decisions already in existence and to have enacted or amended a statute in light thereof. Consequently, when a statute has been construed by judicial decision, and that construction is not altered by subsequent legislation, it must be presumed that the legislature is aware of the judicial construction and approves of it. *Blankenship v. Allstate Ins. Co.*, 186 Cal.App.4th 87 (2010).

It is well settled that a general provision is controlled by one that is special, the latter being treated as an exception to the former. A specific provision relating to a particular subject will govern in respect to that subject, as against a general provision, although the latter, standing alone, would be broad enough to include the subject to which the more particular provision relates. *Mackay v. Super. Ct.*, 188 Cal.App.4th 1427 (2010).

Statutory Offer to Compromise

The lack of a net monetary sum in a pretrial statutory settlement offer does not create a presumption of unreasonableness. *Essex Ins. Co. v. Heck*, 186 Cal.App.4th 1513 (2010).

A modest settlement offer may be in good faith if it is believed the defendant has a significant likelihood of prevailing at trial. *Essex Ins. Co. v. Heck*, 186 Cal.App.4th 1513 (2010).

Stay of Declaratory Relief Action

A stay of a declaratory relief action is appropriate where the factual issues to be resolved in the declaratory relief action overlap issues to be resolved in the underlying litigation. *United Enterprises, Inc. v. Super. Ct.*, 183 Cal.App.4th 1004 (2010).

Subrogation

Subrogation is an equitable doctrine that permits an insurer to assert the rights and remedies of an insured against a third-party tortfeasor. *Chandler v. State Farm Mutual Auto. Ins. Co.*, 598 F.3d 1115 (9th Cir. 2010).

Parties that fail to fulfill their alleged indemnification obligations should not be rewarded, particularly under the rubric that they are in as good or better equitable position as the insurer that did fulfill its alleged indemnification obligation. To the extent this results in a windfall, it is better for the windfall to go to the one that undisputedly fulfilled its contractual obligations. *Interstate Fire & Casualty Ins. Co. v. Cleveland Wrecking Co.*, 182 Cal.App.4th 23 (2010).

Insurer not precluded from subrogation of insured's contractual indemnification claim, where insured entered good faith settlement in underlying litigation. *Interstate Fire & Casualty Ins. Co. v. Cleveland Wrecking Co.*, 182 Cal.App.4th 23 (2010).

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Suit Defined

Defined as a “civil proceeding,” a suit is broader than an action or lawsuit initiated by a complaint filed in court. *Clarendon Am. Ins. Co. v. StarNet Ins. Co.*, 186 Cal.App.4th 1397 (2010).

In *Foster-Gardner, Inc. v. National Union Fire Insurance Co.*, 18 Cal.4th 857 (1998), the court took a bright-line, literal approach in interpreting the duty to defend suits, holding a “suit” is a court proceeding initiated by filing a complaint where “suit” is not defined in the policy. *Clarendon Am. Ins. Co. v. StarNet Ins. Co.*, 186 Cal.App.4th 1397 (2010).

In 1986, standard CGL policy wording was amended to define “suit” as “a civil proceeding in which damages because of ‘bodily injury,’ ‘property damage,’ ‘personal injury’ or ‘advertising injury’ are alleged.” *Clarendon Am. Ins. Co. v. StarNet Ins. Co.*, 186 Cal.App.4th 1397 (2010).

In 1988, the standard CGL definition of “suit” was expanded to cover alternative dispute resolution with the intent “to encourage the use of any type of alternative dispute resolution technique.” *Clarendon Am. Ins. Co. v. StarNet Ins. Co.*, 186 Cal.App.4th 1397 (2010).

Summary Judgment

It is well established that the pleadings determine the scope of relevant issues on a summary judgment motion. *Nieto v. Blue Shield of Cal. Life and Health Ins. Co.*, 181 Cal.App.4th 60 (2010).

Summary judgment is appropriate in a bad faith action where the undisputed facts show the insured’s intentional acts do not create a potential for coverage under a homeowner’s policy excluding nonaccidental occurrences. *Fire Ins. Exch. v. Super. Ct.*, 181 Cal.App.4th 388 (2010).

In a suit for equitable indemnity, the insurer’s burden of proof on a motion for summary judgment is to demonstrate there was no potential for coverage under the terms of its policy. *Clarendon Am. Ins. Co. v. N. Am. Capacity Ins. Co.*, 186 Cal.App.4th 556 (2010).

On a motion for summary judgment, in a state law disability insurance benefits action, evidence that insurer’s experts had financial incentive to provide opinions favorable to the insurer, and experts’ opinion were not reasonable interpretations of the evidence sufficed to raise a material question as to bias. *Bravo v. The U. S. Life Ins. Co. in the City of N. Y.*, 701 F.Supp. 2d 1145 (E.D. Cal. 2010).

On a motion for summary judgment, in a state law disability insurance benefits action, evidence that the insurer unreasonably ignored the limits imposed by a treating physician and afforded too little weight to subjective reports raises a material question as to whether Insurer’s conclusion that Insured was not disabled was reasonable. *Bravo v. The U. S. Life Ins. Co. in the City of N. Y.*, 701 F.Supp. 2d 1145 (E.D. Cal. 2010).

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On a motion for summary judgment, in a state law disability insurance benefits action, where insured presents substantial evidence of disability, insurer's motion for summary judgment of breach of contract claim will be denied. *Bravo v. The U. S. Life Ins. Co. in the City of N. Y.*, 701 F.Supp. 2d 1145 (E.D. Cal. 2010).

Title Insurance

If an "ordinary reading" of the legal description of land was unambiguous, then any reasonable expectation of coverage would be precluded from consideration. However, a description may be ambiguous if, looking to the "ordinary reading" of words in the insurance policy that are to be interpreted according to the plain meaning which a layman (not an attorney or insurance expert) would ordinarily attach to the words, laypersons would have no way of knowing from the surveyor's metes and bounds description of the land in their title policy whether a property was covered. *Lee v. Fidelity Nat'l Title Ins. Co.*, 188 Cal.App.4th 583 (2010).

The preliminary report is an offer identifying the risk the insurer will agree to assume, which the insured accepts by buying the title policy, and the insured has the right to reasonably expect that the contract thus formed will be consistent with the terms of the offer. *Lee v. Fidelity Nat'l Title Ins. Co.*, 188 Cal.App.4th 583 (2010).

Umbrella Insurance

The general rule limiting the duty of excess insurers to defend only when primary insurance is exhausted does not apply to insurers that provide umbrella coverage subject to a self-insured retention absent clear language providing the defense obligation, as well as the indemnity obligation, is subject to the retention. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The phrase "not within the terms of the coverage of underlying insurance" refers to the fact of coverage not whether underlying insurance was exhausted. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The term "underlying insurance," interpreted in the context of the whole of an excess-umbrella policy, when used in a duty to defend provision applicable to umbrella coverage without qualification, but used in other provisions with qualification, refers to the specific underlying insurance set forth in the policy's Schedule of Underlying Insurance. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

The ordinary rules applicable to the duty to defend, including application of the duty to defend potentially covered claims, apply to the duty to defend of an umbrella insurer in the absence of policy language to the contrary. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

A provision affording defense coverage for claims for which underlying insurance provides no coverage provides umbrella coverage. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

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Where an umbrella policy does not state that the duty to defend is subject to a retained limit, even if the indemnity obligation is so limited, the defense obligation applies without regard to exhaustion or satisfaction of the retained limit amount. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

If, under the terms of the policy, the insured would have a reasonable expectation that that insurer would provide a defense, any limitation on the insurer's defense obligation must be conspicuous, plain and clear. *Legacy Vulcan Corp. v. Super. Ct.*, 185 Cal.App.4th 677 (2010).

Uninsured Motorist

Minority does not, in and of itself, excuse compliance with Insurance Code section 11580.2(i)(1) as a condition for claiming UM benefits. *Blankenship v. Allstate Ins. Co.*, 186 Cal.App.4th 87 (2010).

Insurance Code section 11580.2(i)(3) does not violate the constitutional right to equal protection. The exceptions set forth therein to excuse noncompliance with section 11580.2(i)(1) bear a rational relationship to legitimate government interest to encourage prompt determination that a tortfeasor is uninsured, and thus, effectuate prompt settlement of UM claims. *Blankenship v. Allstate Ins. Co.*, 186 Cal.App.4th 87 (2010).

Policy language providing that the insurer "will pay those damages that an insured person is legally entitled to recover from the owner or operator of an uninsured auto because of ... bodily injury sustained by an insured person" does not toll the statutory limitations period set forth in Insurance Code section 11580.2(i)(1). *Blankenship v. Allstate Ins. Co.*, 186 Cal.App.4th 87 (2010).

Voluntary Payments

The purpose of the "voluntary payments" clause is to protect the insurer's right to a fair adjudication of the insured's liability and to prevent collusion between the insured and the injured person, such that the actions had an actual and substantial adverse effect on the insurer. *Desert Mountain Properties Ltd. P'ship v. Liberty Mutual Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Waiver

When an insured agrees to an insurer's settlement of a third party claim, the insured waives any right to maintain a bad faith action against the insurer based on the settlement, unless the insured's agreement to the settlement was procured by coercion, duress, fraud or some other improper means. *Essex Ins. Co. v. Heck*, 186 Cal.App.4th 1513 (2010).

California courts will find waiver when a party intentionally relinquishes a right or when that party's acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

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The right to information of material facts may be waived, either (a) by the terms of insurance or (b) by neglect to make inquiries as to such facts, where they are distinctly implied in other facts of which information is communicated. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

An insurer waives information about a material fact where it neglects to make inquiry about material facts distinctly implied from other facts that had been revealed. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Waiver applies where an insurer has actual knowledge that facts presented in an application were untrue. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

An insurer does not waive the right to information of material facts by neglecting to make inquiry. An insured who withholds information and then blames the insurer for not discovering it is at best exhibiting gamesmanship. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Insured has duty to divulge fully; insurer is not required to assume falsity of statements made to insurer's examiner. *Colony Ins. Co. v. Crusader Ins. Co.*, 188 Cal.App.4th 743 (2010).

Weighing of Equities

An insurer is subrogated to its insured's express contractual indemnity claim against a party who contributed to the loss. *Interstate Fire & Cas. Ins. Co. v. Cleveland Wrecking Co.*, 182 Cal.App.4th 23 (2010).

The agreement between the parties who were connected to the incident giving rise to the loss creates the greater equitable responsibility for indemnification, as compared to that of the general liability insurer. *Interstate Fire & Cas. Ins. Co. v. Cleveland Wrecking Co.*, 182 Cal.App.4th 23 (2010).

Workers' Compensation

The WCAB has general subject matter jurisdiction over claims to workers' compensation benefits. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

The WCAB has express statutory authority to enter orders based on parties' factual stipulations. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

Workers' Compensation Appeals Board

Labor Code section 5803 accords the Workers' Compensation Appeals Board continuing jurisdiction to rescind or revise its awards upon good cause shown. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

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Good cause under Labor Code section 5803 may include newly discovered evidence previously unavailable, a change in the law, or any factor or circumstance unknown at the time the original award or order was made which renders the previous findings and award inequitable. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

An award based on an executed stipulation may be reopened and rescinded if the stipulation has been entered into through inadvertence, excusable neglect, fraud, mistake of fact or law, where the facts stipulated have changed or there has been a change in the underlying conditions that could not have been anticipated, or where special circumstances exist rendering it unjust to enforce the stipulation. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

When parties knowingly take the risk of unsettled law and their settlement agreement reflects such basis for their settlement, there is no good cause to reopen. *Fireman's Fund Ins. Co. v. Workers' Comp. Appeals Bd.*, 181 Cal.App.4th 752 (2010).

Writ of Mandamus

An ordinary mandamus action under Code of Civil Procedure section 1085 permits judicial review of ministerial duties and quasi-legislative acts of public agencies, including the California Department of Insurance. Mandamus lies to compel the performance of a clear, present, and ministerial duty where the petitioner has a beneficial right to performance of that duty. *Schwartz v. Poizner*, 187 Cal.App.4th 592 (2010).

Where judicial review is sought of the Insurance Commissioner's discharge of its discretionary duties, the proper standard of review is limited to determining whether the decision of the agency was arbitrary, capricious, entirely lacking in evidentiary support, or unlawfully or procedurally unfair. Courts do not inquire whether, if it had power to act in the first instance, it would have taken the action taken by the administrative agency. *Schwartz v. Poizner*, 187 Cal.App.4th 592 (2010).

Your Work

When a person provides a service for a customer, for payment from that customer, the person is working or otherwise performing an operation in the context of his or her business activities. *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

A proverbial layperson would understand the term 'work' to mean something along the lines of 'the labor that is one's means of livelihood' and would accept that a business' 'inspection services' were a type of 'work,' particularly where the business charged a fee for the inspection." *Baker v. Nat'l Interstate Ins. Co.*, 180 Cal.App.4th 1319 (2009).

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Arizona Law

When presented with extrinsic evidence the judge first considers the offered evidence and, if he or she finds that the contract language is reasonably susceptible to the interpretation asserted by its proponent, the evidence is admissible to determine the meaning intended by the parties. If the asserted interpretation is unreasonable or the offered evidence is not persuasive, then the judge bars admission of the extrinsic evidence. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Courts interpret a contract “so that every part is given effect, and each section of an agreement must be read in relation to each other to bring harmony, if possible, between all parts of the writing.” *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

A court’s reading of one provision of a contract must not render a related provision meaningless. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

The specific provisions of a contract qualify the meaning of a general provision. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Arizona law requires courts eschew technical jargon or commercial customs that are both unexplained and unincorporated in the terms of the insurance policy itself and in fact contrary to a commonly held view of the term in dispute. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Decreased and lost anticipated patronage resulting from incomplete property may be covered under a business interruption policy coverage as loss resulting directly from necessary interruption of business whether total or partial. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

Loss resulting from decreased and lost anticipated patronage following collapse and delay of hotel expansion is not covered because the damage was to property that was not yet contributing to insured’s business income and not covered under the policy. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

In the context of contingent business interruption loss coverage, the ordinary meaning of “contributing property” is that the property is presently in operation or production and adding to the Insured’s business when the loss occurs. *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

If an enterprise spent substantial amounts of money building on-site signage to attract customers to its premises to purchase goods that created a documented increase in customers and the signage is subsequently destroyed by a covered peril, then although the production facility itself has not been impacted, the insured should nonetheless be entitled to coverage if the policy provides for interruption of its “business.” *Aztar Corp. v. U.S. Fire Ins. Co.*, 224 P.3d 960 (Ariz. 2010).

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In lay terms, there is simply no question that the term “business” in a business interruption policy is not limited to the “operation” or “ability to use” one’s premises, as contrasted with a broader definition that also includes the ability to sell the services available or the goods produced. One would not be able to stay in “business” if one’s production facility was not impaired, but there was no ability to sell any items produced. [Aztar Corp. v. U.S. Fire Ins. Co.](#), 224 P.3d 960 (Ariz. 2010).

Courts interpret a contract ‘so that every part is given effect, and each section of an agreement must be read in relation to each other to bring harmony, if possible, between all parts of the writing.’” [Aztar Corp. v. U.S. Fire Ins. Co.](#), 224 P.3d 960 (Ariz. 2010).

Interpretation of an insurance contract is a question of law, reviewed de novo. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

When a contract contains a specific provision that appears to conflict with a general provision, the usual interpretive rule is that the specific provision controls. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

When contract provisions appear to contradict each other, courts try to harmonize all parts of the contract by a reasonable interpretation in view of the entire instrument. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

Insurance contracts must be construed consistent with the public policy that forbids contracts indemnifying a person against loss resulting from his own willful wrongdoing. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

The public policy against insuring against one’s own wrongdoing is designed to prevent an insured from acting wrongfully with the security of knowing that his insurance company will pay the piper for the damages. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

The intentional-injury exclusion bars coverage of injury caused when the insured intentionally acts wrongfully with a purpose to injure. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

The intentional-act exclusion must be construed narrowly so that the exclusion for intentional acts does not totally eliminate the coverage for intentional torts. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

Coverage of a claim for false imprisonment would not be barred by an intentional-act exclusion if the insured intended to confine an individual and was later found to have acted wrongfully. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

There is an absolute prohibition of coverage when an insured acts wrongfully and with a purpose to inflict injury. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

There can be no breach of the implied covenant of good faith and fair dealing where there is no coverage under the policy. [Wilshire Ins. Co. v. S.A.](#), 227 P.3d 504 (Ariz. 2010).

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Arizona law rejects the “first in time, first in right” rule as applied to multiple claims to a single insurance policy when no factual basis exists upon which a meaningful temporal priority can be established. *McReynolds v. Am. Commerce Ins. Co.*, 235 P.3d 278 (Ariz. 2010).

The prompt, good faith filing of an interpleader as to all known claimants with payment of the policy limits into the court and the continued provision of a defense for the insured as to each pending claim, acts as a safe harbor for an insurer against a bad faith claim for failure to properly manage the policy limits (or give equal consideration to settlement offers) when multiple claimants are involved and the expected claims are in excess of the applicable policy limits. *McReynolds v. Am. Commerce Ins. Co.*, 235 P.3d 278 (Ariz. 2010).

Generally, when an insurer’s breach of contract places the insured in a situation that makes it necessary to incur expense to protect its interest, such costs and expenses, including attorney’s fees, should be treated as the legal consequences of the original wrongful act and may be recovered as damages. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

An insured alleging breach of the duty of good faith must show both that the insurer acted unreasonably in investigating, evaluating or processing the claim and that it either knew or was conscious of the fact that it acted unreasonably. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

An insurer’s failure to pay a claim is not unreasonable when the claim’s validity is fairly debatable. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

An insurer’s reasonable but incorrect policy interpretation does not, by itself, constitute bad faith. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

An insurer does not commit bad faith simply by asserting a policy defense that turns out to be invalid or unfounded. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

In determining whether a CGL policy covers a particular situation involving damage, the proper inquiry is whether an occurrence has caused property damage, not whether the ultimate remedy for that claims lies in contract or in tort. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

An assumption of liability in a contract exclusion does not encompass any contract, regardless of its nature. This exclusion applies only to the assumption of another’s liability, such as an agreement to indemnify or hold another harmless. *Desert Mountain Properties Ltd. P’ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

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A legal obligation to pay means any obligation enforceable by law, including, for example, an obligation created by statute, contract or the common law. Once created, the obligation exists prior to and even in the absence of a suit to enforce it or a court order compelling performance. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Coverage for sums an insured becomes “legally obligated to pay as damages” may be triggered even in the absence of a civil lawsuit against the insured or a court order requiring the insured to make payment. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

The meaning of “damages” is far broader than sums that a court orders to be paid. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Property Damages exclusion does not bar coverage of damage to non-defective property resulting from faulty workmanship. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Generally, when an insurer’s breach of contract places the insured in a situation that makes it necessary to incur expense to protect its interest, such costs and expenses, including attorney’s fees, should be treated as the legal consequences of the original wrongful act and may be recovered as damages. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

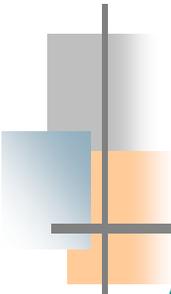
The purpose of the “voluntary payments” clause is to protect the insurer’s right to a fair adjudication of the insured’s liability and to prevent collusion between the insured and the injured person, such that the actions had an actual and substantial adverse effect on the insurer. *Desert Mountain Properties Ltd. P'ship v. Liberty Mutual Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Known loss provision does not apply where, parties could reasonably conclude settlement problems that caused homeowners to complain prior to the policy periods had been fully resolved. *Desert Mountain Properties Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 236 P.3d 421 (Ariz. 2010).

Hawaii Law

Objective reasonable-person standard used in Hawaii's Deceptive Practices Act does not require showing of individualized reliance on deceptive practices. Instead, an “objective ‘reasonable person’ standard” is the test. *Yokoyama v. Midland Nat'l Life Ins. Co.*, 594 F.3d 1087 (9th Cir. 2010).

Though individual claims against brokers may not be suitable for adjudication within the class action framework, the existence of individual claims against other parties, such as brokers, does not necessarily defeat the availability of a class action against the company under a statute aimed at protecting reasonable consumers from deceptive business practices. *Yokoyama v. Midland Nat'l Life Ins. Co.*, 594 F.3d 1087 (9th Cir. 2010).



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