Chapter 25

Insurance Issues

by

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§ 25:1 Introduction

Virtually every lease contains an insurance section. In most cases, insurance is the obligation of the lessee. In some transactions the lessor will arrange the insurance, although insurance is virtually never the responsibility of a lender. Insurance law and practice is, even for sophisticated business people, rather arcane—it certainly has its own terminology and customs. This chapter attempts to explain many of the basic insurance concepts, procedures for evaluating and purchasing insurance, and the benefits of insurance. This chapter does not deal with unique insurance issues arising from specialized assets, such as aircraft and ships, which are dealt with elsewhere in this treatise.

§ 25:2 The Difference Between Insurance and Contractual Indemnity

It is common in leasing, and by definition universal in net leasing, for the lessee to (1) provide a general indemnity to the other parties against, among other things, their liability to third parties arising from the leased asset, and (2) assume all risk of loss regarding the leased asset and be responsible for repairing the asset if damaged or replacing it (or paying for it) if destroyed. In this indemnity, the lessee also agrees to pay costs of defense, settlement, or judgment for any third-party claims brought that involve operation of the asset, such as a lawsuit brought by a construction worker for personal injury allegedly caused by a leased piece of equipment. When the lessee has very strong credit, this indemnity may be sufficient to protect the lessor or lender.

In most situations, however, lessors and lenders insist that the lessee purchase insurance with regard to the leased equipment naming them as additional insureds or loss payees, or insist that the lessee add them as additional insureds or loss payees on the lessee’s existing insurance coverage. By doing so, lessors and lenders aim to protect themselves from adverse consequence if the leased property is totally destroyed, or if a third party brings an action against them claiming injury related to operation of the leased property, and the lessee is unable to honor its contractual indemnity. When parties to the lease are listed as additional insureds under the lessee’s insurance policy, they have direct rights to seek insurance from the insurance company, regardless of the status of the lessee. If listed as loss payees, lessors and lenders have rights to the proceeds payable under a first-party insurance policy, regardless of the financial status of the lessee.

Accordingly, securing additional insured status ensures that, even if the lessee is bankrupted by the insured loss or otherwise goes out of business—a real possibility given that the catastrophe affecting the asset likely affects the operations and profits of the lessee—the lessor or lender can seek its losses from the insurance company. Further,
under some state law, there is a risk that certain of the contractual indemnities will be found to be void. Requiring additional insured status—and making clear in the lease that such status is not linked to the indemnity obligations in the lease—not only ensures that, if the indemnity is void, the lessor is protected, but also reduces the risk that the insurance itself will be voided as having been purchased solely to fund an improper indemnity.

Additionally, insurance companies have broad experience in evaluating and assuming risk; indeed, it is their business to do so. Insurance companies also can further spread their risk of loss through reinsurance or by agreeing to insure only a share of the exposure, essentially eliminating the risk that a single catastrophe will jeopardize the existence of the insurance company. Accordingly, although there have been a number of spectacular insurance company failures in the last two decades and other signs of distress over the last three years, most lessors and lenders can assume that the insurance company or companies selling policies to the lessee will be financially able to perform the obligations they assume. Whether the insurance companies will actually pay their claims without pressure is a different question, which is explored below.

Note that indemnity clauses in lease agreements generally are much broader than the coverage provided by insurance policies, which are bounded by dollar limits, the scope of their coverage, and by conditions and exclusions. Accordingly, for a number of exposures, the only recourse of the lender or the lessor will be the contractual indemnity. Further, note that under a number of “additional insured” endorsements, a lender or lessor or other party is made an additional insured only to the extent “required by contract.” Accordingly, lease agreements should be express as to the nature of the exposures for which the borrower or lessee must purchase insurance. The reverse of this situation is also possible: The parties may contract for a limited indemnity obligation, but the policy may grant additional insured status without reference to those limitations in the lease, making the policy much broader than the indemnity. A court construing the policy in this context may refuse to examine the lease, because the lease is evidence extrinsic to the policy, and resorting to extrinsic evidence to construe an unambiguous policy is sometimes forbidden under state law.\(^1\) This provides another reason for the parties to spell out the express coverage intended in the additional insured endorsement.

Accordingly, although requiring the lessee to purchase insurance naming other parties to the lease is a prudent precaution, it cannot be

\(^1\) See, e.g., Corbitt v. Diamond M. Drilling Co., 654 F.2d 329 (5th Cir. 1981).
viewed as a substitute for a well-crafted contractual indemnity provision, and it may raise complications of its own. These complications, which are explored below, generally can be solved by careful drafting of indemnity obligations and insistence upon correctly formulated endorsements in the lessee’s insurance policies.

§ 25:3 The Nature of Insurance

Insurance performs a socially useful function by spreading risks of loss. The cost of a loss that might cripple an individual insured is collectively borne by a number of insureds through premiums paid to the insurance company. In turn, the insurance company uses information regarding the rate and severity of losses suffered by types of property or classes of insured—gathered not only from its own experience but from the experience of insurance companies nationwide—to set the premium, ensuring that, along with the interest it earns on the “float” of investing premiums before claims must be paid out, it has enough money to pay claims and earn profit.

Commercial insurance policies are purchased by almost every business, yet few business people read their insurance policies, let alone understand the meaning of insurance policy language. It is, however, critical for business people to understand insurance policies because, when catastrophe strikes, they may be the only hope for keeping a business afloat. Further, because of the complexity of first- and third-party insurance policies, knowledge of the coverage they provide is the only way an insured can protect itself in coverage disputes. Such disputes are inevitable if the claim is large; indeed, the nature of the insurance transaction virtually guarantees them.

Insurance policies are a particular form of contract—an “aleatory” contract—under which performance is not simultaneous; rather, one party performs first and the second party performs only if an event in the control of neither party occurs. Specifically, the named insured performs first by paying premium, and the insurance company performs second, only if a loss occurs. The aleatory nature of insurance contracts grants insurance companies a great deal of leverage. Unlike a situation where one contracts for a Cadillac and is tendered a Yugo, where the would-be purchaser can cancel the check and go to another

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2. The industry shares information through such organizations as the Insurance Services Office, Inc. [ISO]. ISO is the insurance industry trade association that drafts standard form insurance policy language for nearly all of the principal property and casualty insurance companies in the United States. For a description of ISO’s activities, see In re Ins. Antitrust Litig., 938 F.2d 919 [9th Cir. 1991]; see also In re Hoechst Celanese Corp., 584 N.Y.S.2d 805 [App. Div. 1992].
car dealership, an insured who is promised “Cadillac” insurance at the point of sale and receives “Yugo” insurance at the point of claim cannot “cover” by going back in time and purchasing alternative Cadillac insurance, as the loss has already taken place. Additionally, the insured whose claim is improperly denied will typically have fewer resources to contest that denial, as it will simultaneously be under financial pressure from the very catastrophe that led to the claim. A number of states have recognized that the peculiarities of the insurance transactions require the availability of punitive damages for wrongful denials to protect the insured.\(^3\) As a practical matter, however, this remedy is legally, or functionally, unavailable in many states.\(^4\)

\(^3\) See, e.g., E.I. du Pont de Nemours & Co. v. Pressman, 679 A.2d 436, 447 (Del. 1996) (“Insurance is different. Once an insured files a claim, the insurer has a strong incentive to conserve its financial resources balanced against the effect on its reputation of a ‘hardball’ approach. Insurance contracts are also unique in another respect. Unlike other contracts, the insured has no ability to ‘cover’ if the insurer refuses without justification to pay a claim. Insurance contracts are like many other contracts in that one party [the insured] renders performance first [by paying premiums] and then awaits counterperformance in the event of a claim. Insurance is different, however, if the insurer breaches by refusing to render the counterperformance. In a typical contract, the non-breaching party can replace the performance of the breaching party by paying the then-prevailing market price for the counterperformance. With insurance this is simply not possible. This feature of insurance contracts distinguishes them from other contracts and justifies the availability of punitive damages in limited circumstances.”).

\(^4\) For instance, technically, New York law permits bad-faith claims to vindicate a public right and to deter insurance companies from engaging in morally reprehensible conduct or committing acts of such wanton dishonesty as to imply a criminal indifference to civil obligations. See Rocanova v. Equitable Life Assurance Soc’y, 634 N.E.2d 940, 944 (N.Y. 1994). Under the standards set forth by the court of appeals in N.Y. Univ. v. Cont’l Ins. Co., 662 N.E.2d 763, 767 (N.Y. 1995), “punitive damages may be recoverable if necessary to vindicate a public right.” In N.Y. Univ., the court stated that a party may be liable in tort when: it has breached a duty of reasonable care distinct from its contractual obligations; it has engaged in tortious conduct separate and apart from its breach of contract; or it has engaged in conduct outside the contract which is intended to defeat the contract. Thus, in cases involving breach of an insurance policy, punitive damages may be obtained when: (i) the insurance company’s conduct is actionable as an independent tort; (ii) the tortious conduct is egregious; (iii) the egregious conduct is directed at a policyholder or claimant; and (iv) it is part of a pattern directed at the public generally. Id. (citing Rocanova, 634 N.E.2d at 944). As a legal matter, N.Y. Univ. and Rocanova technically do not foreclose punitive damages in all cases for breach of an insurance policy. As a practical matter, however, they do. Since 1995, no New York court has awarded punitive damages against an insurance company for bad faith.
Further, insurance policies are not physical products that can be inspected prior to sale and remain constant, but promises, expressed in words that are often uncertain, can be subject to multiple interpretations or have meanings established through custom and practice. At the point of sale, it is difficult to evaluate the nature of the promises one purchases; one cannot “kick the tires” of an insurance contract. Rather, the quality of the promises in an insurance contract can be evaluated only when, or if, the insurance company performs.

Moreover, most insurance coverage disputes are resolved not by a judgment of a court but by “negotiation.” Insureds are under an inherent disadvantage in negotiating: an insured cannot start the negotiations by asking for more than it lost—that is called “insurance fraud”—but an insurance company is free to begin negotiations with a very conservative figure. Under those circumstances, negotiations are bound to end up somewhere in between, meaning the insured does not recover its full claim. The insured’s only effective remedy to an insurance company offer of less than it knows it owes—fraud—is to bring a lawsuit, which will almost certainly end in a “negotiated” settlement, in which the insured will be under the same constraints as it was prior to filing suit. In cases of egregious insurance company conduct, insureds can gain some leverage by threatening to seek punitive damages, but, again, that remedy is unavailable in many states.

Another characteristic of first-party, or property, insurance virtually guarantees disputes: Unlike third-party, or liability, insurance coverage—where the question is whether a sum certain paid to a third party is covered or excluded—there is almost never a sum certain that is owed or excluded in first-party insurance coverage. Rather, there is typically an admittedly covered bolus of damage or expense, and the question is how much is owed. For example, what was the “actual cash value” of a destroyed asset? Or how much does an insurance company have to pay to clean machinery corroded in the aftermath of fire suppression? Given that different answers to such questions can have huge implications on the amount of money actually paid, one need not be cynical to realize that these are questions upon which insurance companies and insureds rarely agree.

Finally, as many insureds find out the hard way, the insurance company personnel who work in the claims department are an entirely different set of people than the ones who sold the policy. Claims personnel do not get “gold stars” for paying claims in full, and insurance company schemes to cap the amount paid out to claimants, regardless of the bona fides of their claims, have recently been uncovered.5 Further, additional insureds or loss payees making claims

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under policies for which they did not pay—a frequent occurrence in the context of leased property—are not insurance company customers. There is, thus, little business reason for most insurance company claims handlers to refrain from taking coverage-minimizing positions with regard to additional insureds or loss payees.

Accordingly, if the insured’s claim is a large one, there will almost certainly be a dispute between the insured and the insurance company as to the amount of coverage owed. The end of this chapter sets forth some guidance for insureds when such disputes arise.

§ 25:4 General Types of Insurance Involving Leased Assets

§ 25:4.1 Insurance Policies

Standard insurance policies have seven components:

(1) Policy Declarations;
(2) Who Is an Insured?;
(3) Limits of Insurance;
(4) Coverages;
(5) Definitions;
(6) Exclusions; and
(7) Conditions.

These components are discussed below.6

[A] Declarations

The declarations set forth information including the identity of the “named insured,” the policy number, the insurance company, the effective dates of the policy, a description of the named insured’s business, the type of coverage purchased, the amount of coverage purchased (with any deductibles or self-insured retentions), the premium charged and, occasionally, a list of endorsements.7

6. Note that copies of standard-form first- and third-party insurance policies and endorsements drafted by ISO and other bodies are available in a number of hornbooks. See, e.g., STEPHEN A. COZEN, INSURING REAL PROPERTY (2008); SUSAN J. MILLER & PHILLIP LEFEBVRE, MILLER’S STANDARD INSURANCE POLICIES ANNOTATED (2008); INTERNATIONAL RISK MANAGEMENT INSTITUTE, COMMERCIAL PROPERTY INSURANCE (2008); INTERNATIONAL RISK MANAGEMENT INSTITUTE, COMMERCIAL LIABILITY INSURANCE (2008).

Endorsements are specific changes or amendments to the terms and conditions of the standard-form policy language, and are typically numbered and appended to the back of the standard-form policy. The declarations are contained in a cover sheet, usually called a “dec page.” The “named insured” is the person or organization to whom the policy is sold. There may be more than one named insured included on a policy; in such case, the policy typically designates the first named insured to undertake certain responsibilities, for instance, maintaining records, paying premiums, authorizing changes, or canceling or renewing coverage.

[B] Who Is an Insured?

The second component of the policy describes the persons and entities that automatically qualify as “insureds” under the policy. For third-party insurance policies, such persons typically include the named insured’s employees. An “additional insured” is a party who is not automatically an insured under the policy, but to whom the named insured wishes or is obligated to extend a measure of protection under its policy. For purposes of this chapter, a named insured lessee is typically contractually bound to provide additional insured status to its lender or lessor as part of the lease contract (as well as any trustees, agents or other parties involved in the lease transaction).

Additional insured status is accomplished by means of an endorsement. Additional insured endorsement provisions come in wide variety, from those that simply list parties as additional insureds to those that spell out the limits of additional insured protection afforded. Endorsements are available that include as additional insureds any party that the named insured is obligated by any contract to name as an additional insured.

Additional insureds have direct rights in the insurance policy. For example, the additional insured under a third-party policy can demand that the insurance company provide it with defense and indemnification in third-party claims brought against it. The additional insured need not, for instance, pay for its own defense and seek reimbursement from the named insured.

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most likely to be read and understood by the insured” and “the one page of the policy tailored to the particular insured and not merely boilerplate, which must be deemed to define coverage and the insured’s expectation of coverage.”

8. Note that endorsements often change the provisions of the policy, or change the provisions of earlier endorsements. In general, it is accepted that the endorsement with the latest date controls over earlier endorsements and over language in the body of the policy.
[C] Limits of Insurance

The limits of insurance, set forth on the declarations page, set a ceiling on the amount of money the insurance company will pay, regardless of the number of insureds covered by the policy, the number of losses, the number of claims made, or the number of persons or organizations making claims. Insurance policies may have more than one type of limit. There may be a per-occurrence limit, capping the amount the insurance company will pay for losses stemming from one event or series of related events (or however “occurrence” is defined), and an aggregate limit, capping the amount the insurance company will pay for losses from all occurrences.

Many “primary” policies—the lowest level of insurance in an insurance program—contain deductible clauses requiring payment by the named insured of a specified portion of the loss before the insurance company’s indemnity obligation is triggered. Some insurance policies contain a self-insured retention (SIR) rather than a true deductible, which functions somewhat differently. If the insurance policy has a deductible, the limit of insurance will be reduced by the amount of the deductible. Thus, if there is a covered loss totaling $1,100,000, and a $1 million limit of insurance with a $100,000 deductible, the coverage available will be $900,000 (the limit minus the deductible). If a $1 million insurance policy is subject to a $100,000 SIR rather than a deductible, the same loss would result in a payment of $1 million. Thus, with an SIR, the full limits are available once the SIR is paid, while a policy with a deductible will only provide coverage for the policy limits minus the deductible. Because both SIRs and deductibles insulate the insurance company to some extent, they can affect, sometimes dramatically, the amount of premium required to secure a certain level of coverage.

Deductibles may also have aggregate features. For instance, the policy can require that, regardless of the number of claims, the named insured pays the first $100,000 in losses under the policy, with the insurance company being responsible for payments on any claim once the named insured has paid $100,000, that is, whether the insured pays the first $100,000 on a $200,000 loss or the first one hundred of two hundred $1,000 losses. Alternatively, the policy can impose, for example, a $100,000 per-occurrence deductible on claims, with a $300,000 “stop-loss,” meaning that once the named insured has paid $300,000 in the aggregate for all claims, it no longer is obligated to pay a deductible on any claim.

[D] The Coverages

The coverage grants, or the insuring agreements, describe the type of coverage provided by the insurance policy. For third-party or liability insurance policies, a typical insuring agreement requires the
insurance company to “pay those sums that the insured becomes legally obligated to pay as damages” to a third party because of personal injury, property damage or advertising injury to the third party, and to defend any suit seeking such damages. The insuring agreements of first-party or property insurance policies typically are broken into separate sections corresponding to the coverages purchased by the insured, for example, property damage coverage for damaged or destroyed property, business income coverage for loss of profit because of the destruction of property, etc.

[E] The Definitions

Insurance policies typically have a section defining terms used in the balance of the policy. In the body of the policy, defined terms are usually indicated by being capitalized, in bold or in quotation marks. Third-party or liability policies typically have only one definitions section, where first-party or property policies often include a section of “general” definitions and conditions, and then include additional definitions and conditions in the separate coverage parts [property damage, business income, etc.]. Most terms in insurance policies are not defined, and often definitions provided actually serve to compound ambiguities [for example, by being unclear themselves or by being circular in incorporating other defined terms that, in turn, incorporate the original, relating definition].

[F] The Exclusions

Insurance companies commonly invoke insurance policy exclusions as a basis for denying coverage to their insureds. Examples include exclusions for loss or liability stemming from “pollution” or “asbestos,” or liability for injuries intended by a named insured. While the insured has the burden of showing that the claim falls with the coverage grant of the policy, the insurance company bears the burden of showing that a particular exclusion applies and bars coverage for the insured’s claim. In most jurisdictions, if a loss has concurrent causes, one of which is covered and the other of which is not, the loss is nonetheless covered.9 Note, however, that some exclusions contain, or are preceded by, anti-concurrent causation language, such as the following: “Such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the

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loss, even if such other event would otherwise be covered.” The effect of such language may be to bar coverage if the excluded cause exists anywhere in the chain of causation.

[G] The Conditions

The conditions section of an insurance policy specifies various duties of the insured and the insurance company both prior to, and after, a loss. For insureds, a failure to comply with a condition such as giving notice may lead to forfeiture of coverage. Under the law of most states, however, and consistent with contract law generally, an insured’s failure to comply with a condition of coverage serves to forfeit that coverage only if the insurance company is prejudiced by such failure.¹⁰

§ 25:4.2 First-Party Insurance

“First-party” or “property” policies obligate insurance companies to pay benefits directly to insureds for losses suffered by insureds to their own property or profits. First-party insurance policies cover both tangible property (furniture, equipment, business records, inventory, etc.) and intangible property (anticipated profits, lost income during an interruption, lost income after an interruption, etc.). In general, for leased assets, the purpose of first-party insurance is to insure the leased asset for physical injury or destruction, by promising to pay for the value of the asset, or the cost to repair or replace the asset.

[A] Property Damage

[A][1] The Coverage

The bedrock coverage provided by a standard-form first-party insurance policy is for property damage:

We will pay for direct physical loss of or damage to Covered Property at the premises described in the Declarations caused by or resulting from any Covered Cause of Loss.

“Covered property” typically includes a named insured’s building, equipment, personal property and stock, as well as the personal property of others. “Covered property” may also be defined more broadly, to include “property owned, controlled, used, leased or intended for use by the Insured,” which may be important when the insured suffers an interruption of business stemming from the destruction of property in

which the insured had an insurable interest, but did not necessarily "own."\footnote{11}

"Covered Cause of Loss" usually refers to a form attached to the policy which either will include (1) "all risks of direct physical loss" but those excluded by the form, such as "earth movement" or "flood" or "war or military action" (an "all risk" form) or (2) only certain "named perils" like "fire" and "windstorm" (a "named peril" form). In general, "all risk" coverage is preferred. It is generally referred to as the broadest coverage available, and provides coverage if the property is destroyed for almost any conceivable reason, as long as the loss is fortuitous.\footnote{12}

For damaged property, first-party policies generally provide the cost of repair. For destroyed property, the policy may obligate the insurance company to pay on the basis of the actual cash value of the property (the value of the property when it was destroyed, typically figured as replacement cost minus depreciation), replacement cost (the cost of replacing the property), or agreed value (an amount agreed to in advance by the parties, regardless of actual cash value or replacement cost). The latter bases are generally preferable for property unless it is of the type that does not suffer depreciation (such as masonry walls or an anvil). Further, for leased assets, an insurance company commonly agrees to insure the agreed value of the asset (usually called the Termination Value of Stipulated Loss Value) under the lease, which is typically higher than the actual cash value of the asset (and thus which generates, up front, a higher premium for the insurance company).

\section*{[A][2] Potential Coverage Issues Generally}

There are a number of potential stumbling blocks standing in the way of recovering for property damage under a first-party property insurance policy. First, if the insured has purchased replacement cost coverage, first-party insurance policies typically require the insured to seek the actual cash value of the property, use that money to rebuild or replace, and then, later, seek replacement cost from the insurance company. The insurance company is obligated to pay replacement cost only \textit{after} replacement. If the insured does not have the money to fund the replacement, it may be out of luck: under the law of many states, the insurance company does not have to "front" the replacement cost to the insured, and therefore escapes its obligation to pay replacement cost.\footnote{13}


\footnote{13} There are some exceptions to this rule. For instance, the insurance company cannot insist on replacement prior to paying replacement cost.
Second, there are a number of issues dealing with the quality of repair or replacement of damaged property. For instance, if the property is only damaged, and is to be repaired, to what standard must it be repaired? [Typically, the repaired property must be of the quality that existed before it was damaged.] Similarly, if the property is to be replaced, with what can the insurance company replace it? [Typically, the insurance company must replace the destroyed property with new property rather than reconditioned or used property.] Further, what if the insurance company says the property can be repaired, and the insured does not think the property will be as good as it was before {that is, what if the insurance company wants to hire the lowest bidder, a car mechanic, to repair specialized computers}? There may also be issues involving potential future third-party liability from property that has been contaminated by dust or mold; that is, the fear that employees using contaminated property will later bring actions for bodily injury. Most first-party insurance policies provide no guidance on these issues, forcing the parties to resolve them by negotiation or litigation. One way to avoid such issues is to require the insurance company to agree to match any warranties that existed on the original property, and to agree to defend any future third-party suits. Faced with such a demand, most insurance companies prefer to purchase new replacement property.

A third hurdle may be co-insurance. This is a number, typically 80% or 90%, used by the insurance company to ensure that the property is not underinsured {so that the insurance company can get maximum premiums, which are typically based on exposure}. Briefly, at the time if it has wrongfully denied coverage {see Bailey v. Farmers Union Cooperatives Ins. Co., 498 N.W.2d 591 [Neb. Ct. App. 1992]}, or if to enforce this condition would render the replacement cost coverage illusory {Zaitchick v. Am. Motorists Ins. Co., 554 F. Supp. 209 [S.D.N.Y. 1982]}.

14. See generally Cozen, § 25:4.2[6], at 25-24.8 to 25-24.9 ("In most cases involving replacement cost insurance, there is no question that damaged property must be replaced. Occasionally, however, the extent of the damage to the property may not require complete replacement. The standard replacement cost policy does not set out guidelines to determine when the property only needs repair and when it needs to be replaced. Because it will typically cost more to replace damaged property than repair it, disputes arise between the insurer and the insured on this issue. Courts that have addressed this problem have typically ruled that the insurer must pay the cost to replace the damaged property unless it can be shown that repair will fully compensate the insured.") [emphasis added]; see also Higginbotham v. N.H. Indem. Co., 498 So. 2d 1149, 1152 [La. Ct. App. 1986]; Hayes v. Allstate Ins. Co., 1984 U.S. Dist. LEXIS 24167 [S.D. Ind. Aug. 22, 1984].

of the loss, take the value of the property, multiply it by the co-
insurance percentage, and unless the resulting number is higher than
the limits, the insured will pay a penalty. In other words, if a
specialized piece of equipment has an actual cash value of $1 million,
and the policy has an 80% co-insurance clause, the policy must have
limits of at least $800,000. If the limits are $700,000, the insurance
company will pay only 7/8 of the loss, even if the loss is just $200,000.
Some insureds seek to avoid co-insurance risks at the time of purchase
by having the insurance company waive co-insurance, or by buying
“agreed value” policies, which state that the insurance company and
insured agree that X property is worth Y amount of dollars. In the
context of leased assets, lessors and lenders are best advised to follow
one of these courses to avoid co-insurance penalties.

Fourth, some insurance policies contain language stating that the
insurance company will not pay the difference between actual cash
value and replacement cost unless replacement or repair of the
destroyed property is begun within twenty-four months. In a number
of different situations—such as where the loss is catastrophic or
involves specialty equipment which takes a number of months to
manufacture—strict enforcement of this provision will prevent an
insured from recovering replacement cost. Accordingly, insureds will
argue that the beginning of that twenty-four-month period should be
tolled until the time when such replacement is first possible, which may
not be for many years. In analogous situations involving the hypo-
thetical period of interruption for business income losses—typically
running from the date of destruction of property until the date upon
which such property could be replaced with due diligence and dispatch—
courts have tolled the beginning of the period where reconstruction of
the tenant’s property could not commence because of delays occasioned
by reconstruction by the landlord.¹⁶

[B] Business Income

The next important coverage provided by typical first-party insur-
ance policies is the promise to pay for losses of business income
incurred in the wake of damage to property. Although many such
provisions are in use, a typical one reads as follows:

App. 1965) (affirming judgment that permitted drug store a six-month
period of interruption instead of six weeks, where drug store could have
been rebuilt in six weeks but where landlord supermarket planned to
rebuild drug store as part of rebuilding supermarket, which would take
six months); see also Anchor Toy Corp. v. Am. Eagle Fire Ins. Co., 155
N.Y.S.2d 600 (N.Y. Sup. 1956) [finding that period of interruption included
time for construction delays].
We will pay for the actual loss of Business Income you sustain due to the necessary suspension of your "operations" during the "period of restoration." The suspension must be caused by direct physical loss of or damage to property. . . . The loss or damage must be caused by or result from a Covered Cause of Loss.

“Business Income” may be defined to include “Net Income (Net Profit or Loss before income taxes) that would have been earned or incurred” and “Continuing normal operating expenses incurred, including payroll.” “Period of Restoration” or “Period of Interruption” is typically defined to begin at the time of “direct physical loss or damage” and end on the earlier of “the date when the property at the described premises should be repaired, rebuilt or replaced with reasonable speed and similar quality” or “the date when business is resumed at a new permanent location.” Business Income coverage is designed to pay the profits and unavoidable continuing expenses caused by an interruption of the insured’s business. Business Income coverage protects insureds who have to suspend production or business due to property damage; it also reimburses insureds for expenses that continue despite the cessation of business, such as salaries, certain utility charges and insurance premiums.

In the context of lease transactions, lessors and lenders may wish to ensure that the lessee purchases business income coverage, because such coverage may be crucial if the lessee is going to continue in business after a catastrophic loss, and thus continue to be able to fulfill its indemnity obligations under the lease contract. Such insurance requirements are relatively unusual in leases, as typically the insurance is limited to damage to the leased asset plus third-party liability.

[C] Other Common Coverages and Exclusions

First-party policies typically contain a raft of standard-form exclusions from coverage, some of which (for example, asbestos and nuclear) are essentially non-negotiable. Other exclusions can be the subject of negotiation.

[C][1] Terrorism Coverage and Exclusions

The Risk Insurance Program Reauthorization Act of 2007 (the “Act”) provides reinsurance for commercial first-party insurance companies, including captive insurance companies who underwrite direct insurance policies, with the aim of improving the availability of affordable insurance for losses arising out of “certified” terrorist acts in the United States. Under the Act, insureds have the choice of purchasing terrorist coverage as defined by the Act for additional premium, whereby any terrorism exclusions in their policies are voided, or foregoing such coverage and accepting the applicability of terrorism exclusions in their policies.
Specifically, for each named insured, the Act requires a first-party insurance company to offer terrorist insurance coverage that is not materially different from the terms, conditions, and limits of the named insured’s existing first-party insurance coverage for losses arising from events other than acts of terrorism. There are limits to the ambit of the Act. First, the Act charges the Secretary of Treasury, in concurrence with the Secretary of State and the U.S. Attorney General, with the duty to certify an “act of terrorism” triggering the Act. Only a “certified act of terrorism” is covered under the Act, and the determination of the Secretary of Treasury is not subject of judicial review.

The Act provides an exclusive federal cause of action for claims arising from an “act of terrorism,” for which the Judicial Panel on Multidistrict Litigation shall designate one or more federal courts to have original and exclusive jurisdiction; accordingly, all cases arising under the Act will be heard in federal court. However, there is no federal preemption with regard to regulation of premiums and insurance policy forms and, as they have been historically, these issues will continue to be regulated by state insurance departments.

Obviously, a number of issues will confront named insureds seeking to insure their assets in light of the Act, including the following:

• First, named insureds will face gaps in their coverage. In fact, insurance industry organizations that draft and seek approval of domestic insurance policy forms have taken steps to seek approval of insurance policy exclusions that exclude insurance coverage for “non-certified” acts of terrorism; that is, those causing less than $100 million in total insured losses, or not certified by the Secretary of the Treasury. Accordingly, named insureds electing to purchase the coverage bounded by the Act should carefully review their insurance policies with regard to coverage for terrorism, the scope of any terrorism exclusion made part of their insurance policies, and evaluate their risk of being a victim of terrorism for which there is a gap in their coverage.

• Second, because the Act largely leaves in place state authority to regulate policy forms, there may be issues with whether terrorism exclusions permitted by the Act are in fact enforceable. Relatedly, there may be issues with regard to the approval of exclusions for non-certified terrorist acts, domestic terrorist acts, or terrorist acts that cause less than $100 million.

• Third, the Act provides no ceiling on the price that insurance companies can charge for the terrorist insurance coverage they are required to offer. Accordingly, named insureds are encountering wild variations in the prices they are being quoted for this coverage.
Fourth, the Act does not address the timing of the determinations of the Secretary of the Treasury with regard to whether or not a loss stems from an act of terrorism.

**[C][2] Earthquake, Flood, Windstorm**

These three exposures are typically excluded by first-party insurance policies. They can be endorsed back into coverage, although, depending upon the area in which the asset is located, insurance companies typically agree to offer them for high premium and subject to low sublimits. More specifically, insurance companies use maps and geographical surveys to predict the risk to property in a given area from these exposures, and price the coverage accordingly. The parties to the lease obviously must decide whether pursuit of such coverage makes economic sense, given the location and value of the equipment.

**[C][3] War**

First party insurance policies universally exclude damage from the risk of war, rebellion, insurrection and related perils. As with earthquake, flood and windstorm, this coverage can often be purchased by endorsement, at considerable cost, depending on the location of the asset, and subject to various limitations and likely a sublimit.

It is reasonably clear, however, that war risk exclusions do not bar coverage for acts of terrorism. The leading case on war risk exclusions issue is *Pan Am. World Airways, Inc. v. Aetna Casualty & Surety Co.*, which addressed whether various “war risk” exclusions precluded coverage for damages stemming from the hijacking and subsequent destruction of a Boeing 747. The U.S. Court of Appeals for the Second Circuit found that “war” refers to the use of force between governments or entities essentially like governments, and that the hijacking terrorists were not representatives of a government or government policy:

> The loss of the Pan American 747 was not caused by any act that is recognized as a warlike act. The hijackers did not wear insignia. They did not openly carry arms. Their acts had criminal rather than military overtones. They were the agents of a radical political group, rather than a sovereign government.

Other cases have followed this reasoning.

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[C][4] Total Loss Only

Depending on the type of coverage purchased by the lessee, there may be a difference in the insured value of the asset and the lessee’s obligation under the lease. Total Loss Only coverage pays for the difference between the actual value of the asset and the stipulated loss value or casualty value set forth in the lease.\(^{19}\)

§ 25:4.3 Third-Party Insurance

“Third-party” or “liability” policies cover amounts an insured must pay third parties for personal injury or property damage for which the insured is liable. Third-party insurance is essentially “litigation insurance,” covering an insured for all costs associated with litigation, or threatened litigation, including costs of investigation, defense and settlement, and amounts paid in judgment. Specifically, a typical third-party insurance policy promises to protect the insured with legal representation, at the insurance company’s expense, if a third party makes a claim for injury or damage allegedly caused by the insured, and also promises to pay for any settlement reached by, or adverse judgment entered against, the insured.

Lessors and lenders may be held responsible for personal injury or property damage stemming from the use of an asset simply because of their interests in that asset. Further, they may face allegations of negligence in providing a defective asset to the lessee, or in negligently providing the asset to a lessee unqualified to operate it properly. Regardless of actual culpability, lessors and lenders—because they are “deep pockets”—may be alleged to be liable, and thus face huge defense costs and, in some jurisdictions, the real possibility of an adverse verdict with little hope of help on appeal. Allegations against lessors and lenders are more likely to be asserted in situations where the lessee is of limited means—precisely the situations where insurance is most important, because the lessee is unlikely to be able to fulfill its indemnity obligations.

[A] Comprehensive or Commercial General Liability Insurance

Seventy years ago, third-party insurance policies were written for specific hazards, such as boilers, elevators and the work of teamsters, and an insured would have to purchase a separate third-party insurance policy for each hazard. Further, the terms of that coverage were not standard, and would differ among insurance companies. Beginning

in 1941, the coverages provided by these separate policies were combined into a single standard-form policy called a Comprehensive General Liability (CGL) policy. CGL policies are designed to cover all liabilities except those specifically excluded.

Most CGL policies are sold on an “occurrence” basis, meaning that they cover personal injury, property damage or advertising injury that takes place during the policy period, if such injuries stem from an “occurrence” taking place at any time. Thus, the “trigger” of “occurrence” policies, or that which requires the insurance company to provide coverage, is injury—property damage, bodily injury or advertising injury—during the policy period.

An “occurrence” is generally defined to be an “accident,” or a series of related conditions collectively constituting an accident. Often, there may be a question of how many occurrences took place, either under a third-party or a property insurance policy. For example, if one hail-storm damages five of ten leased cement mixers located at ten different construction locations throughout a metropolitan area, does the loss stem from one or five occurrences? The number of occurrences may dramatically affect coverage. For instance, insureds with low deductibles and low per-occurrence limits but high or no aggregate limits will typically argue for multiple occurrences. In contrast, insureds with high deductibles are frequently better served by a finding of a single occurrence.

Other CGL policies are sold on a “claims made” basis, covering the insured for claims made (and, usually, reported to the insurance company) during the policy period, regardless of when the occurrence, or when the personal injury, property damage or advertising injury took place. Typically, however the occurrence must take place after the “retroactive date,” which frequently is the year in which the named insured began to purchase claims-made coverage, or the date the named insured began to purchase claims-made coverage from a specific insurance company. Note that, under most claims-made policies, not only must the claim be made against the insured during the policy period, but the insured also must forward notice of that claim to the insurance company during the policy period (or some small “tail” period afterward, typically thirty days). Because of the potential pitfalls in these claims-reporting requirements, most parties in lease transactions view occurrence coverage to be superior to claims-made coverage.

CGL policies impose two obligations upon insurance companies: to indemnify and to defend. The fundamental obligation of third-party insurance policies is the duty of the insurance company to indemnify or reimburse the insured for the loss sustained. This duty attaches when the insured becomes legally obligated to pay damages in an underlying action, on account of property damage, personal injury or
advertising injury caused by an occurrence. The duty to defend is separate and distinct from the duty to indemnify, is broader than the duty to indemnify, and arises if the allegations in the underlying action against the insured raise the possibility of insurance coverage under the insurance policy.\(^{20}\) The provision of a defense is of utmost importance to insureds because the costs of defending an action can far exceed the amount paid in judgment or settlement. In virtually all jurisdictions, the insurance company must defend the insured even if only one count in a multiple-count complaint is potentially covered.\(^{21}\)

**[B] Umbrella and Excess Liability Insurance**

Often, an insured cannot adequately address its third-party exposure through primary CGL insurance alone. Indeed, some insureds need tens or hundreds of millions of dollars worth of third-party coverage, and the insurance company selling it primary CGL coverage will not sell it more than $1 million in coverage. Such insureds typically purchase umbrella and excess liability insurance policies, which provide two fundamentally different types of coverage.

Umbrella liability insurance policies have been referred to as “kitchen sink” insurance policies, and are generally regarded to be the broadest third-party coverage available. Typically, umbrella policies contain two coverage agreements. First, under “Coverage A,” for losses covered by underlying (primary) insurance, they promise to pay defense and indemnity costs—combined into “ultimate net loss”—after the underlying insurance is exhausted. Second, under “Coverage B,” for losses that are not covered by underlying (primary) insurance, they agree to defend the insured and pay any resulting settlement or judgment, just as if they were a primary CGL insurance policy. This second coverage typically attaches above a nominal SIR (for example, $10,000 or $25,000).

Excess liability insurance policies are different from umbrella liability insurance policies in that they provide one type of coverage: the exact coverage provided by the underlying, controlling third-party insurance policy. That controlling policy is typically identified in the

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20. See, e.g., Universal Underwriters Ins. Co. v. Stokes, 990 F.2d 598 [11th Cir. 1993]; Jasper v. Employers Ins. Co., 987 F.2d 453 [7th Cir. 1993]; Gulf Chem. & Metallurgical Corp. v. Associated Metals & Minerals Corp., 1 F.3d 365 [5th Cir. 1993]. As one commentator has stated, the broad scope of the duty to defend is justified because “one of the primary purposes of the [insurance] policy has always been to protect the insured against the expense and inconvenience of litigation.” W. PAGE KEETON, ET AL., PROSSER & KEETON ON THE LAW OF TORTS, § 82, at 585 [5th ed. 1984].

declarations of the excess liability policy; indeed, the declarations page may be the only page of the excess liability insurance policy. Ambiguities may arise when the excess liability insurance policy identifies a controlling form, but then attaches a few endorsements of its own, for example, if the controlling form and the excess form both attach pollution exclusions, but the pollution exclusions differ, which exclusion controls? The few courts to confront such situations have held that such ambiguities must be resolved in favor of coverage, so that the insured gets the benefit of the broadest coverage.\(^\text{22}\)

Note that, because of cost, some larger named insureds forego purchase of “real” primary CGL insurance coverage, and instead purchase an umbrella policy to sit over, for instance, a primary CGL insurance policy sold by a captive insurance company of the insured or a primary CGL insurance policy that obligates the insured to reimburse the primary insurance company for all claims payments (typically with an added claims-handling fee). Although any lessee electing to structure its program in this manner is probably large enough to have secure credit, lenders and lessors should be aware that, in such situations, there may be no real insurance for defense costs outside of limits or for any loss short of the attachment point of the umbrella policy.

\section*{[C] Common Endorsements and Exclusions}

Obviously, the lessor and the lender will seek to have the third-party coverage be as broad as possible. As with first-party coverage, however, there are a number of exclusions (for example, pollution, nuclear, asbestos) that are essentially non-negotiable. For some exposures, however, coverage may be added by endorsement or through a separate third-party insurance policy.

\section*{[C][1] Workers’ Compensation}

Most leases do not require purchase of workers’ compensation insurance. However, to the extent that, in the operation of the asset that is the subject of the lease, employees of the lessor will be involved, the lessor can purchase an “alternate employee” endorsement to cover the costs to the lessee of its workers’ compensation exposure to the lessor’s employees.\(^\text{23}\)

\footnotesize
\begin{itemize}
\item Cal Dive Int’l Co. v. Sea-Bright Ins. Co., 2009 WL 3673014, at *4 (E.D. La. 2009) (“Where an employee is injured in the course of temporary employment by an alternate employer pursuant to a contract . . . [insurer] agreed to treat the alternate employer as if it were insured.”).
\end{itemize}
[C][2] Pollution

The majority of cases construing pollution exclusions outside of the context of traditional, long-term, industrial pollution of the environment have found that such pollution exclusions do not bar coverage.24 In other words, cases construing the application of pollution exclusions to claims by workers of exposure to chemicals from burst pipes, or from incidental workplace exposure to exhaust or fumes, have found that liabilities from such exposures are not barred by the pollution exclusion.25 Instead, these courts have held that the pollution exclusions are so very broadly written that they must have a limiting principle, and such principle is that they exclude coverage only for truly environmental exposures of the type addressed by environmental authorities. Typically, any exposures faced by parties in a lease relating to the operation of a leased asset will, thus, not fall within the pollution exclusion.

[C][3] Specialty Coverages

General liability insurance policies typically exclude liabilities relating to watercraft, aircraft and related types of equipment. Obviously, if the asset that is the subject of the lease falls within one of these exclusions, the parties will have to secure a specific third-party insurance policy designed for coverage of liabilities stemming from such type of asset.

§ 25:4.4 Specialty Coverages for Lessors and Lenders

The first- and third-party coverages discussed above typically are purchased by most commercial entities to cover their exposures. As discussed below, lessors and lenders typically insist that lessees grant them rights to access the lessees’ insurance for losses to, or claims arising from the operation of, leased assets. Lessors and lenders can, however, also purchase other coverage for such exposures.

[A] Lessors’ and Lenders’ Own First- and Third-Party Insurance

Again, commercial entities typically purchase first- and third-party insurance to protect them against losses stemming from their operations. Such coverage must be sufficient to cover not only exposures from the lessor’s or lender’s existing operations, but also:

(1) its operations in the event that it retakes possession of the leased asset during the term of the insurance, either due to the termination of the lease or through default of the lessee;

(2) catastrophic liabilities that exhaust the lessee’s insurance; and

(3) losses or liabilities if both the lessee cannot perform its indemnities and the lessee’s insurance is unavailable.

In general, such coverage is viewed by lessors and lenders, and by most courts, as “backstop” insurance, to be sought only if, for whatever reason, coverage is unavailable under the lessees’ policies, and the lessees are unable to fulfill their contractual indemnification obligations. As discussed below, however, some courts will undermine this intent by prorating coverage for a loss between the policies of the lessee and those of the lessor or the lender, leading to erosion of the lessor’s or lender’s own insurance and possibly higher premium rates on renewal.

[B] Lessor’s or Lender’s Single Interest

Lessors and lenders can purchase this insurance in the event that the existence of the lessor’s and lender’s rights under valid and collectible first-party insurance purchased by the lessee is in question, either because certificates of insurance or additional insured endorsements cannot be located, the lessee’s insurance has been canceled, or for some other reason. Lessor’s or lender’s single interest insurance is, thus, first-party insurance coverage on the asset paid directly to the lessor or lender in the event of a loss.  

[C] Contingent Physical Damage

Contingent physical damage insurance is essentially a blanket form of lessor’s or lender’s single interest insurance, written not to cover a single asset but to cover all assets in the portfolio of a lessor or lender. The lessor or lender may be required to give a schedule of values of the covered assets, but coverage is typically provided on a blanket rather than a per-asset basis.

26. See Everest Nat’l Ins. Co. v. Sutton, 2008 U.S. Dist. LEXIS 62081, at *2 [D.N.J. Aug. 11, 2008] (“[S]ingle interest insurance ... provided protection to lenders in the event a repossessed motor vehicle was damaged or in the event a vehicle could not be recovered from a defaulted borrower.”); Certain Underwriters at Lloyd’s v. Nat’l Installment Ins. Servs., 2007 Del. Ch. LEXIS 190, at *5–*6 [Del. Ch. Dec. 21, 2007] (“A lender obtains [vendor single interest, or VSI] coverage for its automobile lending in order to shift the risk to the insurer of damage to the loans’ automobile collateral. With VSI insurance a lender is reimbursed, a delinquent borrower’s collateral is repossessed and there is either uninsured physical damage or the collateral is unrecoverable.”).
[D] Residual Value Insurance

Residual value insurance is designed to protect the lessor or lender against unexpected decreases in the value of the asset at the termination of the lease. Most leased assets have residual market value, and lessors or lenders can expect to be able to sell the asset or release it at the end of the initial lease term. Under a residual value insurance policy, this residual value is estimated and agreed by the parties and, if at the end of the term the asset is worth less than this value, and if a variety of conditions are satisfied, the insurance company pays the difference. Given the uncertainties inherent in underwriting this coverage, it may prove difficult or expensive to acquire. Residual value insurance can also be purchased on a blanket basis to cover a portfolio of assets.

§ 25:5 Insurance Protection of Lender’s and Lessor’s Interests

§ 25:5.1 Parameters and Priority of Coverage

[A] Insured Status

[A][1] Additional Insured Versus Named Insured

As noted above, many parties to a lease transaction will insist on being named as additional insureds under the lessee’s first- and third-party insurance policies so that they have direct rights against the insurance company in the event of a loss or third-party claim. Additional insureds differ from named insureds in several respects. Most insurance policies, in setting forth the duties of insureds and the insurance company, are quite specific in referring to the “named insured” as compared to the “insureds.” Specifically, under most insurance policies, it is only the named insured which has the obligation to pay the premium and the insurance company need only give the named insured notice of cancellation. The latter circumstance is of obvious concern to lessors and lenders: A named insured receiving a cancellation notice for failing to pay premiums is unlikely to have the resources to satisfy its independent indemnification obligations. Without notice of the impending cancellation, a lessor or lender cannot act to protect their interests by fronting payment of premium or purchasing alternate insurance.

With regard to payment of losses, settlements or judgments, or demanding a defense, however, the additional insured typically has rights equivalent to the named insured, at least with regard to losses

and claims involving the subject of the insurance. As noted above, however, the additional insured endorsement can, and probably should, limit the circumstances under which parties to the lease are additional insureds to the requirements of the lease, or at least to claims relating to operation of the subject of the lease. Otherwise, there is a potential that the additional insureds could have rights under the policy greater than those intended; they could, for example, seek coverage for losses unrelated to the subject of the lease or for liabilities stemming from their sole negligence. Some courts refuse to examine documents extrinsic to the insurance policy unless they deem the insurance policy to be ambiguous; accordingly, parties cannot be certain that a court would limit the rights of an additional insured to those spelled out in the lease agreement.

Additional insureds have direct rights of payment under the policy, and do not need to seek the consent of the named insured to get paid. These rights can have very broad implications, especially in liability policies with a duty to defend. For instance, a subcontractor that is an additional insured under a policy will be entitled to a defense even if it is not clear whether that subcontractor, or another of many subcontractors at a worksite, caused the injury. Because insureds and additional insureds have equivalent rights to access the proceeds of the policy—that is, the insured cannot demand priority of payment over the additional insured, and vice versa—there is a danger that the policy will be exhausted by payment of other claims. For instance, because each insured has separate, individual contract rights with which other insureds cannot interfere, the policy limits could be exhausted by payments to the named insured on other claims before


the additional insured could make a claim for loss stemming from the subject of the lease. As a practical matter with regard to competing claims for the same loss, however, insurance companies are unlikely to disburse funds to any party to a lease unless all conceivably interested parties agree. Accordingly, an insurance company is likely to issue checks jointly to named and additional insureds, thus requiring an additional insured to get the consent of the named insured to receive payment. In more extreme situations, the insurance company may even deposit the proceeds in a trust account, or file an interpleader action asking a court of law to determine which party is rightfully entitled to the funds. Accordingly, it is advisable for the parties to a lease to spell out their interests in the insurance policy, perhaps in a loss payee endorsement of the type discussed below.  

Most lenders know that a UCC-1 financing statement should describe not only the equipment or inventory but also identify the insurance coverage. However, the filing of a financing statement merely places other creditors on notice of the secured party’s interest in the equipment collateral, and is not a substitute for being named as an additional insured under the insurance policy. For instance, in Badillo v. Tower Insurance Co., a secured party sued an insurance company for paying the proceeds of the policy for a fire loss to the lessee. Nowhere in the policy was the secured party’s name mentioned. The Appellate Division held the insurance company liable to the secured party based on the UCC-1 financing statements, which it ruled gave the insurance company constructive notice of the secured party’s security interest in the lost proceeds. The court of appeals reversed, holding that the policy behind the constructive notice provided by UCC-1 financing statements is not applicable to a lessee’s property insurance company in the context of good-faith payment of loss proceeds. Therefore, secured parties like lessors should not rely

31. An insurer owes a duty of good faith to all insureds covered under a policy, whether as named or additional insureds, and cannot favor the interests of one insured over another. See BMW Fin. Servs. NA, Inc. v. Hassan, 710 N.Y.S.2d 607 [App. Div. 2000] [holding that “an insurer undertakes a separate and distinct obligation to each of the various insured parties, whether named as principal or additional insured”]; Smoral v. Hanover Ins. Co., 322 N.Y.S.2d 12, 14 [App. Div. 1971] [holding that excess insurer, as additional insured’s subrogee, could maintain a bad faith action against the primary insurer which settled the underlying claim and procured a release for named insured but not additional insured].


33. The court observed that a secured party under a UCC-1 should take additional protective steps by having itself named as a loss payee or additional insured on the insurance policy, and that an insurance company is not required to examine the filing index because to do so would “complicate and delay the payment of claims.” Id. at 107.
on the filing of financing statements to protect them, and must insist on being named in the insurance policy itself.

**[A][2] Loss Payee**

In a first-party policy, secured lenders can arrange to be named as loss payees under the policy. Such status does not entitle them to any rights under the policy except to be paid the proceeds after the loss, jointly along with the insured. Accordingly, even if a lender is a loss payee, the insurance company likely will refuse to pay the proceeds unless the insureds agree to the payment.

The parties typically can negotiate other types of arrangements with the insurance company. For example, lessors will usually require that any insurance proceeds (or proceeds in excess of a stated amount) received on account of a loss under the policy be applied to reduce the outstanding debt to the lessor. As an alternative, the covenant may provide that, for losses over a stated amount, the proceeds or some portion may be used by the lessee within a reasonable time to replace the property that was the subject of the loss, so long as the lessee is not otherwise in default under the agreement.

Note that a loss payee provision is unlike an additional insured endorsement in that it is not a separate agreement between the insurance company and the loss payee; accordingly, loss payees generally have no right to payment of proceeds where the named insured has no right to recover.\(^\text{34}\)

For instance, under a loss payable clause or open-mortgage clause, a loss payee is usually prevented from recovering under the insured’s policy when the insured misrepresents or conceals a material matter.\(^\text{35}\)

Further, breach of policy conditions by the insured that prevent recovery by the insured also precludes recovery by the loss payee.\(^\text{36}\)

The loss payee is not an insured under the policy, only a designated entity to whom loss is to be paid, and a specific policy provision may be required for the loss payee to recover when the insured’s acts

\(^{34}\) See generally Transamerica Leasing Inc. v. Inst. of London Underwriters, 267 F.3d 1303 (11th Cir. 2001). But see Assocs. Comm. Corp. v. Nationwide Mut. Ins. Co., 748 N.Y.S.2d 792, 793 (App. Div. 2002) (holding insurance company liable to lender as loss payee although payment had been made to insured following insured’s misrepresentation that an equipment lien had been satisfied).


\(^{36}\) See Waltman v. Cantor, 292 N.Y.S.2d 549, 554 (Sup. Ct. 1967) (holding that a simple loss payable clause does not give rise to any contract between the mortgagee and the insurer).
invalidate the policy.\textsuperscript{37} Depending upon the jurisdiction, a loss payee may be entitled to recover irrespective of an insured’s breach of the policy.\textsuperscript{38} Finally, at least one court has ruled that a creditor is entitled to policy proceeds even if it obtains loss payee status after the loss has occurred.\textsuperscript{39}

\textbf{[A][3] Lender’s Loss Payable Endorsements}

Given the limitations of loss payee and additional insured endorsements in the first-party context, it may be advisable for a lender in a lease transaction to secure a lender’s loss payable endorsement. These endorsements provide that payment for covered loss will be made to the lender, not to the insured, that the lender’s coverage will not be jeopardized by acts of the insured, and that notice of cancellation must be provided to the lender.\textsuperscript{40} Accordingly, such endorsements avoid many of the pitfalls of additional insured and loss payee endorsements.

\textbf{[A][4] Contractual Liability Coverage}

Many third-party insurance policies provide coverage for obligations assumed by contract in certain circumstances, typically, contractual obligations that predate the inception of the policy. In the context of a lease, this would mean that the lessee might have coverage for its costs to indemnify the lessor for the lessor’s costs of defense, settlement and judgment in an underlying case. Contractual liability coverage that is automatically included in a standard-form CGL policy typically is an

\begin{itemize}
\item \textsuperscript{38} See Chase Auto. Fin. Corp. v. Allstate Ins. Co., 721 N.Y.S.2d 116 (3d Dep’t 2001) (holding that insured’s neglect, if any, would not be imputed to lienholder, and lienholder was not prevented from recovering by loss payable clause that precluded payment to lienholder for act or neglect of insured).
\end{itemize}
exception to an exclusion. CGL policies often exclude coverage for bodily injury or property damage that the insured has agreed to pay under contract unless the liability was assumed in an “insured contract” (defined to include leases) prior to the occurrence of the injury. A contractual liability endorsement can and should be requested if there is any uncertainty about whether the underlying policy provides the requisite coverage.

This coverage does not grant any direct rights in the indemnified party. Thus, from the perspective of the lessor, relying on the existence of this coverage is not as attractive as being named as an additional insured. First, the lessor must pay its costs out of pocket, and rely upon the lessee to make a claim, get the claim paid, and pay the proceeds to the lessor. Second, under this coverage, the defense costs typically are paid within the limits of the policy, unlike the situation where the lessor can directly seek a defense obligation as an additional insured, when defense costs are paid outside, or in addition to, indemnity limits for settlements or judgments. This may severely limit the amount of insurance coverage available. Third, where a court finds that the indemnity agreement is not valid, there will be no contractual liability coverage. In contrast, as noted above, an additional insured can typically seek to enforce its rights whether or not the indemnity is voided.

In any event, as a backstop, the insurance clause in an agreement should require the lessee to include contractual liability coverage.

[A][5] Notice to Insurance Company

Note, however, that, when a third party and an insured have a security agreement requiring the third party to be named on the policy, and an insurance company receives actual written notice of a third party’s claim, the insurance company may have a duty to preserve the proceeds until the issue of ownership can be resolved.42

41. But see Rodriguez v. JLF Props., Inc., 594 N.Y.S.2d 206, 206–07 (App. Div. 1993) (holding that an indemnified party, who is a stranger to the insurance contract, can maintain an action against the insurance company for the insured’s liability if there has been an entry of judgment against the insured, and the insurance company has been notified by the indemnified party).

42. See Rosario-Paolo, Inc. v. C&M Pizza Rest., Inc., 643 N.E.2d 85 (N.Y. 1994) (holding an insurance company liable to a vendor with an equitable interest in loss insurance proceeds where the vendor had provided the insurance company written notice of its claim before the proceeds were paid out); but see Citigroup, Inc. v. Indus. Risk Insurers, 336 F. Supp. 2d 282, 293 (S.D.N.Y. 2004) (distinguishing Rosario-Paolo where the third party did not have a security agreement with the insured).
[A][6] Insurable Interest

Finally, note that a party cannot make a claim for coverage as an additional insured or seek proceeds as a loss payee unless it has an insurable interest in the subject of the insurance. Generally, this is an easy hurdle to meet, especially for lessors or lenders in a lease transaction. Under the law of New York and most other states, an "insurable interest" includes "any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage." Lenders have insurable interests in the collateral for the loan, and lessors have insurable interest in the asset as a rent-producer, and in its continued existence at the end of the lease. With regard to the timing of these interests—that is, when the lessee acquires an insurable interest in leased property—consult the provisions of the Uniform Commercial Code.

[B] Other Insurance—Priority of Application

Frequently, in situations involving lessors or their lenders, multiple insurance policies will apply concurrently to the same loss. For instance, a lessor of construction equipment will have its own third-party insurance policies and will be listed as an additional insured under the third-party policies of its lessee. If a loss occurs, can the lessee’s insurance company insist that the lessor’s policy pay first, or that any payments be allocated between the two policies, either on a 50/50 basis or in proportion to limits (which typically is a much worse result for the lessor, as it purchases higher limits of coverage)? Any of these results would fundamentally contravene the purpose of being named as an additional insured in the first place, which was to protect the lessor, its insurance, and its loss experience.

Policy language is typically of no assistance. Most primary policies provide that they apply as primary insurance, unless the other applicable policies are also primary policies, in which case they call for proration. Most umbrella or excess policies contain language purporting to make them excess of any other applicable insurance. Simply

43. N.Y. INS. LAW § 3401; see also Zurich Am. Ins. Co. v. ABM Indus., Inc., 397 F.3d 158, 167–68 [2d Cir. 2005]; Scarola v. Ins. Co. of N. Am., 292 N.E.2d 776, 777 [N.Y. 1972] (“An ‘insurable interest’ is sui generis, and peculiar in its texture and operation. In general a person has an insurable interest in the subject matter insured where he has such a relation or connection with, or concern in, such subject matter that he will derive pecuniary benefit or advantage from its preservation, or will suffer pecuniary loss or damage from its destruction, termination, or injury by the happening of the event insured against. Great liberality is indulged in determining whether a person has anything at hazard in the subject matter of the insurance, and any interest which would be recognized at law or equity is an insurable interest.”).
examining such standard-form language, thus, creates some danger that a court would require contribution from the policies of an additional insured. Further, in general, courts enforce clauses in competing primary policies calling for proration, and refuse to enforce “excess” or “escape” other insurance clauses in umbrella and excess policies, and instead pro-rate. In short, naming a third party as an additional insured provides the third party with primary coverage, “unless unambiguously stated otherwise.” However, where a lessor’s own liability policy and the lessee’s policy on which the lessor was named as an additional insured contain mutually repugnant excess other insurance clauses, claims may be satisfied on a prorated basis between the two policies.

Payment by the lessee’s policy first, rather than proration, is the result required by the insurance industry itself in the Guiding Principles of Overlapping Insurance Coverages, a document created to address problems of determining the priority of application when multiple insurance policies all are applicable to a loss. The Guiding Principles are referred to in case law, and provide, in the context of leases, that the policy of insurance with the most direct connection to the asset—which would be that of the lessee—is primary to all other applicable insurance. Despite this, there is a significant risk that a court will allocate responsibility for a loss between the policy naming the additional insured and the additional insured’s own policies.

To address the risk that a court will impose an allocation which undermines the reasons for seeking additional insured status, it is usually possible to secure appropriate endorsements to the involved policies. Although the insurance company of the lessee may be reticent to endorse its policy to provide that it is primary to the policies sold to the lessor or to the lender, the insurance companies selling policies to

44. See, e.g., Scottsdale Ins. Co. v. Underwriters at Lloyd’s London, 2009 WL 3284231, at *7, 48 Conn. L. Rptr. 509 (Conn. Super. Ct. Sept. 8, 2009) (“Where two primary policies both contain excess ‘other insurance’ clauses, the excess clauses are generally treated as mutually repugnant and the loss is pro-rated between the insurers,” quoting 15 COUCH ON INSURANCE (3d ed. 1995) § 219:47); Cosmopolitan Mut. Ins. Co. v. Cont'l Cas. Co., 147 A.2d 529 (N.J. 1959). “The general rule is . . . that where there are multiple policies covering the same risk, and each generally purports to be excess to the other, the excess coverage clauses are held to cancel out each other and each insurer contributes in proportion to its limit amount of insurance,” Lumbermens Mut. Cas. Co. v. Allstate Ins. Co., 417 N.E.2d 66, 68 [N.Y. 1980].


the lessor and lender will likely be amenable (because it reduces their own exposure) to providing that their policies are excess to the insurance policy sold to the lessee, or excess to policies under which the lessor or lender is named as an additional insured. This intent should also be reflected in the lease, although it is no sure thing that a court of law would examine such lease if it deemed it to be extrinsic to the insurance policies.

§ 25:5.2 Breach of Warranty

Ordinarily, additional insureds are subject to the insurance company’s defense for any misrepresentations made in the process of purchase of the insurance. Further, in general, loss payees have rights to payment only if the named insured has a right to payment, and thus also can lose their rights to insurance protection if the named insured breaches conditions of the policy. Accordingly, additional insureds and loss payees can insist on a “breach of warranty” clause providing that the insurance company must pay a loss despite having a defense against doing so by reason of the lessee having breached some condition of the policy.

§ 25:5.3 Limits

In determining the limits of insurance they wish to purchase, insureds must examine their loss history and evaluate their appetite for risk. Frequently, especially in the third-party insurance context, no one insurance company will agree to provide all the insurance needed by the insured, forcing the insured to purchase layers of coverage from multiple insurance companies. Obviously, as the layers get higher, the cost per thousand dollars of coverage decreases. At times, however, the insurance industry’s appetite for risk dramatically decreases (known as a “hard market”), severely limiting the amount of insurance available for purchase and dramatically increasing the price. Further, the more specialized the operation involving the asset, and the higher the risk of catastrophic loss, the fewer the third-party insurance companies participating in the market for insuring that risk, thereby increasing the cost of that insurance. If the insured cannot afford sufficient coverage, there are other options. For instance, it can accept a higher deductible or SIR, or purchase coverage that is retrospectively rated and which rewards lower loss experience with lower premiums.

For lenders and lessors, the amount of insurance they require for the property in which they have an interest is usually a matter set forth in the lease. The amount of first-party protection will likely be determined by the type of insurance purchased, actual cash value, replacement cost or agreed value, although most larger leases require agreed value coverage. The amount of third-party insurance required
should factor both the relative frequency of losses experienced, as well as the risk of catastrophic loss, as well as the credit-worthiness of the lessee. To determine the amount of risk, it will likely be necessary to consider experience in the industry or related industries, for which a broker, or the insurance company itself, may prove helpful.

§ 25:5.4  Deductibles

As noted above, the lender or lessor should ensure that the lessee does not eviscerate the protection provided by insurance by purchasing policies with high deductibles. Additionally, the lessor or lender should ensure that the lessee has adequate financial resources to pay the deductible. The level of deductibles will typically be established in the lease. Deductible amounts, along with premium cost per thousand dollars in coverage, fluctuate dramatically with the “hard” and “soft” insurance markets.

Further, for claims made by additional insureds, questions may arise as to which party is responsible for payment of the deductible: the named insured or the additional insured. From the perspective of the additional insured, high deductibles may frustrate the purpose of requiring the named insured to add the additional insured to the policy. Of course, the additional insured can resort to its contractual indemnities to recover this amount, but such action likely raises the type of problems that motivated the additional insured to request being added to the policy in the first place.

§ 25:5.5  Cancellation and Changes

Under standard insurance policies, the insurance company owes no duties to provide notice of cancellation, non-renewal or changes to additional insureds or loss payees; rather, it owes such duties only to the named insured. Accordingly, parties to the lease transaction should insist that the insurance policy contain a clause giving the lessor or other interested party twenty or thirty days advance notice of any cancellation, non-renewal or material adverse change in the policy before any of such events become effective vis-à-vis such parties. Some endorsements as originally issued provide only ten days, but this can be the subject of negotiation. Further, if the policy, certificate or endorsement states only that the insurance company will “endeavor” to give the additional insureds notice of cancellation or changes, the lessor or lender should request such language to be modified to require such notice to be provided.

Note that state regulations on cancellation and notices of cancellation vary widely. Typically, such regulations are reduced to endorsement and appended to the policy, but, if questions arise, the parties to the lease should consult these regulations directly.
§ 25:5.6 Subrogation

Most insurance policies permit the insurance company the right of subrogation, or the right to pursue parties who may be legally responsible for losses for which the insurance company has paid the insured. For instance, if leased equipment is destroyed in a fire that started because of faulty wiring, the insurance company, once it pays for the value of the equipment, becomes vested with the insured’s tort rights against the electrician who installed that wiring. The insurance company has subrogation rights only to the extent it has paid for the loss, and, if the insurance company has paid less than the full claim, the insured can argue that is entitled to be made whole before the insurance company receives anything.

Under the rules of most states, an insurance company cannot subrogate against its own insured.\textsuperscript{48} Accordingly, additional insureds should not have to fear subrogation actions against them, although loss payees could potentially be the subject of subrogation actions. However, it is a good practice to insist that the insurance company waive its rights to subrogation generally or at least as to the additional insureds and loss payees.

Further, because a subrogation action is usually filed by the insurance company in the name of the insured, and because the insured is typically obligated to assist the insurance company in prosecuting the subrogation action, subrogation can cause unexpected problems for the insured. For instance, an insurance company may seek to bring a subrogation action against the insured’s landlord or its main supplier of a component of its product. Accordingly, an insured may seek to have the insurance company waive its rights to subrogation entirely, or at least with regard to specific companies, and have that understanding confirmed in the insurance policies.

§ 25:5.7 Quality of Insurance Company

In most transactions, the parties specifically spell out the requirements for the company selling the insurance. Because lessees are naturally unwilling to grant control over selection of the insurance company to the lessors, the parties typically settle upon an objective measure of insurance company performance, of which there are many. A.M. Best Company rates the financial size and underwriting capacity of admitted domestic insurance companies, rating them from A++ to F along with size from XV down to I, with the best rating being A++ XV. Leases employing Best ratings as a standard typically require an A rating.

\textsuperscript{48} See, e.g., Pa. Gen. Ins. Co. v. Austin Powder Co., 502 N.E.2d 982, 983 [N.Y. 1986] ("An insurer has no right of subrogation against its own insured for a claim arising from the very risk for which the insured was covered.").
Corporate rating agencies such as Moody’s and Standard & Poor’s issue ratings of domestic insurance companies’ claims-paying ability. Obviously, given the events of the summer of 2008, these ratings are in flux, as is the reliability of rating agencies.

Unfortunately, these agencies limit their ratings to domestic companies, and thus do not rate foreign insurance providers, including the syndicates and companies at Lloyd’s, London and the various insurance companies constituting the London subscription market. This is indeed unfortunate for lessors and lenders because, for many types of leased equipment and property, the underwriters at Lloyd’s and the London Market are the insurance experts. Further still, the financial status of various underwriting syndicates at Lloyd’s and many insurance companies in the London Market has been in serious question for the last decade, owing largely to massive payouts for asbestos losses and questionable financial decisions.

Accordingly, many leases simply state that the insurance company selected must be a reputable domestic or international insurance provider. Further, lessees should agree that the insurance provider selected should be of the same nature and quality as that providing insurance for similar property owned or leased by the lessee, or of the same nature and quality as is common for comparable property of other owners or operators comparably situated.

 Obviously, the lessee, being in the first instance responsible for damage or destruction to the property at issue, has a keen interest in selecting a company with a good claims history. If the insurance company that sold the insurance is marked by a dubious claims handling history, or is struggling financially, the insurance policy may be of little actual value. Insurance that does not insure is more dangerous than no insurance because it provides false assurances of protection. It may be advisable to speak with colleagues, insurance brokers, and state insurance departments for further information about any insurance company under consideration.

§ 25:5.8 Evidence of Insurance

In many leases, the lessee is required to produce the policy for inspection by the lessor. This may be possible if the lessor is being added as an additional insured to an existing policy, but in the typical purchase of insurance, the parties agree to terms and conditions, a binder is signed and provided to the insured, and the policy is provided months, or even years, later. Under the law of most jurisdictions, until the policy is issued, the binder is the operative contract. 49 Accordingly,

lessors must ensure that the binder correctly reflects the agreement of the parties. Certainly, lessors should request copies of the policy both in case the copy of the named insured is lost or destroyed and to ensure that it reflects the requirements of the lease. The policy, however, may cover the named insured for a host of other exposures, some of which it might prefer to keep confidential from the additional insured or loss payee; accordingly, named insureds often agree to provide only a certificate of insurance.

Lessors and lenders should receive some evidence of the insurance prior to the commencement of the lease period and prior to the expiration of any policy period. At a minimum, the certificate should indicate the insurance company, the policy number, the policy period, the applicable coverages, the limits (along with deductibles or SIRs), and any special conditions or endorsements affecting coverage. Most important, the certificate should indicate the status of the lessor or lender as an additional insured or loss payee.

Often, evidence of insurance, whether by binder or certificate of insurance, is provided by the broker of the lessee. As explored below, unless signed by the insurance company, these may be worthless, if the broker does not have the authority to bind the insurance company. Finally, additional insureds or loss payees will also sometimes receive opinions from the broker that the insurance purchased conforms to the obligations of the lease; as shown below, however, such opinions are of dubious value vis-à-vis the insurance company.

§ 25:6 How to Purchase Insurance

§ 25:6.1 The Forms

The insurance industry, immune from antitrust laws through the McCarran-Ferguson Act, is permitted to share vast quantities of information with regard to exposures and claims. This data is meaningful, however, only if it relates to identically worded coverages. Accordingly, the policies offered for sale by the insurance industry often make use of standard forms or at least standard wording drafted by insurance industry organizations such as the Insurance Services Office. Individual insurance policies vary more at the edges (the endorsements) than at the core (the coverage promises). From the perspective of the insured, similarity in policy forms is essential to permit meaningful price comparisons.

In general, standard-form policies or endorsements can address all of the exposures of an insured. Insureds are likely well advised to

confine themselves to such standard-form policies and endorsements for two reasons: (1) they probably have been the subject of judicial construction, which will serve to confine the constructions available to the insurance company at the point of claim, and (2) if policy forms or endorsements are “manuscripted,” or drafted specifically for the insured, the insurance company can argue that ambiguities in such manuscript forms should not be construed against the insurance company. If an insurance coverage dispute ripens into litigation, the rule that ambiguities are construed against the drafting insurance company is one of the best weapons in the insured’s arsenal. Accordingly, if an insured is going to rely upon a manuscript form or endorsement, it must ensure that the coverage provided by that form or endorsement is clear and significantly more favorable than that provided by the standard form.

§ 25:6.2 Brokers

Many insureds find it essential to employ brokers when purchasing coverage. Such brokers may have a much better understanding of the insured’s coverage needs, and exclusive access to the insurance companies best suited to providing that coverage. Brokers also are skilled at putting together coverage applications, or the information required by insurance company underwriters if they are to agree to provide coverage. Very few insurance companies are “direct writers,” or companies that sell commercial insurance to insureds directly and not through a broker; accordingly, for many types of coverage, a broker must be employed. Some insurance companies sell commercial insurance through agents, who indisputably act as agents of insurance companies. Brokers raise more complicated questions of agency.

[A] Brokers As Agents

In insurance coverage actions, insurance companies universally seek to characterize brokers as the agent of the insured. Typically, this is so that the insurance company can attribute some coverage-minimizing statement or opinion of a broker to the insured, or to avoid having a coverage-maximizing statement or opinion of a broker attributed to the insurance company. In reality, brokers are likely agents of both insurance companies and insureds, depending upon the particular action at issue. For instance, in receiving premiums or receiving notice of loss, insureds will argue that brokers are agents of the insurance company. In submitting applications for insurance, insurance companies will argue that brokers are agents of the insured.

Although case law on some of these issues exists in some jurisdictions, sufficient uncertainty remains to make it imperative for insureds to be very careful when dealing with brokers.

[B] Role in Placement

For instance, when an insured employs a broker, it may be difficult for the insured to determine whether explanations of coverage come from the broker or the insurance company. As an example, an insured may ask the broker to confirm that the pollution exclusion is confined to losses of the type addressed by environmental authorities and would not apply to ordinary industrial accidents which involve chemicals. As an initial matter, it is critical to reduce all such pre-sale understandings to writing: In coverage disputes, a good rule of thumb is that, if it is not in writing, it does not exist. When the broker does so, however, and provides the insured with a letter, on the broker's letterhead, explaining the ambit of the exclusion, this may not be enough to ensure that, in a subsequent dispute, this explanation controls. Because of the uncertainty surrounding whether the broker is the agent of the insured or the insurance company, such letter may be worthless vis-à-vis the insurance company (that is, if the broker is found to be the agent of the insured for this particular action), although it might permit an action against the broker for malpractice. Accordingly, in seeking commitments about the content and meaning of insurance coverage provisions, the insured can truly rely only upon communications from the insurance company on insurance company letterhead.

[C] Role After Placement

Rarely is an insurance policy ready on the date of its inception. Commonly, the parties agree to terms and conditions, and the insurance company signs a binder confirming those terms and conditions. Thereafter, sometimes months or even years later, the policy is physically put together and sent to the broker or insured. Upon receipt, the broker should confirm that the actual policy conforms to the agreement of the parties. It is not uncommon for an insurance company, either mistakenly or intentionally, to add or drop endorsements or other coverage forms that were not part of the binder. The broker should also ensure that the premium is paid and that any mid-term endorsements are added, for example, an endorsement naming a client secured mid-policy term as an additional insured.

[D] Role in Claims

It is often advisable to send notice of loss through the broker. The broker should know to which insurance companies to send the notice, and, at particular insurance companies, to whose attention to send the
notice. A broker should send notice to all potentially implicated insurance companies, and the insured should request a copy of these notice letters. If the broker fails to provide notice to a potentially implicated insurance company, the insured must do so.

Thereafter, an insured may enlist the broker to assist it in securing payment for the claim. This is often fraught with peril for insureds. Although the broker may wish to ensure claim payment to keep its insured client happy (and to stave off a potential broker malpractice action), brokers also have important—and sometimes, as the actions brought against brokers by Eliot Spitzer in New York demonstrate, inappropriate—relationships with insurance companies. In other words, it may be difficult for a broker to press hard for payment of a claim to one insured from an insurance company if the broker wants to secure favorable terms for a new insurance policy from the same insurance company for a different client.

Further, as shown above, the status of a broker during any particular action may not be clear. For instance, although a court may find that the broker is an agent of the insured for some purposes, it may also find that the presence of the broker in otherwise attorney-client privileged discussions regarding insurance coverage for a claim vitiates that privilege, entitling the insurance company to discovery of the substance of those discussions. Further, brokers frequently draft coverage opinions after a loss. Some courts may consider such opinions discoverable. Accordingly, although insureds should seek the input of brokers and any assistance they can provide with regard to getting claims paid in a timely manner, insureds should assume that any communications involving, or correspondence to or from, brokers will eventually be discoverable if the coverage dispute ripens into a lawsuit.

§ 25:7 Checklist of Concerns for Lessors/Lenders and Lessees

Obviously, all parties in a lease transaction have an interest in making sure that the leased asset is properly insured. The lessor has an ownership interest in the asset, and is interested in the lease payments it can generate and in its residual value after termination of the lease. The lender is interested in protecting the collateral for its loan. Finally, the lessee is interested in the continued existence of the asset because it is typically required by contract to replace the asset if destroyed, and because of the loss of income the lessee will suffer if it cannot repair or replace the asset immediately.

The specific concerns about which the parties to a lease must be concerned are discussed above. What follows is a checklist for lessors, lenders and lessees.
A. For Lessor/Lender

1. Lease Document
   a. Detail required indemnities.
   b. Detail insurance purchase obligations.
      (1) Detail required limits; ensure third-party limits are sufficient in view of lessee’s other exposures.
      (2) Detail acceptable SIR/deductible amounts.
      (3) Detail required quality of insurance provider, and ensure that primary insurance is provided by an insurance company and not a captive.
      (4) Require breach of warranty insurance.
      (5) Require waiver of subrogation generally or, at a minimum, against the lessor and lender.
      (6) Require “all-risk” rather than named-peril first-party coverage.
      (7) Require “agreed value” or “replacement cost” first-party coverage, if not on “agreed value” basis, attempt to have coinsurance waived.
      (8) Require policies to state that notice of cancellation and notice of changes will be sent to lessor and lender.
      (9) Evaluate whether to insist upon earthquake, flood and windstorm coverage and in what amounts.
   c. Ensure indemnity and insurance obligations are separate.

2. Lessee’s Policies
   a. Determine whether to be additional insured, loss payee or, preferably, both.
   b. If additional insured, specify to what extent.
   c. Consider negotiating with lessee’s insurance company the extent of the interest of each loss payee and the priority of payment.
3. Evidence of Lessee’s Insurance
   a. Ensure that insurance company, not simply broker, has committed to providing insurance.
   b. Secure copy of policy or certificate of insurance.
   c. Ensure insurance purchased matches contractual requirements.
   d. Be cautious of broker analyses.
4. Lessor’s/Lender’s Insurance
   a. Ensure proper backstop coverage is purchased.
   b. Secure endorsement making own insurance excess of lessee’s insurance.

B. For Lessee
1. Lease Agreement
   a. Negotiate appropriate coverage limits.
   b. Negotiate appropriate SIR/deductible limits.
   c. Negotiate appropriate parameters of quality for insurance provider.
2. Purchase
   a. Match insurance requirements of lease.
   b. If broker is used, ensure that commitments as to coverage are made by company, not broker alone.
3. Lessee’s Coverage
   a. Ensure policy, when received, matches binder.
   b. Ensure proper limits on additional insured status of lessor/lender.
   c. Attempt to secure first-party coverage on agreed value basis for value of leased asset under lease, if higher than anticipated actual cash value or replacement cost.

§ 25:8 How to Make and Pursue an Insurance Claim

Of course, no policy is worth purchasing if you cannot collect; thus, an insured must handle its claim properly and protect its interests from notice until payment of the final check. To ensure its interests are protected, an insured should follow the following steps.
§ 25:8.1  *Locate Evidence of the Coverage*

As an initial matter, an insured must locate its policies and pore over them. First- and third-party insurance policies come under a variety of names—commercial or comprehensive general liability, bumbershoot, multiperil, fire insurance, inland marine, boiler and machinery—and insureds must read each policy under which they have rights. Further, if evidence of the coverage is “lost,” the insured must request a copy of the policy from the broker, agent and insurance company, or from the insured which was obligated to add the insured to its coverage. As a preventative measure, an insured should keep copies of its insurance policies and certificates off-site, in case the very catastrophe for which it seeks coverage destroys the policies and certificates, too.

§ 25:8.2  *Read the Policy*

Insurance policies typically are bulky, and their wordings and coverages complex, but insurance is not high-energy physics. A close reading of an insurance policy will probably reveal most of the provisions under which coverage may exist, and form a basis for intelligent discussion with the broker or insurance company.

§ 25:8.3  *Give Notice*

An insured should give notice as soon as possible. There is no harm in doing so, and the failure to do so can be disastrous. It may even be worthwhile to have an internal procedure to make sure that notice is given in the event of a loss. The insured should include all known losses and a catchall to cover losses that may be discovered after the fact. The insured should not wait, however, for complete information; if necessary, the insured can provide updates later. If the insured cannot determine which insurance policy provides coverage, it should provide notice under all conceivably applicable policies.

§ 25:8.4  *Quantify the Claim*

Third-party disputes typically involve sums certain paid in judgment or settlement, so quantification of the claim is typically not an issue. Many insurance companies, however, will require evidence of the quantum of damages suffered by the underlying claimant before they pay for a settlement of those damages. In general, this is improper: Coverage follows liability, and if one is liable, coverage should exist regardless of the bona fides underlying the liability. Quantification will, however, typically ease settlement with the insurance company.
For first-party claims, however, an insured must properly quantify a claim. In doing so, the insured should consider hiring a loss adjuster. Loss adjusters specialize in presenting first-party claims to insurance companies, working with the insurance company’s adjusters, and getting the claims paid. Further, if the claim is big enough, the insured should consider hiring an accounting firm that specializes in first-party insurance coverage accounting. Inevitably, the insurance company will hire one or more accounting firms that specialize in representing insurance companies; it will also probably hire, and conceal the hiring of, a law firm. If the insurance company presents an accounting firm as the insured’s or an “independent” accountant, the insured should do a little research on that accounting firm. Insurance companies typically hire accounting firms that specialize in representing insurance companies in first-party insurance disputes. The insurance company’s engagement of such a firm may give the insured an early indication of how it is treating the claim.

§ 25:8.5  Be a Squeaky Wheel

To many insureds, it appears that insurance companies “ration by hassle”: They deny claims and do all they can to discourage insureds, finally paying only the persistent insureds who do not take “no” for an answer. It is, in fact, a good practice for insureds to do everything in their power to demonstrate that they will not simply go away. For instance, the insured should write letters and demand information and positions on, and explanations of, coverage. If unanswered, the insured should write further letters incorporating all previous requests for information and demanding immediate responses. Further, the insured should confirm all conversations in writing immediately. Written, contemporaneous correspondence is a must if the claim goes to litigation.

Last, the insured should endeavor to respond immediately in writing to all requests for information by the insurance company. Frequently, such requests are of a blanket nature requesting huge amounts of documents; timely, detailed responses providing relevant documents and explaining why other requested documents do not exist or are irrelevant can be of immense aid if the claim goes to litigation in rebutting charges that the insured failed to cooperate with the insurance company.

§ 25:8.6  Be Aware of Policy Deadlines

For first-party losses, the insured should be aware of deadlines in the policies. For instance, some policies require that proofs of loss be filed within a certain amount of time (often, sixty days). The law of some states, like New York, tolls this time limit until the insurance
company requests a proof of loss and sends the insured a blank form. Nonetheless, the insured should confirm in writing when the insurance company considers the proof due. If the date indicated by the insurance company does not provide sufficient time for the insured to file a proof of loss, it should submit a “partial” proof of loss setting forth losses to date and reserving the right to file subsequent and more complete proofs.

Of more import, most first-party insurance policies require that any suit filed against the insurance company must be filed within a short time (usually, one or two years). Further, regardless of what the policy says, the period may be controlled by state statute, so the insured must examine the statutes of the states whose law might apply. If there is any doubt, obtain from the insurance company its understanding of the appropriate suit limitation. If the insured is in negotiations with the insurance company at the time the limitation expires, it may be able to argue the insurance company waived or is estopped to assert this limit, but if negotiations are running up against that limit, the insured should get a written extension of its time to file suit.

§ 25:8.7 Avoid Appraisal

During the course of a first-party dispute, the insurance company may demand an “appraisal” to decide the amount of the loss. In an appraisal, each side picks an appraiser, and if the appraisers cannot agree on a dollar figure they pick an umpire to decide the amount. Umpires, however, tend to come from the ranks of the insurance industry; accordingly, appraisal is typically bad for insureds. Unfortunately, first-party insurance companies can usually convince courts to dismiss lawsuits filed prior to appraisals on the ground that an insured may not file an action at law until it complies with the appraisal condition. An insured, however, can contest the primacy of appraisal in a court of law if the nature of the dispute between the parties is a legal one rather than one as to value. For instance, if an insurance company insists that destroyed property can be repaired, and the insured insists upon replacement of the property, this is a legal issue that is not a proper subject of appraisal. Appraisals are only proper for pure issues of valuation.

52. For instance, N.Y. INS. L AW § 3404 extends “suit” limitations in all property insurance policies to which it applies to two years.

53. 6 JOHN A. APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE, § 3929, at 564 (1972); see also Hanson v. Commercial Union Ins. Co., 723 P.2d 101, 103 [Ariz. Ct. App. 1986] (“The function of appraisers is to determine the amount of damage resulting to various items submitted for their consideration. It is certainly not their function to resolve questions of coverage and interpret provisions of the policy.”).
§ 25:8.8  Conclusion—Be Prepared

As the above should make clear, if the insured has a large loss, it will have coverage issues with its insurance company. Accordingly, an insured must be aware of the coverage provided by its insurance policies, and the potential hurdles in securing the coverage they promise, so that it can ensure it gets the coverage for which it paid.