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Are You Covered?
– Risk Management and Insurance for Professional Fiduciaries.©

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Mr. Jones is also grateful to his co-presenter at this year's PFAC conference: **Lawrence D. Hilton, Esq.**, President of the Moraga, California-based Dominion Insurance Services. Mr. Hilton is admitted to both the Utah and California Bar Associations, and practiced in the area of insurance coverage and defense for more than 20 years. Larry formed a boutique insurance agency in San Francisco catering to professional coverage needs. That entity has since grown into a full-service brokerage operating in all 50 states.

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Learning Objectives

I. Avoiding claims and disputes, including avoiding lawsuits against fiduciaries;

II. Understanding the insurance terms that are most relevant/important to fiduciaries;

III. Knowing what to do and what to expect in the event of a claim or potential claim.

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Introduction

This guide will help Professional Fiduciaries: (1) avoid disputes; (2) make sure they are covered by insurance if a dispute is simply unavoidable (some are) and a claim is made; and (3) navigate the claim handling/professional liability insurance process smoothly.

Section one discusses ways to avoid disputes, including lawsuits, be it with clients/wards/persons or others, such as beneficiaries, disgruntled family members, or any number of other third parties who appear increasingly "targeting" or seeking to recover from Professional Fiduciaries. We address what can be done before a potential matter arrives on the fiduciary's desk, including engagement letters (sample letters provided); discuss what can be done during the life of a file to help reduce the chances of a claim - from managing expectations and memorializing important decisions - to risk management "checklists" (again, samples provided); we then discuss proper withdrawal/disengagement (sample letter provided). All of these suggestions are designed to help Fiduciaries avoid and/or "manage" risk.

Section two (my favorite) seeks to explain the often-considered-"dry" topic of insurance coverage. How does it work? What do I need to put in my insurance application? Why do I even need to do an application, I have a million other things to do? "Claims-made coverage" – what does that even mean? What is a "Claim"? What is a "Circumstance that may lead to a Claim"? If someone verbally tells me that I made a mistake and they will hold me responsible, is that something I need to tell my carrier about? (yes – it actually meets the definition of Claim). What is a Policy "retroactive date"? Is that important? (Hugely). Can I obtain coverage for "prior acts"? (Sure – you can buy that if you think you need it). Etc.

Section three discusses giving proper and timely notice to your insurer (who you should regard as your business partner, by the way) and what to expect and how things will proceed if a Claim (or Circumstance) occurs.

*********For legal reasons (after all, I AM a lawyer) we must note that the following materials are intended as a <u>general guide only</u> and do <u>not</u> represent a complete analysis of the issues covered. They are intended to highlight matters that may be of interest and benefit to fiduciaries, but <u>fiduciaries should always seek specific guidance on particular matters</u>. *********

I. Avoiding Disputes – Smart Matter Intake/Management

"Fiduciary malpractice" or "breach of fiduciary duty" claims are increasing exponentially. So are claims of negligence, fraud, misrepresentation, overbilling, mismanagement, failing to obtain a better outcome, neglect, conflict of interest, and a host of other allegations covering a wide-range of Professional Fiduciaries' daily activities. These claims can be devastating- they can cause considerable financial exposure that could threaten the financial viability of your entire practice, regardless of the extent of professional liability insurance coverage available with respect to the claim. Beyond the apparent/actual financial loss involved, malpractice claims (as we will refer to them, for ease of reference) drain valuable time and other resources from you and your practice. The repercussions of a malpractice claim within the Fiduciary's client base can be incalculable and have career-altering implications. In a profession founded upon one's reputation and honesty, any malpractice claim (substantiated or not) can have devastating future effects.

In today's litigious environment (where plaintiffs look for collateral sources of recovery), the economic and reputational threats presented by claims make basic risk management essential. With that said, very little focus and energy is placed on risk management, as most Fiduciaries would rather focus on tasks that will further their clients' interests immediately and tasks that will further their practice and profitability in the short term; as opposed to a focus on identifying and reducing potential malpractice exposures and laying the foundations for long term success.

This section sets forth basic techniques to help Fiduciaries reduce their risk of malpractice claims. We attempted to organize the techniques chronologically through the life of a typical file (if there is such a thing) so that they can be applied and considered in the context of everyday practice.

1. Client Intake & Matter Screening (Sample "Checklist" Provided)

The most dangerous people to you (from a risk management perspective) are your own clients/wards/persons. These are the people you are charged with serving/protecting. A close second are family members or other "interested persons" who may disagree with your methods. The best time to protect yourself against "that client" or "that file" (you know – the one above all others that you have anxiety about) is *before you take the file*.

First, is the dull but necessary practice of running a conflict search. The proper identification and resolution of conflicts of interest are major concerns facing Fiduciaries today. It is incredibly difficult to defend a professional liability claim against you where a conflict of interest exists. Judges and juries do not like them. Even if you think they are not a problem, the moment the slightest thing goes wrong, "conflicts" become a big problem.

To avoid conflict problems, before permitting a client or prospective client to provide confidential information regarding a prospective representation, the names of relevant parties and other public facts concerning the matter should be run through a conflicts system. The system can be very basic. In this day and age virtually every fiduciary has some kind of document management or file management system. And all of these have search capabilities.[1] Spend a few minutes searching the relevant names through your current and old files. If you are lucky enough to have one, train your secretary or support staff to do this for you. Make this a simple, but routine part of your practice. Better than that, have this part of your practice reduced to writing, i.e. memorialize the steps you or your secretary go through for each new matter and you now have a clear, formal written conflict checking and resolution procedure.

If a conflict exists, it must be identified, and where possible, resolved through the use of an appropriate conflict waiver agreement. Conflict issues must be addressed before proceeding with the matter and prior to deciding if it is in the best interests of both the client and the Fiduciary to take on this matter.

If no conflict is present, a Fiduciary can proceed to decide if they wish to take on the new Client.[2] When deciding to take on a new assignment, again ask yourself: "is this something I want to do/a person I want to work with?" Here is a short list of basic "self-audit" risk management questions that a Fiduciary should ask:

(1) What are the client's expectations?

(2) Are the prospective client's expectations reasonable?

(3) Has the scope of the Fiduciary's representation been made clear?

(4) Is it likely that this client will blame the Fiduciary if things go wrong? If so, should the client be accepted?

(5) Does the Fiduciary need to protect itself from risk exposure by first investigating the prospective client, the prospective client's background and history, and their objectives before it agrees to the representation?

[1] Various specialized software is also currently available to search all active and closed files to ensure up to date conflicts awareness.

[2] Fiduciaries appointed through the Court, for example as temporary trustees, may feel pressured to take on new appointments when a judge is calling their name in the courtroom. Such appointments often occur without any opportunity for the Insured to either review the operative documents or ask themselves if "this is something I want." It is important that Fiduciaries remember that they are permitted to decline an engagement and/or request more information prior to their agreement. In such a scenario, it is also important to memorialize in the appointment language that such an engagement is being commenced at the request of the Court and prior to any review of any documentation.

(6) Has this client had any past conflicts with Fiduciaries, including the filing of objections to past accountings or the commencement of litigation against past Fiduciaries?

(7) Has this client paid all of his Fiduciary expenses to date and all accounts are otherwise settled?

(8) Have other Fiduciaries refused to take on this client or have other Fiduciaries withdrawn from their representation of the Client?

(9) How will the Fiduciary manage this client's expectations?

(10) If the client is accepted, what resources/personnel should be involved to handle this relationship?

(11) What does the Fiduciary need to do throughout the life of the engagement to maintain clear and open communications with the client so that the scope of the responsibilities and decisions are made clear?

The answers to these questions will help determine whether a new client poses an unreasonable risk to the Fiduciary. See also the risk management "checklist" we have formulated located at: https://dominion-insurance.com/items/index/265. We loaded the checklist online so that it can be updated with suggestions from professional fiduciaries. Please email ajones@fkblaw.com and/or larry.hilton@dominioninsurance.com with any such suggestions.

2. Engagement Letters (Sample Letter Provided)

After the conflicts check is completed, the next step is to draft an appropriate letter of engagement. The purpose of this is to confirm the scope of representation, discuss who you will be reporting to and reporting expectations (including frequency and information provided i.e.: accountings and status reports), to set forth the methods of communicating, including availability to clients, preferred methods [phone/fax/email], preferred methods for receipt of information, and to chart out what the fiduciary's responsibilities are, and billing practices. From a risk management perspective this letter is critically important.

Engagement letters help manage client expectations and avoid misunderstandings that could leave the Fiduciary exposed later on. Many Fiduciaries, especially those with a long-standing relationship with a particular client, will balk at sending such letters, under the theory that the client would be offended by such a correspondence or that such a correspondence is unnecessary because of the nature of the relationship. Such excuses are not credible in today's business environment. First, almost all clients will transact the purchase of goods and services

via written agreement. Thus, the fact that a letter has been sent confirming the services to be performed and the manner on which the Fiduciary will seek reimbursement for such services is hardly a threat- in fact it is something that a client should actually expect to see, as it is largely for their benefit. The letter can be drafted in a such a way that incorporates the Fiduciaries' familiarity with the client and the client's business, while making clear exactly what the Fiduciary will (*or will not*) be doing in connection with a particular representation, so that there is no misunderstanding of the scope of the services to be performed.

Engagement letters are the first opportunity that a Fiduciary has to minimize any potential disputes with Clients and/or their family members/persons at interest. Because of the nature of the engagement and the condition of the Clients (mental and physical) most claims are filed by persons' interested [both positively and negatively] in issues affecting the Client. We recommend that a Fiduciary identify all possible stakeholders or interested persons at the onset, and forward them a copy of the engagement letter.[3] It is important to give all interested persons sufficient time to contact you and discuss the planned course of action or raise objections if applicable. Resolving a potential conflict prior to the commencement of a complicated or life altering decision on behalf of the Client is the essence of risk management.

A sample Engagement Letter can be found at: https://dominion-insurance.com/items/index/265. Again, please email any suggestions to ajones@fkblaw.com and/or larry.hilton@dominioninsurance.com.

Some real-life examples of engagement letters preventing disputes from arising and working effectively to outline the Fiduciary's role and responsibilities at the time of engagement/appointment include the following (names changed to protect confidentiality):

A. Real Life Scenario "A" (The Money Manager)

The Insured, Mrs. Carlson, was engaged by Mr. Wilson to assist with managing his finances. It was Mrs. Carlson's responsibility to pay certain expenses and not others. Mrs. Carlson memorialized her payee responsibilities in an engagement letter to Mr. Wilson outlining the specific entities she was responsible for issuing payment to, the process of issuing payment, and from which funding source the payments would be made. Mr. Wilson signed the engagement letter confirming his understanding of Mrs. Carlson's role.

The signed engagement letter prevented Mr. Wilson from later disputing the (since inflated) expectations he had regarding Mrs. Carlson engagement and which payments and from which funding sources he anticipated the payments would be made.

[3] We recommend speaking with the Client, the Court and/or an Fiduciary prior to issuing an engagement letter to "all interested persons" to make sure that no privacy rights of the Client are violated.

B. Real Life Scenario "B" (The Guardian)

The Insured, Mr. Frank, was appointed as Guardian of the Person and Property of Mr. Lewis. Following his appointment, Mr. Frank drafted an engagement letter outlining a care plan for Mr. Lewis. The care plan included: the transfer of Mr. Lewis from his home to an assisted living facility, the names of entities and individuals whom Mr. Frank anticipated engaging to assist with the care of Mr. Lewis and his property, the various options available to Mr. Lewis regarding maintaining his home versus selling/renting the asset, and an inventory of current assets/incomes/and future anticipated expenses and how Mr. Frank anticipated to manage them. This engagement letter was provided to the Court and all interested family members.

The engagement letter specifically outlined a care plan for Mr. Lewis and clearly memorialized Mr. Frank's intentions for the future care of Mr. Lewis and management of his property. This document was submitted to the Court and forwarded to interested family members, so that they knew the plan of action prior to commencement. This prevented future claims alleging mismanagement of resources and not acting in Mr. Lewis' best interests. All interested family members were given an opportunity to contact Mr. Frank and discuss their concerns prior to commencement of the care plan.

C. Real Life Scenario "C" (The Trustee)

The Insured, James Smith, was appointed to act as temporary trustee of the Mr. Davis & Mrs. Jones Trust pending resolution of a trust dispute between Mrs. Jones and Mr. Davis Jr. (Mr. Davis' son from a prior marriage). Mrs. Jones filed a petition alleging that the Insured breached his fiduciary duties by "colluding" with Mr. Davis Jr. and Mr. Davis Jr.'s attorney in order to pressure Mrs. Jones to settle the trust dispute with Mr. Davis Jr. Mrs. Jones requested that the Court remove the Insured as temporary trustee, reinstate Mrs. Jones as trustee, and compel the Insured to redress breach of trust by payment of money damages, surcharge, attorney fees and costs. The Insured had strong defenses demonstrating that he did not breach his fiduciary duties, had taken no action that would warrant his removal, and that there was no justification for any surcharge of the temporary trustee. Nonetheless, while it appeared that the claims against the Assured were frivolous and lacked factual support, given the complicated "factual issues" a jury would need to resolve, it was a realistic threat that the Insured could have been held liable to the trust.

The Insured began his appointment as temporary trustee of the Trust in the midst of a trust dispute amongst family members. This should have been his first warning sign. Had the Insured drafted an engagement letter setting forth the exact scope of his representation and the work he planned on performing on behalf of the Trust in

anticipation of performing the services, this would have helped prevent Mrs. Jones from later asserting a claim for breach of services. The Insured should have obtained all interested parties signatures on the engagement letter, to confirm their understanding of his role and responsibilities.

D. Real Life Scenario "D" (The Bill Payer)

The Insured, Mr. Freed, was engaged by Mrs. Wilson to assist with the payment of her bills. Mr. Wilson was responsible for funding the account out of which the Insured was requested to make payments from. Although Mr. Freed was not responsible for transferring money into the account, this understanding was verbal (not reduced to writing). One day, Mr. Freed received an invoice for the payment of Mrs. Wilson's property insurance; however he was unable to pay the invoice because of lack of funds in the account. As a result the property insurance policy lapsed and thereafter significant flooding and water damage occurred. The property damage claim was denied as the property insurance policy had lapsed. Mrs. Wilson filed a claim for negligence against Mr. Freed.

The Insured could have prevented this claim by memorializing his obligations for the payment of Mrs. Wilson's bills in an engagement letter to Mrs. Wilson in which he specifically set forth what he was not responsible for – i.e. funding the account. By failing to do so, Mr. Freed opened himself up to being sued for the subsequent lapse in the property insurance policy and the damages that resulted because of his purported negligence. It is now "word against word" as to what the agreement actually was.

3. During The Course of Representation - Key Decisions

As can be seen from the above, effective communication as well as memorializing and maintaining proper documentation of communications with the Person and/or their family is an important tool in risk management. **It is also crucial that a Fiduciary obtain Court approval for and/or memorialize key decisions wherever necessary or possible during the course of representation to further eliminate the possibility of a dispute.**

There are no easy or objective tests to define a "big" decision, but you usually have a sense of what they are. They are usually situations where you are making a complicated or life altering decision on behalf of the Client. Examples include:

i. relocation of a client from a home to a care facility;
ii. end of life decisions;
iii. the sale of an asset;
iv. the rental of an asset;

v. the commencement or decision not to commence litigation on behalf of the client;
vi. the placement of pets/livestock;
vii. the engagement of in-home staff on behalf of the client;
viii. the hiring of third parties to assist with every-day activities;
ix. the decision of where to allocate resources/funds;
x. decisions regarding visitation of family members and friends; and
xi. any other significant, difficult, or "judgment call" decision.

In these instances, particularly ones which involve judgment calls, it is important to memorialize in writing the available options and the basis for the final decision. A short letter will often suffice.

Where possible and appropriate you should: (a) identify the problem or issue; (b) outline the various options for resolving the problem; (c) specify various efforts made to effectuate the aforementioned options; consider (d) contacting the various interested parties to advise them of the problem, possible solutions, and your efforts to effectuate a resolution which is in the best interests of the Client; and very importantly; (e) if applicable, seek Court approval prior to making a decision, particularly if you believe there are conflicting interests that you simply cannot resolve. Thereafter you should (f) document the final decision in a correspondence to the Client and/or interested persons.

Again, see the sample risk management "check list" located at: https://dominion-insurance.com/items/index/265. Please email any suggestions to ajones@fkblaw.com and/or larry.hilton@dominioninsurance.com. If you are a Dominion Insurance Services Insured, please also feel free to contact the Lloyd's of London Fiduciary Risk Management Hotline directly (24/7) on: (212) 376-8599.

4. Proper Withdrawal/Disengagement (sample letter provided)

Written confirmation of the termination of the Fiduciary relationship with a client once the services in connection with the particular matter are complete is not only good for the client relationship, it is an essential risk management tool.

Before you disengage, however, please seek advice – preferably from your lawyer and/or a risk management professional, including via the Lloyd's of London Fiduciary Risk Management Hotline: (212) 376-8599. We have seen many instances of Fiduciaries "rushing to be disengaged." At the first sign of trouble, some fiduciaries have an instinct (perhaps natural) to simply want to "get out of there". It is not always the best strategic move, however. Often it is a very bad one. Once you are "off the case," you lose certain benefits your prior position entitled you to. You also often lose a degree of leverage in being able to ensure you are treated fairly and properly as you exit the assignment. For example, one of the commonly sought

"reliefs" filed in a trustee or guardianship matter is the removal of the fiduciary. So by voluntarily providing that very relief – particularly, for example, prior to getting paid your final fee or having the Court or client "sign off" on the good work you have done - you are effectively giving the claimant what they are after (taking a "bargaining chip" off the table) in many occasions allowing the claimant to focus on other relief– like recovery from you, your carrier, or repayment of you bills (the latter of which is almost always not covered by insurance).

With that said, there are many instances where voluntary disengagement is entirely appropriate. In those instances, setting forth the terms of withdrawal/disengagement is an important way to help prevent claims/lawsuits and help your outgoing clients. Listing all tasks which will be performed during disengagement, the status of the person/inventory of the estate at the time of disengagement, and providing a list of tasks that remain outstanding are a few examples of items which can be discussed during withdrawal. This not only helps provide clarity as to what needs to be done moving forward, from a pure risk management perspective, it also helps to evidence when your professional relationship ended. This could be useful later, for example, in: (1) demonstrating that events occurred "on someone else's watch"; and (2) starting the applicable statute of limitations period running for claims against you and preventing the "continuous representation doctrine" from keeping you and your practice "on the hook" for any future problems.

Similarly to engagement letter, we recommend that Fiduciaries provide all interested persons with copies of disengagement letters and offer all interested persons sufficient time to contact the Fiduciary regarding any objections they may have to the Fiduciary's accounting or final settlement of the matter. It is important to do this prior to resignation, as this affords the Fiduciary the opportunity to mitigate the potential damages thereby preventing Claims from being asserted.

II. Insurance Coverage – How does it Work?

1. Introduction

Navigating the terms of your professional liability coverage can be complicated. There are different types of policies, each with their individual reporting requirements. The following explanation of the various policy types ("Claims-made" vs "occurrence") and the reporting requirements associated with them, along with other important policy terms should help you navigate the potentially tricky – but very important - topic of insurance coverage.

Fiduciary professional liability insurance is "specialty insurance" that commonly covers "errors and omissions" committed by a Fiduciary. Generally, the policy is obtained in an effort to protect a Fiduciary against claims filed by third parties arising from the fiduciary's "professional services." The resulting Fiduciary professional liability policy ("FPL policy") is

generally issued by the insurer following the submission of an application by the potential Insured wherein the potential Insured is required to answer various questions truthfully, as the application is the primary tool used by the insurer in determining whether to afford Fiduciary professional liability coverage to the potential Insured.

If the insurer decides to provide coverage to the fiduciary (generally then referred to as the "Insured"), coverage is usually afforded on a "claims-made" or "claims made and reported" basis, meaning that the claim must be made (and often, reported) during the policy period (typically one year). Although the language may vary, a "claim" is generally defined as a demand received by the Insured for money or services, including the service of a lawsuit.

Most FPL policies provide coverage for claims arising out of negligent acts, errors or omissions committed by the Insured in the course of rendering "professional services." "Professional services" is defined and generally includes activities performed for others as a fiduciary, guardian, executor or estate administrator, bankruptcy administrator, representative payee, received, agent or attorney in fact, trustee, Daily Money Manager, or Care Manager, bookkeeper. Clearly, most work performed by a fiduciary for a client arising out of a fiduciary-client relationship is deemed "professional services."

However, it should be noted that Fiduciary generally does not mean an Insured's capacity, nor activities as a lawyer, accountant, property manager, nurse or other health care provider, securities broker, mortgage banker, mortgage broker, independent third party escrow agent, real estate and/or construction advisor, real estate and/or property appraiser, real estate and/or property developer, insurance agent or insurance broker, or activities involving property syndication, real estate investment trusts, limited partnerships or similar investments.

Additionally, activities encountered in the "Ordinary Course of Business" are not reimbursable. In other words, the usual, routine or customary services, practices and procedures of an Assured in rendering Professional Services, including but not limited to the production of, revision or supplement to an accounting, financial statement, invoice or other similar report or document will generally not be covered by insurance.

Most FPL policies also specifically ***exclude*** known claims or circumstances that could lead to a claim, fraudulent, criminal or deliberately wrongful acts or omissions, interoffice claims (Insured vs. Insured), claims for reimbursement of professional fees, as well as property damage or bodily injury claims.

The determination of whether a particular claim arises from covered "professional services" under an FPL policy depends upon an analysis of the alleged negligent act, error or omission and whether such conduct constitutes "professional services" pursuant to a plain reading of the policy. The FPL policy is a contractual agreement, generally interpreted as a

matter of law by a court.[4] Where an insurance contract is complete, clear and unambiguous on its face, it must be enforced according to the plain meaning of its terms, and extrinsic evidence of the parties' intent may not be considered.[5] Accordingly, the language in most FPL policies is intentionally drafted to be as unambiguous as possible.

Many insured fiduciaries are often unconcerned with the terms of their FPL policies until there is a "problem." The average Insured is usually aware only that he or she is insured, but is unable to state even the basic terms of the policy without first reviewing it. At the very least, the Insured should be aware of two very important policy terms that could significantly impact the availability of professional liability coverage in the event of a "problem": (1) the Insured's knowledge of a claim prior to the inception of his or her subject policy; and (2) notification by the Insured to the insurer of a claim or potential claim during the lifetime of the policy.

2. "Claims-Made Coverage" – How Does It Work Again?

Almost all fiduciary professional liability policies are "claims made" policies. There are other types of policies called "occurrence policies," more typically in the general liability context – *i.e.* bodily injury and property damage, but these are very rare in the fiduciary professional liability world, so we will not discuss them further here (please contact a presenter to discuss them further).

In the claims made context, the insurance policy will typically say (in the first paragraph or so) that it provides coverage for a "Claim" (a defined term) first made during the policy period - and, in most instances, *reported* during the policy period too. So it is the making of a "Claim" that "triggers" the coverage available under the policy.

Many policies define Claim as "a demand received for money or services." Some people do not realize that a Claim therefore does not have to be a lawsuit. A letter or email from a client accusing you of making a mistake and seeking to hold you responsible can be deemed a Claim. Even a verbal demand can qualify.

3. What is a "Claim"? What is a "Circumstance that may lead to a Claim"?

Many fiduciaries have difficulty knowing if and when they should give their carrier notice of various "happenings" in their day-to-day professional lives. Most fiduciaries know

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[4] Parks Real Estate Purchasing Group v. St. Paul Fire and Marine Ins. Co., 472 F.3d 33, 42 (2d Cir. 2006).

[5] NFL Enterprises LLC v. Comcast Cable Comm., LLC, 851 N.Y.S.2d 551, 554 (1st Dept. 2008); Graev v. Graev, 46 A.D.3d 445, 450-1, 848 N.Y.S.2d 627 (1st Dept. 2007) (whether contractual term is ambiguous is determined by looking within four corners of document, and not to extrinsic sources).

that a lawsuit naming them is something that they should give immediate notice of. However, a client or a Court expressing "disappointment" and/or demanding that certain actions be taken can be less-obvious examples of matters that potentially should also be notified to an Insured's carrier.

A. What Constitutes a "Claim"?

Liability policies typically require that an Insured notify its insurance carrier "immediately" of any "claim." It is therefore important for fiduciaries to know or be able to determine when a "claim" is being made. Generally, an Insured can turn to his or her policy for guidance, since most claims-made policies provide a definition of claim (usually along the lines of, "a claim is any demand for monetary or non-monetary relief."). If this does not help, or if the policy does not contain a definition, there are some guidelines fiduciaries can use to assist. However, as will be seen, if ever in doubt fiduciaries should always promptly seek guidance.

Two overlapping criteria that tend to demonstrate that a claim exists are: (1) an assertion of legally cognizable damage; and (2) a demand for compensation or redress, which does *not* necessarily need to be monetary. It has been held in some Courts that a "claim" must relate to "an assertion of a legally cognizable damage, and had to be the type of demand that could be defended, settled and paid by the insurer."[6] A patient's complaint to her physician simply that she was "not happy" with the outcome of her surgery was held not to constitute a claim when there was no demand for compensation.[7] An adjusting company's client's letter speaking of "dissatisfaction" with the company's recent performance was held not to constitute a claim, since the letter did not contain any mention of damages or a demand for compensation. The *threat* of future litigation also typically does not constitute a claim. Rather, the threat of litigation is merely notice of a potential claim. In all of the above examples, however, you may be required to give prompt notice of "Circumstance". See discussion *infra*.

Conversely, the law generally does not require that a formal lawsuit be filed for a claim to exist[8] (Courts have interpreted claims to require more than a request for an explanation or the lodging of a grievance without a demand for compensation, but less than the institution of a formal lawsuit).[9] Thus, where a letter charged an Insured with fraudulent misconduct and breach of fiduciary duty in connection with flipping real estate and advised that a lawsuit would be filed *if the Insured did not comply with a request to compensate the complaining company within ten days*, a Court held that this letter did constitute a claim, as it demanded compensation (and also because it included a draft copy of a complaint demanding damages).[10]

[6] See Evanston Insurance Company v. GAB Business Services, Inc., 132 A.D.2d 180, 521 N.Y.S.2d 692 (1987).
[7] See Hill v. Physicians & Surgeons Exchange of California, 225 Cal. App.3d. 1, 274 Cal.Rptr. 702 (Ct. App. 1990).
[8] See Strauss v. Sheffield Insurance Corp., 2006 WL 6158771 (S.D. Cal).
[9] See Charles Dunn Company, Inc. v. Tudor Insurance Company, 308 Fed. Appx. 149 (2008).
[10] See id.

Where clients demand (or Courts Order) uncompensated work by an Insured, that too may be a "claim" as defined, since it has been held that a "claim" is simply a demand for something of right, or as due.[11]

B. What Constitutes a "Circumstance"?

"Circumstance" is another important term that fiduciaries should be familiar with. Most claims-made policies will require fiduciaries to provide notice of "potential claims" or "circumstances that may lead to a claim" and will typically make providing such notice a condition precedent to receiving coverage. "Circumstances" can be more difficult to discern than "claims." The standards for reporting circumstances vary among policies and predicting potential future activity can be difficult.

Courts have utilized varying "objective-subjective approaches" to determining whether fiduciaries have provided appropriate notice of potential claims. Courts typically seek to understand what a reasonable Insured would have foreseen in like circumstances given the insured's knowledge at the time.[12] Whether someone in the same position as the Insured would reasonably have believed that the circumstance would not amount to a "claim" and therefore did not need to be reported is typically a fact-sensitive inquiry.[13] However, fiduciaries should attempt to avoid such factual inquiries, particularly considering the potential adverse consequences (potentially the complete denial of coverage) associated with a finding of 'late notice' or 'prior knowledge' (the latter being the failure to provide adequate notice of a circumstance in a policy application). This can be done: (1) by erring on the side of caution; and (2) seeking assistance whenever an Insured is uncertain.

In sum, there is no one-size-fits-all answer to the question, "What constitutes a claim or a circumstance?" The Courts have provided some guidelines for situations in which the answer to the question seems uncertain. It is paramount that fiduciaries read and understand the notification provisions of their policies and appreciate when they should report certain matters. In the event of any uncertainty as to whether a particular matter, happening, development, concern, etc, should be reported, fiduciaries would be well advised to seek immediate guidance from their insurance broker or another trusted insurance professional.

4. What is a Policy "Retroactive Date"?

It is an important (material) term of your insurance policy that governs how far back in time you are protected. As noted, most FPL policies provide coverage for claims arising out of negligent acts, errors or omissions committed by the Insured in the course of rendering

[11] See id.
[12] See Chicago Insurance Company v. Lappin, 58 Mass. App.Ct. 769, 792 N.E.2d. 1018 (2003).
[13] See James F. O'Connell & Associates v. Transamerica Indem. Co., 61 Wash. App. 103.

"professional services." However, the coverage under the policy must arise from "professional services" rendered either during the policy period or *subsequent to a specified "retroactive" date.* In other words, if your retroactive date was "January 1, 2012" and a claim was made during the policy period alleging liability *arising out of your conduct performed say solely in 2011,* you would not be covered. Indeed, under that example, any activities performed before the January 1, 2012 retroactive date would not be covered.

5. Can I Obtain Coverage for "Prior Acts"?

Yes. This is offered by many carriers to protect fiduciaries who had a claims-made policy with a different carrier immediately prior to the current policy and who did not want to buy an Extended Reporting Period Endorsement when the old policy ended.

Prior Acts Coverage protects against claims arising out of activities that took place *before* the inception date of a new policy, but which result in claims during the policy. Let's say you purchased a claims-made policy from Company A, with an effective date of January 1, 2011. At the end of 2011, you move your coverage to Company B but you get Prior Acts coverage going back to you original January 2011 Retroactive Date. You are then sued in March 2012 (so the Claim is made in 2012) but arising out of alleged negligent work you did in 2011. You would be covered under the new policy, so long as the Prior Acts endorsement was in place. The new policy would respond to the claim and apply to provide a defense/indemnity. Carriers usually charge an additional premium for this coverage but it is often well worth it. It removes the chance of having a claim come in that falls "in between" the policy years and leaves you without coverage and facing a claim on your own.

6. The Insurance Application – What do I Include?

The process of obtaining FPL coverage generally starts with the completion of an "Application for Claims Made Fiduciary Professional Liability Insurance," which is usually provided to the applicant fiduciary by his or her FPL insurance broker. The broker, in turn, forwards the application to the insurer who makes a determination of whether the proposed Insured is an economically sound "risk."

Most fiduciaries are unaware of the significance insurers place on the fiduciary's responses to the questions on the application. However, an Insured has a duty to exercise good faith and to answer questions posed by the insurer honestly. See for example New York's Insurance Law §3105. Generally included as a condition under the issued policy is the Insured's acknowledgement/representation that the statements in the application are personal representations which are being relied upon by the insurer and shall be deemed "material." With this assumption in mind, professional liability underwriters use the application to predict the potential risk associated with insuring the fiduciary. Two of many factors taken into

consideration include: (1) the fiduciary's history of prior claims; and (2) potential claims. (Usually, this information is specifically requested on the Application.[14]) Once a determination is made by the insurer to insure the fiduciary, the fiduciary generally signs the policy, pays the required premium and is considered insured for the term of the policy, generally one year.

In the event of a "material" misrepresentation on the Application, an insurer is generally entitled to rescind the policy (cancel as if it never existed). See Schirmer v. Penkert, 41 A.D.3d 688, 690, 840 N.Y.S.2d 796 (2d Dept. 2007). The misrepresentation must be "material" and renders the policy void from its inception. See N.Y. Ins. Law § 3105.

Insurance Law defines "misrepresentation" as a false "statement as to past or present fact, made to the insurer by or by the authority of, the applicant for insurance or the prospective Insured, at or before the making of the insurance contract as an inducement to the making thereof."[15] A misrepresentation may be a false affirmative statement or a failure to disclose where a duty to disclose otherwise exists. See Philadelphia Indemnity Ins. Co., 2005 WL 1660961.

Where there is evidence concerning materiality that is "clear and substantially uncontradicted," the matter is one of law within the meaning of Insurance Law §3015(b), and thus, may be determined by the Court.[16] If the insurer can establish that the policy was issued when it might otherwise not have been, it will be entitled to rescind the policy. See Schirmer v. Penkert, supra.[17] Courts have held that even an innocent misrepresentation, if material, will support rescission.[18] The insurer must submit evidence of its underwriting practices with respect to similar applicants.[19]

[14]The Application generally requires that the fiduciary affirmatively list knowledge of any circumstance, act, error or omission that would result in a professional liability claim. The fiduciary is also required to declare after diligent inquiry that the statements contained in the application are true and do not reflect any misrepresentations. The fiduciary must also acknowledge that the insurer has relied upon the facts contained in the Application to reach its determination.

[15]N.Y. Ins. Law § 3105 (a).

[16]Carpinone v. Mutual of Omaha Ins. Co., 265 A.D.2d 752, 697 N.Y.S.2d 381 (3d Dept. 1999); see also Tyras v. Mt. Vernon Fire Ins. Co., 36 A.D.3d 609, 610, 828 N.Y.S.2d 448 (2D Dept. 2007).

[17]Schirmer, 41 A.D.3d at 690.

[18]McLaughlin v. Nationwide Mut. Fire Ins. Co., 8 A.D. 3d 739, 740, 777 N.Y.S.2d 773 (3d Dept. 2004).

[19]Roudneva v. Bankers Life Ins. Co. of New York, 35 A.D.3d 580, 581, 827 N.Y.S.2d 213 (2d Dept. 2006).

III. Proper and Timely Notice and What to expect/how to proceed if a Claim Occurs

Receiving notice of a Claim or a Potential Claim can be daunting and scary at first. The following is an explanation and guide as to how the "Claims Process" typically works and provides suggestions on how to spot and timely report matters to the Carrier.

1. What To Expect/How To Proceed If A Claim Or Potential Claim Occurs

As noted in Section I above, receiving a Claim or a complaint is rarely a pleasant experience. It is stressful and can create feelings of fear, anger, resentment, wishing for retribution, confusion, alarm, uncertainty – or all of the above. Those are not good or productive circumstances for making rash decisions. You want to proceed in a way that is smart, considered, and best protects you - and your client. There are, however, a few "bright line" rules to follow, which will help lead you to calmer waters in which to make the right decisions:

A. Don't panic. You will get through this!

B. Timely report the Claim or potential claim to your insurance carrier and, if applicable, your attorney. Call and ask your carrier if you have any questions or doubts about whether you need to give notice.

C. Be responsive and a good communicator with your carrier and any appointed defense counsel; and

D. View your insurance carrier as your business partner (they are effectively that) and work with them to try to resolve any disagreements that may arise.

2. The Importance Of Proper And Timely Notice To Your Insurer

There are good reasons behind the above "bright line" rules. Most FPL policies require that the Insured provide the insurer with "immediate" notice of any claim and at least "prompt" notice of potential claims. See Bellefonte Insurance Company v. Eli D. Albert, P.C., et al, 99 A.D.2d 947, 472 N.Y.S.2d 635 (1st Dept. 1984). These requirements are usually "conditions precedent" to coverage.

Most FPL policies required that notice of a claim or potential claim be provided to the insurer "as soon as practicable"[20] after an occurrence. It was well-settled that "as soon as

[20] Various terms are utilized by insurers, including "prompt notice," "soon," "as soon as practicable."

practicable" generally equates to the provision of notice within a reasonable time under all the facts and circumstances of each case. See Heydt v. American Home Assurance, 146 A.D.2d 497, 498, 536 N.Y.S.2d 770, 772 (1st Dept.1989) *lv. dismissed* 74 N.Y.2d 651, 542 N.Y.S.2d 520, 540 N.E.2d 715. The reasoning behind the prompt notification requirement is to afford the insurer the opportunity to protect itself, *i.e.,* "to protect itself from fraud by investigating claims soon after the underlying events; to set reserves; and to take an active, early role in settlement discussions." See Brandon v. Nationwide Mutual Insurance Co., 97 N.Y.2d at 496, 743 N.Y.S.2d at 56, 769 N.E.2d 810.

An Insured's fiduciary's delay or failure to give timely notice might be excusable where the Insured had a "reasonable" belief that he or she would not be liable for the subject claim. See Paramount Insurance Co. v. Rosedale Gardens, Inc., 293 A.D.2d 235, 239, 743 N.Y.S.2d 59, 62 (1st Dept. 2002). The burden of showing the reasonableness of the excuse, however, is on the Insured fiduciary. See White v. City of New York, 81 N.Y.2d 955, 598 N.Y.S.2d 759, 615 N.E.2d 216 (1993). Questions as to whether a good-faith belief exists that an injured party will not seek to hold the Insured liable and whether the belief is "reasonable" under the circumstances are questions of fact reserved for the fact finder. See Argentina v. Otsego Mutual Fire Insurance Co., 86 N.Y.2d 748, 750, 631 N.Y.S.2d 125, 126, 655 N.E.2d 166, 167 (1995).

3. Prior Knowledge And Coverage Investigations

In view of the above, it is advisable that immediate notice be provided to one's insurer in the event of a claim or potential claim. Doing so will divest the Insured of his or her notice responsibility. It is noteworthy that the insurer will usually employ its own lawyer ("coverage counsel") to handle the claim and among other things, investigate whether the Insured possibly had undisclosed "prior knowledge" of the claim for which the fiduciary now seeks coverage. The insurer or its appointed representative will likely have a preliminary conversation with the insured fiduciary reporting the claim, ask to review the documents/pleadings involved in the claim, and review the Insured's Application to confirm whether the claim was previously disclosed, etc. It is a condition of the policy to comply with these requests. The process need not be difficult or arduous and is described further below.

A. The Coverage Investigation

The inquiry is generally conducted by coverage counsel retained by the insurer. The insurer generally advises the Insured of the pending coverage investigation and may assign defense counsel to the Insured, pending the outcome of the coverage investigation. If the investigation determines that the insured fiduciary had knowledge prior to the inception of the policy of the claim for which coverage is sought, the FPL insurer may deny coverage and would have viable coverage defenses.

There are multiple reasons why an insured fiduciary may not have previously disclosed his or her prior knowledge of the claim at issue in the insurance Application. Some of these reasons include, but are certainly not limited to:

(1) Fear that the Application may be denied;
(2) Fear of increased premiums;
(3) Embarrassment (personal or to the Firm);
(4) Personal Opinion (a belief that the claim is baseless); or
(5) State of denial.

Coverage counsel may explore any of the foregoing possibilities in an attempt to determine whether or not the insured fiduciary had prior knowledge of the claim. The investigation may include a review of the insured fiduciary's file, interviews and research into the fiduciary's background and prior insurance policies.

B. The "Reasonableness" Test

Once the coverage investigation is complete, the insurer employs a test for determining whether a policy's notice provision has been triggered, i.e., "whether the circumstances known to the Insured at that time would have suggested to a reasonable person the possibility" that a claim would be made. See Security Mut. Ins. Co. v. Acker-Fitzsimmons, Co., 31 N.Y.2d 436, 340 N.Y.S.2d 902 (1972).[21] The Insured bears the burden of proving the reasonableness of his excuse, which must be reasonable under all the circumstances. See Security Mut. at 443; Sirignano v. Chicago Ins. Co, supra.

c. The Outcome

Should the insurer determine that the insured fiduciary had prior undisclosed knowledge of the claim, coverage for that particular claim is generally denied. However, the policy generally remains in effect for its term.[22] The insurer may commence a declaratory judgment action, requesting that the court declare that the policy is not triggered in light of the Insured's prior knowledge of the claim, and on grounds of misrepresentation. If the insurer is successful, the Insured bears uninsured exposure, which, depending on the nature of the plaintiff's damages, could be devastating to the fiduciary. It is therefore extremely important that the fiduciary seeking FPL coverage disclose any prior knowledge of claims or potential claims on the insurance Application to avoid the potential loss of coverage.

[21]As set forth above, the Courts now appear to be adopting a mixed "subjective/objective" standard.
[22]This outcome may be contrasted with a scenario in which the insurer determines that the insured fiduciary affirmatively *misrepresented* certain facts on the insurance Application. In that scenario, the insurer may rescind (cancel) the insurance policy that was issued in reliance upon material representations. See Chicago Insurance Co. v. Kreitzer & Vogelman, No. 97 Civ. 8619 (RWS), 2000 WL 16949, at *15 (S.D.N.Y. Jan. 5, 2000).

4. Extended Reporting Periods/Retirement

Lastly, and this seemed an appropriate topic to end on, we stop to briefly address Extended Reporting Periods ("ERPs") and Retirement. As noted above, Claims made policies cover claims that are made (or circumstances that are noticed) *during the policy period*. So what happens when the policy ends? Firstly, many policies may have a built in (automatic) extended reporting period – in which for something like, 30, 60, or 90 days after the policy expires an Insured can still report a claim and be covered.

After that, you will need to purchase ERP (or "tail") coverage for Claims arising from work performed *up to* retirement or the end of the policy, but that may not be filed for months or years afterwards. ERP or tail coverage basically says something like, we are not coving you for any more activities, but if a claim comes in during the next say 5-6 years that arises out of acts or omissions that took place previously - during the period of time our policy covered - we will cover that.

As I say to many professional fiduciaries: retirement means the end of practice, not the end of risk. What you did today could take years to filter through and make its way into a lawsuit against you. Make sure you cover your tail.

Conclusion

I hope that the above was useful. There are many topics of discussion presented by a paper under the broad umbrella of "Risk Management and Insurance," so the above necessarily touched on just some of the more prominent ones.

You should be focused on doing your work, not worrying about getting sued. By employing some of the above strategies, over time they will become second nature. You can then practice safe in the knowledge that you are protected, which in turn allows you to focus on your work and your clients/wards/persons.

Risk management also involves observing some very basic (but often overlooked) human needs. Figure out how much sleep you need, and get it. Figure out how much time away from work you need, and get that. Figure out how much alone time you need, and get that. Etc. There are whole books written on the topic of self care. For present purposes I will just note that these are very important considerations in risk management, too.

Again, for more information about the above topics, please visit: www.fkblaw.com, www.dominioninsurance.com, www.css-lawfirm.com, or www.pfac-pro.org. And if you are eligible and it is appropriate, please contact the Fiduciary Risk Management Hotline on: (212) 376-8599.