Before it is possible to investigate insurance fraud, it is necessary to understand insurance. This chapter deals with the type of insurance owned by almost everyone—homeowners’ insurance, tenants’ insurance, fire insurance, business property insurance, inland marine policies, and the like.

Contrary to the belief of those insured, property insurance does not insure property. As a risk-spreading device, property insurance insures people, partnerships, or corporations only against specified risks of loss of property described in the policy.

Insurance against the loss of property is a contract of personal indemnity. It insures the person(s) named in the policy—or those who qualify as an insured by definition—against certain specified risks of loss to property in which the person or persons insured have an interest. A person who has an interest in the property but is not named as an insured cannot recover under the policy unless the policy is changed. Similarly, a person named on a policy who has no interest cannot ever recover.

As the California Supreme Court observed in Garvey v. State Farm Fire and Casualty Co.,¹ a first-party insurance policy provides coverage for loss or damage sustained directly by the insured.

A third-party liability policy, on the other hand, provides coverage for liability of the insured to a third party (e.g., a commercial general liability (CGL), a directors’ and officers’ (D & O) liability, or an errors and omissions (E & O) policy).

The term “perils” in traditional property insurance language refers to fortuitous, active physical forces such as lightning, wind, and explosion, which bring about or cause the loss.

The cause of loss in the context of a property insurance contract is totally different from that in a liability policy. On the contrary, the right to indemnity in the third-party

liability insurance context draws on traditional tort concepts of fault, proximate cause, and duty. The liability coverage analysis differs substantially from the coverage analysis in the property insurance context. Analysis of property insurance draws on the relationship between perils that are either covered or excluded by the contract of insurance. In liability insurance, by insuring for personal liability and agreeing to cover the insured for his negligence, the insurer agrees to cover the insured for a broader spectrum of risks than those insured by a property policy.

In *Russell v. Williams*, the fact that insurance is a contract of personal indemnity was made clear. The issue raised was whether a surviving joint tenant may recover from the estate of a deceased joint tenant the proceeds of a fire insurance policy covering improvements on their joint-tenancy property. In this case, the ex-spouse of the decedent claimed that the moneys paid by the insurance company under the policy constituted proceeds of the property that was destroyed and retains the character of that property. It is a principle of long standing that a fire insurance policy does not insure the property, but is a personal contract indemnifying the insured against loss resulting from the destruction of or damage to his interest in that property. Since she was not an insured, and since the policy was personal to the deceased, his estate received the insurance proceeds and his ex-spouse received the real property.

That insurance is a contract of personal indemnity and does not insure property seems universal. For example, in *Smith v. Jim Dandy Markets*, the Ninth Circuit found that:

> regardless of Smith’s interest in the building, he suffered no loss from its destruction. Under California law, which the federal court was required to follow, a fire insurance policy is a personal indemnity contract and a showing of pecuniary damage is prerequisite to recovery.


Consider also the Fifth Circuit Court of Appeal decision in *Lighting Fixture Supply Co. v. Fidelity Union Fire Ins. Co.*, which found that the betterments and improvements insured were movables so long as the appellant retained any interest in them.

3. 172 F.2d 616 (1949).
4. 111 Cal. 409, 415, 43 P. 1115.
6. 55 F.2d 110 (5th Cir. Jan. 1, 1932).
INSURABLE INTEREST

In Carolyn E. Schubert, Personal Representative of the Estate of Thomas v. Auto Owners Insurance Company, Auto Owners Insurance Company (Auto Owners) appealed the order granting summary judgment in favor of Carolyn Schubert and awarding her $124,500, the face value of the insurance policy sold to her by Auto Owners. Because Schubert owned a one-half interest in the dwelling covered by the policy, which was completely destroyed by fire, Auto Owners offered to pay her half the policy value, citing a provision within the policy that limited recovery to “[no] more than the insurable interest the insured has in the covered property at the time of loss.” The district court declared this provision void as contrary to the public policy expressed in the Missouri policy statute. It also found the policy’s language sufficiently ambiguous to allow Schubert to recover the face value of the insurance policy.

Before the insured can gain the benefit of the valued policy statute, he must have “an insurable interest in property both at the time of making the contract and at the time of loss”—a requirement intended to prevent wagering. Satisfying this requirement is, however, easy because “insurable interest” is defined broadly. In general, a person has an insurable interest if he has such a relation or concern in the 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 event insured against. G.M. Battery & Boat Co. v. L.K.N. Corp.

“Under Missouri law, the lack of title is immaterial to determining whether a party has an insurable interest.” Beckon, Inc. v. AMCO Ins. Co. Insurable interest may be “entirely disconnected from any title, lien, or possession.” Am. Cent. Ins. Co. v. Kirby. For example, insurable interest was established by a lessee with an option to buy the leased property who had a contractual obligation to insure it, G.M. Battery & Boat Co., a mortgagor who remained liable for the indebtedness on the property even though she held a legal title to the property in trust for someone else had an insurable interest.

When investigating what may be a fraud, it is always useful to determine who has an insurable interest in the property that is the subject of the claim. Every experienced fraud investigator recognizes that insurance criminals are not necessarily knowledgeable about insurance and may purchase a policy without first establishing an insurable interest. Proving no insurable interest to a jury is easier than convincing a jury that an insured has committed fraud.

8. 649 F.3d 817 (8th Cir. Aug. 12, 2011).
9. 747 S.W.2d 624, 626 (Mo. 1988).
10. 616 F.3d 812, 818 (8th Cir. 2010).
11. 294 S.W.2d 556, 561 (Mo. Ct. App. 1956).
12. 747 S.W.2d at 627–28.
CONSTRUCTION OF INSURANCE CONTRACTS

To adequately investigate a potentially fraudulent claim, it is imperative that all involved know how insurance policies are read, understood, and interpreted by the courts. The insurance fraud investigator, the claims representative faced with a potentially fraudulent claim, and the insurer’s lawyer who does not understand the interpretation of insurance policies will face unnecessary difficulties and may allow a fraud to succeed.

The first thing every person representing an insurer with regard to a potential fraudulent claim must understand is that the insurance policy is the basis for every insurance fraud investigation. Without an insurance policy, there can be no insurance fraud. The insurance policy contract describes the rights and obligations of the parties to the policy of insurance. It contains, in clear and unambiguous language, weapons to defeat a fraudulent claim.

The construction of insurance contracts should be, but often is not, governed by the same rules of construction applicable to all contracts. The courts claim that when they construe an insurance contract, it gives the terms of the policy their ordinary and generally accepted meaning. The primary goal of the court is to give effect to the written expression of the intent of the parties to the insurance policy.

Following are some rules that must be followed when construing or interpreting an insurance contract:

1. If the terms of the policy are in any respect ambiguous or uncertain, it must be interpreted in the sense in which the promisor (the insurer) believed, at the time of making it, that the promisee (the insured) understood it.
2. If the language of a policy or contract is subject to two or more reasonable interpretations, it is probably ambiguous.
3. Where an ambiguity involves an exclusionary provision of an insurance policy, courts adopt the construction urged by the insured as long as the construction is not unreasonable, even if the construction urged by the insurer appears to be more reasonable or a more accurate reflection of the intent of the insured and insurer.
4. In reaching the conclusion that a policy exclusion was ambiguous, and the policy therefore provided coverage, the courts should follow the settled rule that any ambiguity or uncertainty in an insurance policy is to be resolved against the insurer and that, if semantically permissible, the contract will be given such construction as will fairly achieve its object of providing indemnity for the loss to which the insurance relates.13
5. It is a maxim of law that a contract should be construed against its drafter. The maxim is sometimes referred to as the contra preferendum rule.

6. Provisions excluding coverage are strictly construed against the insurer.
7. Ambiguities in insurance applications will usually be construed against the insurer to avoid denial of coverage because of alleged misrepresentations.
8. Where the language of a contract is clear and unambiguous, it must be interpreted solely by reference to the four corners of that document.
9. When a policy is interpreted, the provisions of an endorsement control the interpretation over the body or declarations of a policy when the two are in conflict.

The basic rules of construction or interpretation of an insurance contract are all subject to the limitation that a court cannot and should not do violence to the plain terms of a contract by artificially creating ambiguity where none exists. In situations in which reasonable interpretation favors the insurer, and any other would be strained and tenuous, no compulsion exists to torture or twist the language of the contract. An insurance company has the right to limit the coverage of a policy issued by it, and when it has done so, the plain language of the limitation must be respected.

Basically, the construction of an insurance contract should always be controlled by the statement that “the courts will not indulge in a forced construction of an insurance policy so as to fasten a liability on the insurance company which it has not assumed.” 14 This is a rule often honored in the breach rather than in the following, so, as you read about the cases below, determine if any of the courts indulged in a forced construction of the policy wording to provide coverage other than what was said in the policy.

Interpretation of an insurance contract is a question of law, fully reviewable on appeal. Regardless of the fact that the question posed is one of law, as you read about the next case, determine if there was any attempt by the court to apply equitable principles.

In Trade Center Properties, L.L.C. v. Hartford Fire Insurance Company, 15 an insurance dispute arose out of the unprovoked attack on the United States by terrorists. Consider how the court went about interpreting an insurance contract that had not, prior to the attack, been issued in concrete written form. Remember that the decision of the court involves a dispute over $3.5 billion and has nothing to do with responsibility for the terrorist attack.

The broad question presented was whether the events of September 11, 2001, constituted one or two “occurrences.” The answer will determine whether the Silverstein parties can recover once, up to $3.5 billion, or twice, up to $7 billion, under the insurance coverage. Because the policies had not been issued at the time of the attack, the court was faced with interpreting the terms of a “binder,” or evidence of insurance, whose terms were not announced in full.

15. 345 F.3d 154 (2d Cir. Sept. 26, 2003).
In deciding which terms are to be implied in a binder, reliance may be placed on the extrinsic evidence of the parties’ pre-binder negotiations. The WilProp form, which was the basis of the negotiations for the insurance, provided:

“Occurrence” shall mean all losses or damages that are attributable directly or indirectly to one cause or to one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one occurrence irrespective of the period of time or area over which such losses occur.

Although the Silverstein parties attempted to argue that this definition is ambiguous, the appellate court agreed with the district court that no finder of fact could reasonably fail to find that the intentional crashes into the World Trade Center of two hijacked airplanes 16 minutes apart as a result of a single, coordinated plan of attack was, at the least, a “series of similar causes.” Accordingly, the events of September 11 constituted a single occurrence as a matter of law.

The California Supreme Court, faced with what appeared to be a clear and unambiguous policy exclusion, proved, in MacKinnon v. Truck Insurance Exchange,16 that interpretation of insurance policies requires common sense as well as legal precedent. It concluded that for an exclusionary clause to effectively exclude coverage, it “‘must be conspicuous, plain and clear,’”17 and that a pollution exclusion in question does not plainly and clearly exclude ordinary acts of negligence involving toxic chemicals such as pesticides.

To understand the meaning of the pollution exclusion, the court first referred to the historical background of pollution and insurance. The events leading up to the insurance industry’s adoption of the pollution exclusion are well documented and relatively uncontroversial. Prior to 1966, the standard-form Commercial General Liability (CGL) policy provided coverage for bodily injury or property damage caused by an “accident.” The term “accident” was not defined in the policy. As a result, courts throughout the country were called upon to define the term, which they often interpreted to encompass pollution-related injuries. In response, the insurance industry revised the CGL policy in 1966 and changed the former “accident”-based policy to an “occurrence”-based policy.

Courts have noted that the revised pollution exclusion deleted the “sudden and accidental” exception, because some decisions had misapplied this exception or construed it in a manner contrary to insurers’ original intent. To ascertain the scope of an exclusion, the court must first consider the coverage language of the policy. MacKinnon’s CGL policy obligated the insurer to pay “all sums for which [the insured] become[s] legally obligated to pay as damages caused by bodily injury, property damage or personal injury. Coverage

will therefore be found unless the pollution exclusion conspicuously, plainly and clearly apprises the insured that certain acts of ordinary negligence, such as the spraying of pesticides in this case, will not be covered.”

Because Truck Insurance’s broad interpretation of the pollution exclusion leads to absurd results and ignores the familiar connotations of the words used in the exclusion, the court did not believe that the ordinary layperson would adopt it. What, then, is the plain meaning of the pollution exclusion? The key to this inquiry turns on the meaning of the term “pollutant.” Because the definitional phrase “any irritant or contaminant” is too broad to meaningfully define “pollutant,” the court turned to the common connotative meaning of that term. Limiting the scope of the pollution exclusion to injuries arising from events commonly thought of as pollution, i.e., environmental pollution, also appears to be consistent with the choice of terms “discharge, dispersal, release or escape.” Moreover, as discussed above, there appears to be little dispute that the pollution exclusion was adopted to address the enormous potential liability resulting from antipollution laws enacted between 1966 and 1980. Therefore, the limited dispersal of a pollutant to a single structure was not sufficient to bring the exclusion into effect.

The California Supreme Court thus unanimously concluded that a policy must be interpreted based on the reasonable expectations of the insured and the insurer. In so doing, the court concluded that the pollution exclusion of the CGL policy “does not plainly and clearly exclude ordinary acts of negligence involving toxic chemicals such as pesticides.” Insurers doing business in California (and across the country) should, as a result, reevaluate denials of claims based on the pollution exclusion where the pollution event is limited to a single event, or change the wording of their policy.

The California Supreme Court’s analysis of other terms in the policy found an interpretation limiting the exclusion to environmental pollution to be reasonable in light of the purpose of CGL policies. That purpose is to provide the insured with the broadest spectrum of protection against liability for unintentional and unexpected personal injury or property damage arising out of the conduct of the insured’s business.

When investigating a potential fraudulent claim, it is imperative that the insurer determine the reasonable expectations of the insured by interviewing the insured, the insurance agent, the insurance broker, and the underwriter who made the decision to accept the risk presented by the insured at the time of the application for insurance. The facts gathered will be imperative to determining the intent of both insured and insurer when the policy was acquired.

Sometimes courts fail to follow the rules of interpretation and try to apply equitable principles to a strictly legal question. Justice Kennard, in a vigorous dissent to such a case, E.M.M.I., Inc. v. Zurich American Insurance Company,¹⁸ argued that the California

Supreme Court erred. Her discussion is important to properly understand the appropriate function of the rules of construction. Read Justice Kennard’s dissent and consider the appropriate use of the rules of construction and whether a person can be “in or upon a vehicle” when he is six feet away from it.

The applicable law is well established and clear. The ordinary rules of contract interpretation apply to the construction of an insurance policy.\(^{19}\) Judicial interpretation is controlled by words, as they are understood in their ordinary and popular sense.\(^{20}\) The function of the court in interpreting an instrument is simply to ascertain and declare what is in its terms or in substance contained therein, not to insert what has been omitted, or to omit what has been inserted.

**CLEAR INSURANCE POLICY LANGUAGE MUST BE APPLIED**

An insurer sought a declaratory judgment that it was required to indemnify its insured for no more than 40% of a state court judgment because it had covered its insured for only 40% of the time during which the plaintiff was exposed to lead poisoning. The district court agreed that the insurer was responsible for only a portion of the judgment, notwithstanding the fact that its insured was held jointly and severally liable for the entire judgment in the underlying state proceeding. The state plaintiff (and defendant in the federal declaratory action) appealed. The Fourth Circuit Court of Appeal was called upon to determine, in *Pennsylvania National Mutual v. Lakia C. Roberts*,\(^{21}\) whether an insurance company can be held liable for periods of risk it never contracted to cover.

**Facts**

From her birth on January 17, 1991, until 1998, Lakia Roberts resided at 1740 East Preston Street in Baltimore, Maryland. In September 1992, when she was 20 months old, Roberts was diagnosed with lead poisoning. A test indicated that she had an elevated blood-lead level of 28 micrograms of lead per deciliter (mcg/dL). She continued to exhibit elevated blood-lead levels until August 1995.

On February 4, 2005, Roberts filed a complaint in Maryland state court against Attsgood Realty Company, alleging that the injuries she sustained from the lead poisoning were the result of its negligent management of the East Preston Street property. Attsgood had owned, leased, and managed the property from Roberts’s birth until November 1, 1993, when it had sold the property to Gordon Gondrezick.


\(^{21}\) 668 F.3d 106 (4th Cir. Feb. 3, 2012).
Attsgood then requested defense and indemnification from Pennsylvania National Mutual Casualty Insurance Company (Penn National) under the terms of its insurance contract. In 1992, Penn National had issued a liability insurance policy to Attsgood covering the period from January 13, 1992, to January 13, 1993. The policy was later renewed to extend coverage to January 13, 1994. According to the terms of the contract, Penn National promised Attsgood that it would provide liability insurance for “Premises You Own, Rent or Occupy,” including 1740 East Preston Street.

From Roberts’s birth in January 1991 until the coverage began in January 1992, Attsgood lacked liability insurance for the East Preston Street property. Under the contract, Penn National promised to “pay those sums that [Attsgood] becomes legally obligated to pay as damages because of ‘bodily injury’ or ‘property damage’ to which this insurance applies,” as well as “defend any ‘suit’ seeking those damages.” This guarantee was in turn qualified by a provision stating that “this insurance applies to ‘bodily injury’ and ‘property damage’ only if . . . the ‘bodily injury’ or ‘property damage’ occurs during the policy period.”

The contract also made clear that Attsgood’s “rights and duties under this policy may not be transferred without [Penn National’s] written consent except in the case of death of an individual [n]amed [i]nsured.” In accordance with the policy, Penn National agreed to defend Attsgood subject to a reservation of its rights. Attsgood then filed a third-party complaint against Gondrezick seeking contribution and indemnification in the event that Roberts prevailed. After Gondrezick failed to appear or otherwise defend himself, the Maryland court entered an order of default against him in favor of Attsgood.

Following discovery, the state case went to trial on May 4, 2009, on counts of negligence and unfair trade practices. To prove the property owners’ liability, Roberts’s mother and her expert witness provided testimony indicating that Roberts had been exposed to lead poisoning at the East Preston Street property since her infancy and that this exposure had resulted in permanent brain damage. Attsgood in turn challenged the contention that the presence of lead at its property was the actual source of Roberts’s injuries.

The jury returned a verdict in favor of Roberts for $2,000,000, which was reduced to $850,000 following an application of Maryland’s non-economic damages cap. It was undisputed that Attsgood and Gondrezick are jointly and severally liable for this amount.

The Litigation

Penn National filed a declaratory judgment action against Attsgood and Roberts in federal court on the basis of diversity jurisdiction. The insurer sought a determination that it was obligated to indemnify Attsgood for no more than 40% of the total judgment, or $340,000. Penn National filed a motion for default judgment against Attsgood after it failed to respond. Penn National also filed a motion for summary judgment against Roberts, arguing that it should be liable for only 22 months of the entire period of Roberts’s
exposure to the risk of lead poisoning. It calculated that while it had insured Attsgood for the 24 months from January 1992 to January 1994, Attsgood had sold the property to Gondrezick in November 1993, thereby resulting in a total of 22 months of coverage.

Roberts saw the matter differently. She argued that Penn National was responsible for paying the entire $850,000 judgment in light of the joint and several liability of its insured. She also contended that even if the district court decided to allocate liability, “virtually all” of her “lead exposure occurred during Penn National’s two policy periods,” beginning with the discovery of her elevated blood-lead level in September 1992.

The Continuous Trigger
The district court largely agreed with Penn National. The trial court relied on “continuous trigger” cases in which Maryland courts determine an insurer’s liability through a “pro-rata allocation by ‘time on the risk.’” The district court concluded that Roberts had been exposed to lead poisoning from January 17, 1991, to August 1995, for a total of 55 full months. The district court calculated Penn National’s period of coverage. It concluded that Penn National provided insurance to Attsgood from January 13, 1992, to January 13, 1994, for a total of 24 months. The court rejected Penn National’s argument that its period of coverage should be reduced to 22 months because Attsgood had sold the property to Gondrezick on November 1, 1993, concluding that while “under the terms of the insurance contract Penn National may be correct, the record is entirely barren of facts showing that Penn National’s coverage in fact was terminated.”

In its allocation of liability, the district court used the 24 months of coverage as the numerator and the 55 months of exposure to lead poisoning as the denominator to conclude that Penn National was responsible for 24/55, or approximately 43.6%, of the judgment. It then found that “Penn National is liable to Roberts for $370,600 (43.6% x $850,000), but no more.”

Analysis
The plain language of the insurance contract limited coverage. Penn National did not contract to “pay those sums that [Attsgood] becomes legally obligated to pay as damages because of ‘bodily injury’” without qualification. Rather, it contracted to “pay those sums that [Attsgood] becomes legally obligated to pay as damages because of ‘bodily injury’ . . . to which this insurance applies.” The policy also clearly limited the insurer’s obligation to damage that “occurs during the policy period.”

Not only was Penn National’s coverage limited to the policy period, it was also restricted to premises that Attsgood “Owned, Rented or Occupied.” This language precluded the Fourth Circuit Court of Appeal from holding Penn National liable for injuries that occurred when Gondrezick, not Attsgood, owned the house at 1740 East Preston Street. Roberts asked the Fourth Circuit to turn a blind eye to the policy wording and hold an insurance
company liable for risks for which it never contracted and for which it never received premiums. The court refused.

In addition to ignoring contractual language, Roberts’s position conflicted with Maryland law. In lead paint or continuous-trigger cases such as this one, Maryland courts engage in a “pro rata by time-on-the-risk allocation” of liability.

No one disputed that Attsgood and Gondrezick were jointly and severally liable and that each was responsible for the entire judgment under long-standing principles of tort law. The question before the Fourth Circuit was not whether Attsgood was liable for the entire $850,000 judgment, but whether Penn National was responsible for the entire $850,000 judgment. Finding that the question could be answered only by reference to the insurance contract, which necessarily involves the application of contract law, the Fourth Circuit refused to apply tort law and insisted on applying contract law to a contract dispute.

While contractual text and Maryland precedent provide ample reason to reject Roberts’s position, it is also worth noting that her approach to allocating liability would upend insurance underwriting. As multiple courts have pointed out, Roberts’s approach would impose the same amount of liability on an insurance company that provided coverage for one month as on an insurer that provided coverage for 10 years.

An insurance contract is, at most, an agreement to accept a premium in exchange for a contractually defined risk. If an insurance company cannot limit its risk to a defined period, it will be unable to determine the precise risks assumed under a contract, which in turn will prevent it from accurately pricing coverage. Not only will this hinder rational underwriting, but the higher premiums necessary to compensate for this rising uncertainty will be passed on to policyholders everywhere.

The court recognized that Roberts might not be able to recover her entire judgment from either Attsgood or Gondrezick. It is a dispiriting but inescapable fact that sometimes really bad things happen, and those responsible are either insolvent or inadequately insured. But that regrettable reality does not allow a court to ignore state law, to hold an insurance company to a contractual provision to which it never agreed, or to scramble together whole areas of law that are conceptually distinct.

As the district court suggested, Penn National’s coverage ended “under the terms of the insurance contract” when the property was sold to Gondrezick. There was nothing ambiguous about this aspect of coverage. After Attsgood sold the East Preston Street property to Gondrezick, it obviously neither owned, rented, nor occupied those premises.

It is sad that Roberts may recover only partially on her judgment. The jury obviously believed this child suffered significant brain damage from lead poisoning and that Attsgood and Gondrezick were liable. The condition of the property and the failure to procure appropriate insurance were the property owners’ responsibility. Roberts’s misfortune cannot be laid at Penn National’s feet, for that company has not disputed that it must pay that portion of the judgment to which its policy applied.
The court, therefore, concluded that Penn National is liable for 22/55, or 40%, of the $850,000 judgment.

As the Fourth Circuit made clear, an insurance contract is, at most, an agreement to accept a premium in exchange for a contractually defined risk. Young Ms. Roberts was seriously injured by the actions of the person insured over a long period of time as she ingested lead into her system from a poorly maintained property. She won her lawsuit against the tortfeasors. One was uninsured and the other was insured only for a short period of time during the time Ms. Roberts was injured.

In cases where an injury occurs over a long period of time and where periods of insurance, no insurance, or multiple insurance policies apply to the risk, Maryland and the Fourth Circuit apply a reasonable application of clear and unambiguous policy language. To do otherwise would be a dangerous rewriting of an insurance contract that might help one little girl but would harm the entirety of the insurance-buying public.

Courts must do justice. They should not, nor can they, breach or bend the law of contracts to do what they perceive to be justice. Ms. Roberts and her lawyers will recover 40% of the judgment from the insurer. To recover the rest of the judgment, she and her lawyers must search out all of the assets of the tortfeasors and take them through the process of the court. She had no right to collect from an insurer money for which it did not take any money or agree to insure.

Before insurance fraud can be discussed, it is essential to understand that, as the Restatement of Contracts, Section 291 states:

A fortuitous event . . . is an event which, so far as the parties to the contract are aware, is dependent on chance. It may be beyond the power of any human being to bring the event to pass; it may be within the control of third persons; it may even be a past event, such as the loss of a vessel, provided that the fact is unknown to the parties.

Similarly, California Insurance Code Section 22 provides:

Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.

A fraudulent claim—one made with the intent to deceive an insurer to its detriment—can never be fortuitous, contingent, or due to an unknown event.

It is essential that every person involved in the work to reduce insurance fraud understand the often-unstated exclusion of fortuity: that is, for insurance to apply, there must be an accident, a fortuitous event.

The investigator who collects evidence that establishes, by a preponderance of the evidence, that the claim was based on an intentional act, a fraud, or some event that was not
accidental has established that there is no coverage. It is not necessary to prove that the
insured intended to defraud the insurer, only that the acts were not fortuitous, that the
event was known before the policy was acquired, or that it was not a contingent event.

Contrary to statements made by politicians, insurance is not a right, a means of cur‑
ing social ills, or a means of curing environmental problems. Insurance is not designed to
protect against known losses, intentional acts, or a loss that happened before the policy
was purchased.

Politicians and courts attempt to make insurance something it is not—a charitable
institution that pays losses the insurer did not agree to pay in the insurance contract. Cali‑
fornia courts have struggled with this concept for many years as a result of the discharge
of pollutants from the Stringfellow acid pits and other polluted properties.

In State v. Continental Insurance Co.,22 the California Court of Appeal appears to have
ignored the definition of insurance established by California Insurance Code § 22 and
has allowed the state of California to stack all coverages it had for a loss that continued
over a very long period of time. The court of appeal, in a lengthy decision, ignored a key
concept of insurance law: that a loss, to be covered, must be contingent or unknown to
the insured.

The state of California sought to recover from its liability insurers the amounts that a
federal court had ordered the state to pay—as much as $500 million for the cleanup of a
hazardous waste site that started leaking pollutants in 1969 and continued to cause dam‑
age over a long period of time. The court described the factual basis for the suit as follows:

In 1969, heavy rains caused contaminants to overflow the dam. In 1972, groundwa‑
ter contamination was discovered, and the site was closed. However, it continued to
leak. In 1978, heavy rains once again made the ponds overflow; the State decided
to allow a “controlled discharge” of contaminants into Pyrite Channel. Hazardous
waste released from the site merged into a plume that ultimately extended miles away.

The federal court master outlined the problem as follows:

The hazardous waste disposal facility was opened in 1956. At the direction and under
the control of the State, more than 30 million gallons of liquid industrial waste were
deposited in the Stringfellow ponds during the facility’s operation; the State closed
the site to new deposits in 1972 after the discovery of groundwater contamination . . .

By 1960, . . . a State expert found, chemical pollution was seeping into the ground‑
water through the fractured rock and around the ends of the barrier dam, which

had been negligently constructed. A plume of contaminated groundwater moved down gradient from the site.

In addition to underground leaking, two major overflow episodes occurred at the site. In March 1969, a rainstorm of around 20 inches (statistically expected to occur no more than once every 50 years), following on earlier heavy rains in January and February, flooded the site, causing the waste ponds to overflow and send polluted water down the canyon. In March 1978, again following extraordinarily heavy rains, the ponds were once more near overflowing and the retention dam began to fail. The State made a series of controlled discharges from the ponds, releasing about one million gallons of diluted waste down the Pyrite Creek channel. (The circumstances of the 1969 and 1978 releases are discussed in greater detail in connection with the legal issues.)

The policies issued by the insurer defendants covered periods from 1964 until 1975, after the State first became aware of the pollution.

The trial court ruled that every excess liability policy in effect for any policy period during which the hazardous waste loss was occurring covered the entire loss sustained by the state, subject to the policy limits; that the policies could not be stacked; and that the insurers were entitled to a setoff for prior settlements. The policies defined an occurrence to include a continuous or repeated exposure to conditions.

The court of appeal reversed the judgment and remanded the case for further proceedings. The court held that the continuous-injury trigger of coverage was applicable and that under the all-sums approach, every insurer that issued a liability policy for any period during which a continuous loss occurred was liable for the full extent of the loss up to the policy’s limits. The court determined that the state was entitled to stack the policy limits of all applicable policies across all applicable policy periods.

There was only a single occurrence, which was the deposit of hazardous waste at an unsuitable site. In light of the court’s reversal of the trial court’s no-stacking ruling, a challenge to the setoff ruling was moot.

This, however, seems to conflict with the recent decision of the California Supreme Court, which concluded that “the proper focus of analysis here is on discharges from the ponds, rather than deposits to them.”

Justice Richli, writing for the court of appeal, noted:

In this action, the State of California (the State) seeks to recover from its liability insurers the amounts that a federal court has ordered it to pay for the cleanup of

24. Id.
the Stringfellow hazardous waste site. Some insurers were granted summary judgment; the propriety of that ruling is currently before the California Supreme Court in *State of California v. Underwriters at Lloyd’s London*.\(^{25}\)

At the time of the appeal, only six insurers were left litigating: Continental Insurance Company (Continental), Continental Casualty Company (Casualty), Employers Insurance of Wausau (Wausau), Horace Mann Insurance Company (Horace Mann), Stonebridge Life Insurance Company (Stonebridge), and Yosemite Insurance Company (Yosemite) (collectively the Insurers). Each of them had issued to the State an excess corporate general liability policy covering a two- or three-year policy period. The State was held liable for all past and future remediation costs, which the State claimed could be as much as $700 million. The Insurers stipulated that the State was liable for at least $50 million.

The State was ordered by a federal court to clean up the pollution caused by the construction and use of the Stringfellow Acid Pits in Riverside County, California, which is anticipated to cost up to $700 million. The State, which may not be able to fulfill the order because of a lack of assets and because of growing budget deficits, turned to the California Supreme Court to obtain funds from the Insurers who insured the State while the pits were constructed and during the period when the pits polluted the land and water of Riverside County. To fulfill its obligation to clean up the pollution, the State needed as much money as it could squeeze from its insurers.

The California Supreme Court considered the complex questions of insurance policy coverage interpretation that arose in connection with a federal court-ordered cleanup of the State’s Stringfellow Acid Pits waste site. The court initially addressed the “‘continuous injury’ trigger of coverage,” as that principle was explained in *Montrose Chemical Corp. v. Admiral Ins. Co.*\(^{26}\) and the “all sums” rule adopted in *Aerojet-General Corp. v. Transport Indemnity Co.*\(^{27}\) In *The State of California v. Continental Insurance* the California Supreme Court brought to an end the dispute that started in the 1960s when the Stringfellow Acid Pits began to leak.\(^{28}\)

**THE STATE SUES ITS INSURERS**

The State’s suit was tried in multiple phases. At the conclusion of a June 1999 bench trial, the court ruled that the policy limits under policies with multiple-year periods applied

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\(^{26}\) 10 Cal. 4th 645, 655 (1995).

\(^{27}\) 17 Cal. 4th 38, 55–57 (1997).

“per occurrence” and not annually. Following this, in April 2002, the trial court held that the State’s failure to remediate and its delay in remediating the site were not a breach of any duty to mitigate the insurers’ damages. In September 2002 the State brought a second suit, asserting related claims against additional insurers, including those that were parties to this appeal. This case was consolidated with the first action, and defendant insurers in the second suit agreed to be bound by all prior rulings in the original action. All parties stipulated that the property damage that the Stringfellow site’s selection, design, and construction caused took place continuously throughout the defendant insurers’ multiple consecutive policy periods from 1964 to 1976.

In May 2005, a jury in phase three of the trial rendered special verdicts finding the insurers had breached their policies. By that time, the State had already entered into settlement agreements totaling approximately $120 million with several other insurers. The State filed an appeal, and, with the exception of Wausau, all of the insurers filed cross-appeals. The court of appeal, like the trial court, rejected the insurers’ contention that they could not be liable for property damage occurring outside their respective policy periods. It held that once coverage was triggered, all of the insurers had to indemnify the insured for the loss. The court of appeal allowed the State to stack the total policy limits in effect for any one policy period.

The kind of property damage associated with the Stringfellow site, often termed a “long-tail” injury, is characterized as a series of indivisible injuries attributable to continuing events without a single unambiguous “cause.” Long-tail injuries produce progressive damage that takes place slowly over years or even decades. It is often “virtually impossible” for an insured to prove what specific damage occurred during each of the multiple consecutive policy periods in a progressive property damage case. CGL policies leave unanswered the crucial question for long-tail injuries: When does a continuous condition become an “occurrence” for the purposes of triggering insurance coverage?

While the term “trigger of coverage” does not appear in the language of the CGL insurance policies here, it is a term of convenience used to describe what, under the specific terms of an insurance policy, must happen in the policy period in order for the potential of coverage to arise. The issue is largely one of timing: What must take place within the policy’s effective dates for the potential of coverage to be triggered?

In the context of a third-party liability policy, property damage that is continuous or progressively deteriorating throughout several policy periods is potentially covered by all policies in effect during those periods. As long as the property is insured at some point during the continuing damage period, the insurers’ indemnity obligations persist until the loss is complete or terminates. Neither the State nor the insurers disputed that progressive damage to property at the Stringfellow site “occurred” during numerous policy periods. In addition, the insurers conceded that in cases such as this, it is impossible to prove precisely what property damage occurred during any specific policy period. The California
Supreme Court concluded that the fact that all policies were covering the risk at some point during the property loss is enough to trigger the insurers’ indemnity obligation.

The court decided that, rather than a pro rata share of the damage, the policies obligate the insurers to pay all sums for property damage attributable to the Stringfellow site, up to their policy limits, if applicable, as long as some of the continuous property damage occurred while each policy was “on the loss.” The coverage extends to the entirety of the ensuing damage or injury and best reflects the insurers’ indemnity obligation under the respective policies, the insured’s expectations, and the true character of the damages that flow from a long-tail injury.

The all-sums indemnity coverage envisions that each successive insurer is potentially liable for the entire loss up to its policy limits. When the entire loss is within the limits of one policy, the insured can recover from that insurer, which may then seek contribution from the other insurers. Recognizing, however, that this method stops short of satisfying the responsibilities of the policies covering a continuous long-tail loss, and potentially leaves the insured vastly uncovered for a significant portion of the loss, the present court of appeal allowed the insured to stack the consecutive policies and recover up to the policy limits of the multiple plans.

“Stacking” generally refers to the stacking of policy limits on a particular risk across multiple policy periods. In other words, “Stacking policy limits means that when more than one policy is triggered by an occurrence, each policy can be called upon to respond to the claim up to the full limits of the policy.” The supreme court found that an all-sums-with-stacking rule has numerous advantages: “It resolves the question of insurance coverage as equitably as possible, given the immeasurable aspects of a long-tail injury. It also comports with the parties’ reasonable expectations, in that the insurer reasonably expects to pay for property damage occurring during a long-tail loss it covered, but only up to its policy limits, while the insured reasonably expects indemnification for the time periods in which it purchased insurance coverage.”

The most significant caveat to all-sums-with-stacking indemnity allocation is that it contemplates that an insurer may avoid stacking by specifically including an “antistacking” provision in its policy. Of course, in the future, contracting parties can write into their policies whatever language they agree upon, including limitations on indemnity, equitable pro rata coverage allocation rules, and prohibitions on stacking.

The decision means, simply, that each insurer on the risk must pay its limits for each policy year it had a policy in effect.

Neither the court of appeal nor the supreme court dealt with the fact that the injury that was continuous and progressive began in 1960, before the policies came into effect. The loss was clearly in progress. The State knew of the loss and that the pits were leaking and polluting the land starting in at least 1960, and yet acquired policies of insurance for years after.
Why is this case mentioned in a book on insurance fraud? Because the State knew of the problem and did not advise the multiple insurers on the risk, who would never have insured the risk of loss had they known the truth. The concealment of such a material fact was honored with a favorable judgment rather than allowing the insurers to rescind the insurance they had issued to the State based on concealment of material fact.

The state of California, like all of its citizens, is bound by the maxim of law in the California Civil Code: “No one can take advantage of his own wrong.”

The state of California has held that insurance is a contract of the utmost good faith and that the duty of good faith and fair dealing is imposed equally upon the insured and the insurer, and that “[t]here is an implied covenant of good faith and fair dealing in every contract [including insurance policies] that neither party will do anything which will injure the right of the other to receive the benefits of the agreement.”

The California Court of Appeal, in fact, noted many years ago, that an insurer:

\[h\]as the unquestioned right to select those whom it will insure and to rely upon him who would be insured for such information as it desires as a basis for its determination to the end that a wise discrimination may be exercised in selecting its risks.

A question not answered by the Stringfellow decisions is whether the state of California, in acquiring policies from the insurers after 1960, deprived its insurers of their unquestioned right to rely on the state for the information they needed in order to decide whether to insure the state. If the facts were not disclosed, then the insurers had the right to rescind their policies from the inception. The California Supreme Court noted in a footnote:

The loss-in-progress rule codifies a fundamental principle of insurance law that an insurer cannot insure against a loss that is known or apparent to the insured. The public policy rule is premised on the view that: To hold the insurer liable for a progressive and continuing property loss that was discovered before the carrier insured the risk “would be to impose upon the insurer a guaranty of the good quality of the [property insured] . . ., which liability under the policy the insurer had not assumed.”

29. CAL. CIV. CODE § 3517.
In *Montrose Chemical Corp. v. Admiral Insurance Co.*,\(^\text{34}\) where the existence and extent of injuries were unknown from the insured’s “standpoint,” coverage of continuous or progressively deteriorating property damage under a CGL policy did not offend the loss-in-progress rule. However, in the *Stringfellow* cases, it was clear from the facts established by the original federal action that the state knew of the problem when it received a report from its expert in 1960 that found that chemical pollution was seeping into the groundwater through the fractured rock and around the ends of the barrier dam. The expert also found and reported to the state that a plume of contaminated groundwater had moved down gradient from the site. This is evidence that the existence of the injuries and their ongoing nature were known from the standpoint of the state of California.

The court of appeal began with *Montrose Chemical Corp. v. Admiral Ins. Co.* (Montrose).\(^\text{35}\) There, applying only the part of the California Supreme Court decision that held that “bodily injury and property damage that is continuous or progressively deteriorating throughout several policy periods is potentially covered by all policies in effect during those periods.” The court of appeal adopted the “continuous injury” trigger of coverage and ignored the part of the decision that the losses claimed were known from the insured’s standpoint.

In *Montrose*, seven insurers had issued a series of liability policies collectively covering the period from 1960 to 1986. Admiral Insurance Company (Admiral) had issued policies covering only the last four years of this period.\(^\text{36}\) The issue before the court was whether Admiral had a duty to defend actions alleging either continuous or progressively deteriorating bodily injury or property damage resulting from toxic chemicals manufactured by the insured that began before, but continued during, Admiral’s policy periods.

The insurers conceded that, under *Montrose*, they were liable for any property damage that actually occurred during their respective policy periods. They denied, however, that they were liable for any property damage that occurred before or after their policy periods. *Montrose*, the court of appeal noted, declared it to be a “settled rule that an insurer on the risk when continuous or progressively deteriorating damage or injury first manifests itself remains obligated to indemnify the insured for the entirety of the ensuing damage or injury.”

In *Armstrong World Industries, Inc. v. Aetna Casualty & Surety Co.*,\(^\text{37}\) the appellate court held squarely that every insurer that issued a liability policy for any period during which a continuous loss occurred was liable for “the full extent of the loss up to the policy’s limits . . .”

\(^{34}\) 10 Cal. 4th 645, 691, 693, 42 Cal. Rptr. 2d 324, 913 P.2d 878 (1995).
\(^{35}\) Id.
\(^{36}\) Id. at 656.
\(^{37}\) 45 Cal. App. 4th 1, 52 Cal. Rptr. 2d 690 (1996).
Subsequent decisions unanimously concurred with Armstrong and followed the all-sums approach.

Moreover, in Aerojet-General Corp. v. Transport Indemnity Co.,\(^{38}\) the supreme court itself followed the all-sums approach. It stated that the duty to indemnify

is triggered if specified harm is caused by an included occurrence, so long as at least some such harm results within the policy period. [Citation omitted] *It extends to all specified harm caused by an included occurrence, even if some such harm results beyond the policy period.* [Citation omitted.] In other words, if specified harm is caused by an included occurrence and results, at least in part, within the policy period, it applies to all points of time at which some such harm results thereafter.\(^{39}\)

The court of appeal stated its finding as follows:

> [In] California, when there is a continuous loss spanning multiple policy periods, *any* insurer that covered *any* policy period is liable for the *entire* loss, up to the limits of its policy. The insurer’s remedy is to seek contribution from any other insurers that are also on the risk.

* * *

We therefore conclude that the trial court correctly ruled that each of the Insurers covered the total amount of the State’s liability for property damage (subject to their respective policy limits), *including property damage that actually occurred before or after their policy periods.* (Emphasis added.)

In reaching this conclusion, the court of appeals committed the cardinal sin of insurance policy interpretation: It rewrote the policy to provide coverage for losses not agreed to by the wording of the policy. Contracts are written to have meaning. If a court can change the clear and unambiguous language of an insurance contract after a loss to provide indemnity for a favored plaintiff—the state of California—then there is no reason for written contracts. There is nothing in an “occurrence” policy of insurance that agrees to cover losses that were incurred before the policy came into effect, nor is there anything in a policy that covers damages where the occurrence is subsequent to the expiration of the policy.

Since the California Supreme Court concluded that the “occurrence” was based on “discharges from the ponds, rather than deposits to them, . . .” the loss-in-progress began

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38. 17 Cal. 4th 38, 70 Cal. Rptr. 2d 118, 948 P.2d 909 (1997).
39. Id. at 56–57, italics added, ins. omitted.
in 1960 before any of the policies came into effect, and the loss, if continuous and pro-
gressive, was not fortuitous as to the state or these insurers.

STACKING

“Stacking,” according to the court of appeal, is a useful shorthand term. It has been defined
differently by different courts and legislatures. The court of appeal defined “stacking” as
follows:

In its broadest sense, stacking means treating multiple policies that apply to a single
loss as cumulative—as a “stack” of coverage—rather than as mutually exclusive. Hence, stacking issues can arise almost any time multiple policies cover a single
loss. . . .

Most often—as in this case—stacking refers to stacking of policy limits. Thus, the
California Supreme Court has defined stacking as “‘the ability of the insured, when
covered by more than one insurance policy, to obtain benefits from a second policy
on the same claim when recovery from the first policy would alone be inadequate’
to compensate for the actual damages suffered. . . .”

Also—and again, as in this case—stacking is most often used to refer to the stack-
ing of policy limits across different policy periods. . . . under Montrose, a continuous
loss that occurs across multiple policy periods may be covered under every policy
applicable to every such period; moreover, under Aerojet-General, each such policy
may provide coverage up to the entire amount of the loss. When the entire loss is
within the limits of any one policy, there is no stacking issue; the insured can recover
from that insurer, which will then be entitled to contribution from the other insurers.
However, whenever the loss is greater than the limits of any one applicable policy,
the insured will seek to stack the policy limits across the policy periods.

Under the standard policy definition of “occurrence”—particularly as construed in
Montrose and Aerojet-General—a continuous loss that spans multiple policy periods is,
nevertheless, only a single occurrence. The court of appeal, in a stretch of the language,
concluded that “the policy language only purports to limit each particular insurer’s lia-
ibility under each particular policy.” (Italics in the original.) This conclusion ignores the fact
that all insurance policies “purport” to limit coverages to the policy’s wording, and the
court should be constrained from the temptation to ignore the clear and unambiguous
terms of a policy of insurance.

The court of appeal noted that the first California case in which the issue of stacking
of limits across policy periods was squarely presented held that it is allowed.
The appellate court in *FMC Corp. v. Plaisted & Companies (FMC)*,\(^{40}\) held that the insured was not entitled to stack. It explained:

“[S]tacking” . . . has been criticized as affording the insured substantially more coverage, for liability attributable to any particular single occurrence, than the insured bargained or paid for. [Citations omitted.] Insurers sometimes include “anti‑stacking” provisions in their policies to avoid just this kind of result. Where, as in this action, there is no anti‑stacking provision, there is precedent, characteristically in asbestos cases, for judicial intervention.

The court of appeal disagreed with and refused to follow the decision in *FMC*. The *FMC* court resorted to judicial intervention because it felt that stacking “afford[s] the insured substantially more coverage, for liability attributable to any particular single occurrence, than the insured bargained or paid for.” This argument, the court of appeal concluded, “is circular. It assumes what it is meant to prove—that the policies do not provide for stacking.” In so ruling, the court of appeal ignored the reality of the process of purchasing insurance:

If an occurrence happens entirely within one policy period, the insured has paid one premium and can recover up to one policy limit; however, if an occurrence is continuous across two policy periods, the insured has paid two premiums, and can recover up to the combined total of two policy limits. We see nothing unfair or unexpected in this.

If a loss occurs within a single policy period and continues into subsequent policy periods, the loss is a “loss in progress” and is neither a contingent nor an unknown event. Insurance companies should never be compelled by a court to pay for a loss that is not contingent or unknown.

In this case the state, as insured, was or should have been aware of an ongoing, progressive loss after 1960 when the state was made aware that contaminants were overflowing the Stringfellow pits. Once it had that knowledge, it was obligated to so advise the insurer of a claim and all future insurers of the ongoing loss so that they could properly underwrite the risk. Failure to do so is concealment of a material fact.

Therefore, any policy purchased after 1960, even if the state was unaware of the extent of the damage, the fortuity doctrine, or “loss in progress” rule, states that where damage has begun to occur prior to the inception of the policy, no part of the loss may be insured against.\(^{41}\)


The fortuity doctrine only precludes a party from insuring against a loss that has occurred or is certain to occur within the term of the policy.42

In *Fire Insurance Exchange v. Superior Court of San Bernardino County*,43 the court noted that building a structure that encroaches onto another’s property is not an accident, even if the owners acted in the good faith but mistaken belief that they were legally entitled to build where they did. Because their homeowner policy did not provide coverage for nonaccidental occurrences, the owners’ insurer had no duty to defend when the owners were sued by the adjoining landowner as a result of the encroachment. Accordingly, the owners’ insurer was entitled to summary judgment in the action for breach of contract and bad faith brought by the owners.

“Accident” is given a commonsense interpretation that it is an unintentional, unexpected, chance occurrence.44

An accident does not occur when the insured performs a deliberate act unless some additional unexpected, independent, and unforeseen happening occurs that produces the damage.45 *Merced* explains the distinction by the following examples: When a driver intentionally speeds and, as a result, negligently hits another car, the speeding is an intentional act. However, the act directly responsible for the injury—hitting the other car—was not intended by the driver and was fortuitous. Accordingly, the occurrence resulting in injury would be deemed an accident. This situation is distinct from an instance where a driver speeds and deliberately hits the other car.

The principle that an insured’s mistake of fact or law does not transform a purposeful act into an accident has been applied in situations other than those involving sexual contact and assault and battery.

The Bourguignons intended to build the house where they built it. Accepting their contention that they believed they, rather than the Parsons, owned the five and one-half foot strip of land and had the legal right to build on it, the act of construction was intentional and not an accident, even though they acted under a mistaken belief. In light of the court’s ruling that there is no coverage because the claimed damage does not arise from an “accident,” the court need not consider the additional issue of whether the Parsons have alleged property damage.

Inherent in the plain meaning of “accident” is the doctrine of fortuity. Indeed, the fortuity principle is central to the notion of what constitutes insurance.

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Insurers almost never contract to cover preexisting risks and liabilities known by the insured. Thus, it is generally the insured’s duty to provide truthful and complete information so the insurer can fairly evaluate the risk it is contracting to cover.\footnote{See, e.g., Combs v. Equitable Life Ins. Co. of Iowa, 120 F.2d 432, 437 (4th Cir. 1941) (holding that an insured’s failure to disclose a heart condition breached a condition precedent to coverage on a life insurance policy); Argyris, 189 Va. at 929, 55 S.E.2d at 23 (holding that an insured’s failure to provide complete and timely information breached the policy’s cooperation clause, a condition precedent to coverage); Va. Fire & Marine Ins. Co. v. J.I. Case Threshing Mach. Co., 107 Va. 588, 590–91, 59 S.E. 369, 369–70 (1907) (stating that the insured’s failure to disclose an encumbrance on his property breached the condition precedent that the insured property be unencumbered).} If the insured fails to comply with a clear condition required by the insurer, it is typically not liable on the policy.

The known loss doctrine is a common-law concept that derives from the fundamental requirement of fortuity in insurance law. Its basic premise is that insurance policies are intended to protect insureds against risks of loss, not losses that have already taken place or are substantially certain to occur. Accordingly, the doctrine is properly invoked when the insured “knows” about the claimed loss before the policy is purchased.\footnote{Aetna Cas. & Sur. Co. v. Dow Chem. Co., 10 F. Supp. 2d 771, 789 (E.D. Mich. 1998).}

The professional investigator who discovers that the loss was intentional on the part of the insured must investigate the claim thoroughly, and if a preponderance of the evidence establishes that the loss occurred intentionally and was not fortuitous, he or she should seek the advice of local counsel to determine if the claim is covered by the policy.