Every insurance policy is a contract. You agree to pay a premium, and the insurance company agrees to indemnify you in the event of a covered loss. But the contract of insurance is not that simple. It creates obligations for both the insured and the insurer.

One of the critical obligations of an insured is the duty to timely report claims or circumstances that may give rise to a claim. Failure to report a claim in accordance with the policy requirements can result in a claim being denied, or worse, having the entire policy voided.

This article will review the insured’s responsibilities as it pertains to claims reporting requirements in several key insurance policies. The nature of this discussion is somewhat generic. Each policy should be reviewed for the specifics of what is required in the event of a claim or a circumstance that may give rise to a claim.

**Claims-Made Policies**

Policies written on a claims-made basis (for example, directors and officers liability, employment practices liability, and professional liability,) require that you report any claims or circumstances that may give rise to a claim in a timely fashion.

*Failure to do so can jeopardize your coverage.*

There is a difference between a “claims made” policy and a “claims made and reported” policy. The latter form is more stringent than the former. It only covers claims that are made and reported to the insurance company during the policy year.

Claims-made policies also have retroactive dates. Ideally, the retroactive date is the day the firm started business, but it can also be the day that it first purchased professional liability coverage. Assuming the retroactive date has not been advanced, the policy in force when a claim is made is the policy that will respond, regardless of when the negligent act, error or omission took place. However, there is one important qualifier. Shown in this issue...
below is a provision that can be found in nearly every claims-made policy:

This insurance applies to claims that meet each of the following:

1. The claims arise out of your professional services performed after the retroactive date, but prior to the end of the policy period, provided that you had no knowledge of the claims prior to the effective date shown in the Declarations [emphasis added].

In other words, if you knew of a claim prior to the time you renewed your claims made policy but did not report it, and if a claim is subsequently made, the insurance company can deny coverage. It doesn’t matter whether or not it’s been continuously renewed by one insurance company, the policy excludes it.

This underscores the importance of timely reporting of all claims prior to renewal each year. Although the definition of ‘claim’ varies between insurance companies, in general it is defined as:

a. A demand against you for money or services, or the filing of a suit, or the initiation of an arbitration proceeding naming you and seeking damages for an alleged error, omission, negligent act, or

b. An event or circumstance, an incident or unresolved fee dispute of which you have knowledge that may result in a claim as described in (a).

**Commercial General Liability Policies**

General liability coverage is usually written on an occurrence basis. This means that the policy in force when the occurrence (loosely defined as an “accident”) takes place is the policy that will respond, regardless of when the actual claim is made. While timely reporting of claims and circumstance is not as critical as it is in a claims-made policy, it is still important. Failure to abide by the conditions in the policy could also jeopardize your coverage.

A sidebar to this article shows the actual provision taken out of the ISO CG 00 01 (12/04) General Liability Coverage Form. There are several things you should be aware of.

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**General Liability Coverage Form**

**ISO CG 00 01 (12/04 Edition)**

2. **DUTIES IN THE EVENT OF OCCURRENCE, OFFENSE, CLAIM OR SUIT:**

   a. You must see to it that we are notified as soon as practicable of an “occurrence” or an offense that may result in a claim. To the extent possible, notice should include:

      (1) How, when and where the “occurrence” or offense took place;

      (2) The names and addresses of any injured persons and witnesses; and

      (3) The nature and location of any injury or damage arising out of the “occurrence” or offense.

   b. If a claim is made or “suit” is brought against any insured, you must:

      (1) Immediately record the specifics of the claim or “suit” and the date received and;

      (2) Notify us as soon as practicable.

         You must see to it that we receive written notice of the claim or “suit” as soon as practicable.

   c. You and any other involved insured must:

      (1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or “suit;”

      (2) Authorize us to obtain records and other information;

      (3) Cooperate with us in the investigation or settlement of the claim or defense against the “suit;” and

      (4) Assist us, upon our request, in the enforcement of any right against any person or organization that may be liable to the insured because of the injury or damage to which this insurance may also apply.

   d. No insured will, except at the insured’s own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent. ☡

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**Timely Reporting** (continued from page 1)

**Timely Reporting** (continued on page 3)
You are required to put the insurance company on notice of an “occurrence” or an offense which may result in a claim as soon as “practicable.” Note that *practicable* is not a defined term. In all likelihood, a court would interpret this term to mean something like “as soon as possible” or “as soon as a reasonable person would have been able to notify the insurance company.” Regardless, it is almost certain that if the claim is turned in so late that it compromises the insurance company’s right to settle the issue, then this would be deemed a violation of the policy.

The provision spells out the specific items that should be sent to the insurance company. It requires that you authorize the insurance company to obtain additional records and information, and cooperate with them in the investigation of the claim.

Finally, it prohibits an insured from voluntarily making any payments, assuming any obligations, or incurring any expenses (other than for first aid) without the insurance company’s consent. In other words, you do not have the right to settle the matter on behalf of the insurance company and then ask the insurance company to pay you back.

**Business Automobile Policies**

The business automobile policy ISO CA 00 01 specifically states “the insurer has no duty to provide any coverage under this Coverage Form unless the insured has complied fully with the following duties…” (see sidebar). The business auto policy is similar in scope to the general liability policy, except that it requires “prompt” notice. It also requires that the insured “*must submit to an examination by a physician of the insurer’s choice and at the insurer’s expense as the insurer reasonably requires.*”

As a final note, under the physical damage section, if a vehicle is stolen, the insured is required to notify the police and if a vehicle is damaged, to take reasonable steps to protect the covered auto from further damage. The insurance company also has the right to inspect the automobile before any necessary repairs are made.
Commercial Property Policies

The commercial property coverage form ISO CP 00 10, like the business automobile form, requires that the insured provide “prompt” notice. Like most other policy forms, it requires the insured to:

- Notify the police if a law has been broken
- Provide a description of the property involved and the circumstances surrounding its damage or theft
- Take all reasonable steps to protect the property from further damage
- At the insurance company’s request, to provide complete inventories of damaged and undamaged property
- Allow the insurance company to inspect the property and make available the insured’s books and records to help substantiate any loss
- Send a signed, sworn proof of loss statement
- Cooperate with the insurance company in the investigation or settlement of any claim

Timely Reporting (continued from page 3)

Property Coverage Form
ISO CP 00 10

DUTIES IN THE EVENT OF LOSS OR DAMAGE

a. You must see that the following are done in the event of loss or damage to Covered Property:

1. Notify the policy if a law may have been broken.
2. Give us prompt notice of the loss or damage. Include a description of the property involved.
3. As soon as possible, give us a description of how, when and where the loss or damage occurred.
4. Take all reasonable steps to protect the Covered Property from further damage, and keep a record of your expenses necessary to protect the Covered Property, for consideration in the settlement of the claim. This will not increase the Limit of Insurance. However, we will not pay for any subsequent loss or damage resulting from a cause of loss that is not a Covered Cause of Loss. Also, if feasible, set the damaged property aside and in the best possible order for examination.
5. At our request, give us complete inventories of the damaged and undamaged property. Include quantities, costs, values and amount of loss claimed.
6. As often as may be reasonably required, permit us to inspect the property proving the loss or damage and examine your books and records. Also permit us to take samples of damaged and undamaged property for inspection, testing and analysis, and permit us to make copies from your books and records.
7. Send us a signed, sworn proof of loss containing the information we request to investigate the claim. You must do this within 60 days after our request. We will supply you with the necessary forms.
8. Cooperate with us in the investigation or settlement of the claim.

b. We may examine any insured under oath, while not in the presence of any other insured and at such times as may be reasonably required, about any matter relating to this insurance or the claim, including an insured’s books and records. In the event of an examination, an insured’s answers must be signed.

Commercial Property Coverage Form
ISO WC 00 00 Standard 04/92 Edition

PART FOUR — YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

Timely Reporting (continued on page 5)
complete an “Employers Report of Occupational Injury or Illness” (Form 5020). This report must be sent to your insurance company within five days after you have knowledge of the injury, although we recommend it be sent within 24 hours.

You must also provide an “Employee Claim for Workers Compensation Benefits” (DWC-1) to the injured employee within one working day of receiving notice of a job-related injury. If possible, have your employee complete and return the form immediately, and send the original to your insurance company, keeping a copy for yourself as well as providing a copy to the injured worker.

Copies of both Form 5020 and DWC-1 as well as additional information about workers compensation claims reporting can be found on our Web site at www.cavignac.com.

First Aid Claims

Under California law, employers are allowed to pay first aid claims (as defined by the law), it is important to understand that these should still be reported to the insurance company. Note that a reported claim showing “0” dollars paid will not affect your experience modification factor.

Waivers of Subrogation

Waivers of subrogation are allowed on most standard general liability, auto liability, and property policies if done in writing prior to a loss. They are also generally permitted on workers compensation policies, although this requires an endorsement and usually an additional premium. Waivers of subrogation may or may not be allowed on certain manuscripted policies, such as a professional liability policy. Before waiving rights under a manuscripted policy form, you should verify whether or not your particular policy will allow you to do so.

Subrogation is the right of one party (usually the insurance company) to recover from a third party (usually the party causing the damage) on behalf of the party that was damaged (usually the insured). In other words, if a third party hits your automobile, and your insurance company pays to repair your automobile, then your insurance company would be allowed (subrogated) to pursue your rights against the party who hit you to recover the monies paid for repairs.

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Workers Compensation Policies

Workers compensation is also written on a standard form. Part Four of the policy deals with “your duties if injury occurs” (see sidebar). Workers compensation is more regulated than any other type of insurance. The policy requirements are actually relatively straightforward. However, an employer has additional responsibilities beyond what is spelled out in the policy.

The policy basically allows you to provide immediate medical assistance to an injured employee. You are required to promptly report any injuries and specifics that the insurance company will need to adjust the claim. You are required to cooperate with the insurance company, and do nothing after an injury that would interfere with the insurance company’s right to recover from others (you cannot waive rights of subrogation after a claim). Finally, you are not allowed to voluntarily make payments, assume obligations, or incur expenses for which you would expect to be reimbursed by the insurance company.

In addition to these somewhat “generic” requirements, California law requires you to

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Timely Reporting (continued from page 5)

The key here is that if they do allow waivers of subrogation, nearly all of these policies only allow it if it is done in writing, before a claim occurs. You do not have the right to waive your insurance company’s right of subrogation after a claim happens.

Best Practices

1. Educate yourself and your staff on your obligations under your insurance policy.
2. Make sure everyone understands what is and what is not a claim. Appoint a Risk Management Officer in your company so any employee can approach him/her to discuss potential problems.
3. Claims made policies require additional attention. When completing your renewal application each year, you should touch base with the company’s principals and project managers to determine if there are any claims that need to be reported. A simple e-mail to each party requiring a response can read as follows:

   We are in the process of renewing our professional liability insurance coverage. We need to know if you are aware of any claims or circumstances which may give rise to a claim that should be disclosed to our insurance company.

   A claim is defined as a demand against us for money or services, or the filing of a suit or the initiation of an arbitration proceeding naming us that seeks damages for an alleged error, omission or negligent act. It also includes an event, a circumstance, an incident or an unresolved fee dispute of which we have knowledge that may result in a claim as described above.

   If you are not aware of any such claim or circumstance, please confirm this.

   If you are aware of a claim or circumstance that could give rise to a claim in the future, please complete the attached Claim Supplement Form for each claim and/or circumstance, and submit it to me no later than [Month / Day / Year].

Typically, this type of correspondence is first sent about 90 days prior to renewal. A similar e-mail should be sent on or about the renewal date to make certain that nothing has occurred in the meantime.

If there are questions as to whether or not a circumstance merits being reported to the insurance company, discuss it with your insurance broker, or if necessary, your attorney. Whether or not the decision is made to report the circumstance, the decision will be documented and will protect your insurability.

Summary

Understanding your obligations under your insurance policies is critical. One of your key obligations is to promptly report claims or circumstances that might give rise to a claim against you. If in doubt, you should consult with your attorney or your insurance broker to discuss the specific issues and make certain that you are complying with the terms and conditions of your policy.

Disclaimer: This article is written from an insurance perspective, and is meant to be used for informational purposes only. It is not the intent of this article to provide legal advice, or advice for any specific fact, situation or circumstance. Contact legal counsel for specific advice.