Assume for a moment that a Summons and Complaint arrives at your office. After an unpleasant exchange with the process server, you close your office door, shut off your phone, and begin reading through the numerous allegations. As you plow through the legal jargon, you find you are being sued for alleged negligence that occurred as part of services rendered more than 5 years ago. You remember the difficulties you and your staff encountered dealing with this client and completing your assignment.

You need to report the claim. However, you’ve switched insurers four times in the past five years, and achieved dramatic reductions in your premium costs. Which of the four companies will respond to defend and settle this claim? What factors determine insurance coverage in a situation where a claim is made many years after the project is completed? Were you careful to preserve coverage for prior acts each time you changed insurers? Who can you turn to for help to untangle this mess?

Claims-Made or Occurrence Form?

Two widely differing approaches are used by insurers to determine coverage when writing liability insurance. The difference centers upon the event that triggers coverage, and is known as the “coverage trigger.” The two approaches are known as “claims-made and reported” (“claims-made”) and “occurrence.”

A review of your present liability insurance program will reveal both claims-made and occurrence policy forms as part of your risk management program. For example, your business package policy may include commercial general liability insurance written on an occurrence basis. Your employee benefits liability, professional liability and employment practices liability insurance will use the claims-made coverage trigger.

The differences between claims-made and occurrence forms

The occurrence policy’s coverage trigger is tied to the date of the event or accident giving rise to the claim. Under an occurrence contract, the policy in force on the date of the event causing the loss must respond with both defense and indemnity. The claim may arise years after the policy has expired, and the occurrence coverage trigger places little or no importance on the date the insured receives notice of the claim.

In the case of a claims-made policy, however, determination of coverage is triggered by the date you first became aware and notify the insurer of a claim or poten-
The insurer’s policy in force on the date you became aware and give notice is the insurer who must defend and settle the claim.

Prior acts coverage

Occurrence policies do not provide coverage for prior acts. They do remain available for claims that arise years after they have expired. If an accident or event occurs during the term of an occurrence policy, that policy must respond to any future claim.

A claims-made policy may reach backwards in time and provide coverage for claims made today from negligent acts, errors or omissions that occurred years before the policy was purchased. As outlined later, several conditions must be met before prior acts coverage is granted.

Advantages of claims-made insurance

Claims-made policies offer a number of advantages to both the insurance company and the insured.

Advantages to the insured

They allow you to insure the risks resulting from your past services under your present policy. As a result, you can consider both economic and social inflation when setting policy limits and deductibles.

In addition, most policies contain “annual aggregate” limits which protect you from having prior claims reduce the coverage available for your prior acts exposure.

Advantages to the insurance company

Claims-made insurance allows for a close match between premium dollars and claims. Shortly after the expiration of a claims-made policy, an insurer can close its books and determine its profit or loss. Under an occurrence policy, an insurer cannot determine its profit or loss for decades because of possible incurred but not reported claims.

Disadvantages of claims-made insurance

The primary disadvantage of claims-made insurance is its complexity. This presents challenges for the insurance professionals writing these policies, and makes the purchase of proper coverage difficult for the consumer.

A second disadvantage is the necessity of following precisely the notification procedures for claims and potential claims situations. Because coverage is triggered by your awareness and notification of a claim or potential claim situation, failure to properly provide notification to the insurer will eliminate coverage. The following examples show how this can be a problem.

Example 1

Assume a design professional changes professional liability insurance carriers and fails to notify the expiring carrier of his knowledge of a potential claim situation. Should the matter later develop into a lawsuit, both the old and new insurer will deny coverage based upon a breach of the notification requirements.

Changing from one claims-made policy to another can be accomplished without gaps, but it requires careful compliance with each policy’s reporting provisions.

Example 2

Assume a design professional retires from practice and simply does not renew her claims-made policy. All coverage for prior services ceases once a claims-made policy is allowed to expire. A special endorsement known as an “Extended Reporting Period,” “tail” or “run-off” can be used to solve this problem, but it is not without cost.

Basic claims-made principles

Four conditions trigger a claims-made policy:

1. The insured design professional must receive his/her first notification of a claim or potential claim situation during the policy period.
2. The claim or potential claim situation must be reported to the insurer during the policy period.
3. The negligent act, error or omission giving rise to the claim must occur after a “prior acts” or “retroactive” date that is set forth in the policy declarations.
4. The insured must make a “good faith” statement (in some cases, a certification or warranty) that the design professional and the firm had no knowledge of the mistake, error or controversy on the date coverage was purchased.

“Prior acts” date

(Continued on page 3)
determines retroactive coverage

The “prior acts” or “retroactive” date is an important element in a claims-made policy. The policy declaration page will clearly identify a “prior acts” date that determines the extent of retroactive coverage. Claims resulting from services rendered before the “prior acts” date are not covered.

The prior acts date is a critical item for negotiation and discussion at the time you purchase insurance. Your objective is to negotiate a prior acts date that coincides with the first date you and your predecessors provided services. Your insurer may be reluctant to provide you with extensive prior acts coverage, especially if you are presently uninsured or have gaps in your past insurance.

Claims-made reporting requirements

The reporting requirements set forth in a claims-made policy are also an important factor in determining coverage. Pay special attention to the reporting requirements applicable to both claims and potential claims situations. Most policies state the notice requirements in the Conditions section of the insurance contract. Read and comply strictly with these conditions to preserve your coverage.

Most claims-made policies include a provision that allow you to notify your insurer of a potential claim situation (sometimes called an “awareness provision”) and requires the insurer to accept this notification as the coverage trigger for any future claims. This is important because many claims begin as complaints or controversies that take months, and sometimes years, to develop into actual claims.

Claims-made policies are complex

Your professional liability contract of insurance is the centerpiece of your risk-management program. As such, it is imperative that you understand just how the claims-made coverage trigger works.

Test your Professional Liability Loss Prevention IQ

Do you know as much about professional liability loss prevention as you should?

Following are 12 true/false statements about loss prevention and related concerns. Take your best shot at determining the correct response to each, and then review our answers to see if you’re on target!

Questions:

1. Requesting extensive financial information from a prospective client is unprofessional, and almost a guaranteed client turn-off. True/False

2. The nice thing about dealing with public agencies is their creditworthiness. They always pay their bills. True/False

3. When a client directs a design professional to take an action that will violate the standard of care, the design professional should document all details before following the client’s dictates. True/False

4. Most professional liability insurance policies cover the indemnifications clients
commonly request. True/False

5. As severe as professional liability exposures may be, exposures related to employment practices such as wrongful termination, sexual harassment and discrimination may be just as bad. Employment practices liability insurance is available to cover most such exposures. True/False

6. Although a breach of contract rider can be a somewhat costly additional element of most professional or commercial general liability policies, the protection provided is worth the price. True/False

7. A design professional’s certification of facts is generally acceptable. Certification of opinions can be dangerous. True/False

8. Most A/E claims are filed within 6 months of submission of contract documents. True/False

9. Because of personal liability, design professionals can make themselves “judgment proof” only by dying. True/False

10. With a few exceptions (due to state laws), contractors may not sue design professionals for purely monetary damages. True/False

11. Although limitation of liability is effective, design professionals are much better off with a full indemnification. True/False

12. Limitation of liability works only in states without anti-indemnification statutes. True/False

1. False. Helping to ensure clients’ creditworthiness is not at all unprofessional. Most clients are familiar with the procedures needed to obtain credit.

2. False. Design professionals should be certain that a public entity has received funding for the work involved. In some cases, municipalities “jump the gun,” leaving the design professional holding the bag.

3. False. Design professionals should never knowingly violate the standard of care. Doing so could nullify professional liability insurance coverage, and expose them to severe legal sanctions. If the client states that “So & So Associates down the street will do it,” let the client deal with So & So.

4. False. Clients frequently ask for indemnifications that are not insurable. Accepting them dramatically increases liability exposures while simultaneously eliminating professional liability insurance coverage.

5. True. Ask your agent about such coverage.


7. True. A certification often can be interpreted as a guarantee. As with indemnifications, the end result can be a significant increase in liability exposure and elimination of professional liability insurance coverage.

8. False. Typically, claims are filed within 2 to 3 years of the completion of a project.

9. False. Even death may not afford protection. As long as the estate still exists, it can be sued for damages resulting from the deceased’s prior professional acts.

10. False. Know the law in your state. In many states, contractors may sue design professionals for purely monetary damages.

11. False. A full indemnification for professional negligence is seldom enforceable. As such, it would be the same as no indemnification at all. The courts consider limitation of liability a reasonable alternative. When the provision is properly drafted, they usually will enforce it.

Answers:

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Scoring:

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