Commonwealth of Massachusetts

SUPREME JUDICIAL COURT

FOR THE COMMONWEALTH OF MASSACHUSETTS.

CASE NO. SJC-09834

ALLMERICA FINANCIAL CORPORATION, SMA FINANCIAL CORPORATION, FIRST ALLMERICA FINANCIAL LIFE INSURANCE COMPANY and ALLMERICA FINANCIAL AND LIFE INSURANCE AND ANNUITY COMPANY,

Plaintiffs/Appellants,

v.

CERTAIN UNDERWRITERS AT LLOYD'S LONDON WHO ARE MEMBERS OF SYNDICATES 1212, 435, 1173, 79, 1207 AND 623

Defendants/Appellees.

ON APPEAL FROM A JUDGMENT OF THE WORCESTER SUPERIOR COURT

BRIEF OF AMICUS CURIAE UNITED POLICYHOLDERS, INC. IN SUPPORT OF PLAINTIFFS/APPELLANTS

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INTEREST OF AMICUS CURIAE

Amicus curiae, United Policyholders, was founded in 1991 as a non-profit organization dedicated to educating the public on insurance issues and consumer rights; it is a tax exempt organization under Internal Revenue Code §501(c)(3). United Policyholders is supported by financial donations, grants and by the volunteer work of insurance law practitioners throughout the United States.

In addition to presenting *amicus* briefs in cases affecting policyholders in general, United Policyholders serves as a resource on insurance claims for disaster victims and commercial policyholders; provides pre and post-loss claims education; and is an information clearing house on consumer issues related to commercial and personal lines insurance products. United Policyholders receives frequent invitations to testify at legislative and other public hearings, and to participate in regulatory proceedings on rate and policy issues.

A diverse range of policyholders throughout the United States communicate on a regular basis with United Policyholders, which allows us to provide important and topical information to courts throughout the country *via* the submission of *amicus curiae* briefs in cases involving insurance principles that are likely to impact large segments of the public.

In the following brief, United Policyholders seeks to fulfill the "classic role" of *amicus curiae* by assisting in a case of general public interest, supplementing the efforts of counsel and drawing the Court's attention to law that escaped the trial court's consideration." *Miller-Wohl Co., v. Commissioner of Labor & Ind*, 694 F.2d 203, 204 (9th Cir. 1982). As commentators have often stressed, an *amicus* is often in a superior position to "focus the court's attention on the broader implications of various possible rulings." *R. Stern, E. Greggman & S. Shapiro, Supreme Court Practice,* 570-71 (1986) *(quoting B. Ennis, Symposium on Supreme Court Advocacy: Effective*

Amicus Briefs, 33 Cath. U.L. Rev. 603, 608 (1984)) Symposium on Supreme Court Advocacy: .

United Policyholders has filed over two-hundred twenty-five (225) *amicus* briefs since it was founded. Most recently, our brief was considered and discussed by the California Supreme Court in *Julian v. Hartford Underwriters Ins. Co.*, 110 P.3d 903 (2005). United Policyholders' *amicus* brief also was cited in the U.S. Supreme Court's opinion in *Humana Inc. v. Forsyth*, 525 U.S. 299, 119 S. Ct. 710, 142, L. Ed 2d 753 (1999). We have been invited by several divisions of the California Court of Appeals, to participate in oral argument as *amicus curiae*. Arguments from our *amicus curiae* briefs were cited with approval by the California Supreme Court in *Vandenburg v. Superior Court*, 982 P.2d 229 (1999) and contributed to *Watts Indus., Inc. v. Zurich Am. Ins. Co.*, 18 Cal. Rptr. 3d 61 (Cal. Ct. App. 2004). United Policyholders was the only national consumer organization to submit an *amicus brief* in the landmark case of *State Farm Auto Ins. Co. v. Campbell*, 538 U.S. 408, 123 S. Ct. 1513, 155 L. Ed. 2d 585 (2003). United

Policyholders' active role as *amicus curiae* is testament to its position as the foremost leader in addressing the modern dilemmas faced by policyholders in today's insurance markets.

United Policyholders trusts that this submission can be of assistance to both counsel and this Court by focusing on the public policy and practical considerations associated with multilayered "follow-form" insurance programs, and by bringing to this Court's attention the broader implications associated with the narrow issue before the Court. (United Policyholders hereinafter is referred to as "Amicus").

I. STATEMENT OF THE ISSUE ADDRESSED BY THE COURT'S AMICUS

The fundamental issue on which this Court has requested the submission of an *amicus curiae* brief is "whether an excess insurer, having provided a follow-form excess insurance policy, is bound by the primary insurer's determination of the primary policy's applicability in the settlement of a class action suit that exhausted the primary policy." *See* e-mail notice of Docket Entry dated October 13,

2006. The suggested answer to that question is an emphatic "yes".

II. STATEMENT OF THE CASE

The facts and procedural history of this case are fully set forth in the briefs submitted by the parties. Accordingly, *Amicus* incorporates by reference the facts and procedural history set forth in those briefs.

III. SUMMARY OF THE ARGUMENT

This is a case in which the trial court allowed a follow-form excess insurer to contest the good-faith coverage decisions of a primary insurer concerning the negotiated terms of manuscripted portions of the primary insurer's policy in the context of a class-action settlement that reached the follow-form insurer's limits, triggering its obligation to pay.[1] In doing so, the trial court disregarded the intent of the parties to the primary policy as well as the purpose and structure

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[1] Memorandum of Decision and Order on Defendants' Motion for Summary Judgment and Plaintiff's Cross Motion for Summary Judgment. September 27, 2994 (Agnes, J.). (Addendum 1).

of the policyholder's follow-form insurance program. The trial court effectively re-wrote the policyholder's follow-form excess policy and created rights that a follow-form excess insurer does not possess. *See, infra*, at 10-14. It thus enabled the follow-form insurer to avoid paying excess insurance benefits upon exhaustion of the primary limits and forced the policyholder to either personally shoulder a multi-million liability that the follow-form insurer is obligated to bear or continue to engage in litigation to establish the intent of the primary coverage, an intent already conceded by the primary insurer through the exhaustion of its $20 million limit of primary coverage. *See, infra, id.*

Here, Lloyd's follow-form excess policy expressly "subjects" Lloyd's to the terms, limitations and conditions of the primary policy to the extent the primary policy is not inconsistent with Lloyd's own policy form. Among the "not-inconsistent" conditions of the primary policy is the primary insurer's explicit right to control and associate itself in the defense and settlement of

the underlying litigation. *See, infra*, at 14-24. The primary insurer's right to control necessarily extends to all good faith decisions it makes in the exercise of that control, including the determination of whether to exhaust its limit in the settlement of a claim. *See, infra* at 23-28. Because Lloyd's has expressly agreed to "subject" itself to the primary's insurer's control of the defense and settlement, it is bound by all good-faith determinations made in the exercise of that control, including all decisions leading to the exhaustion of the primary limits. *See, infra, id.*

Lloyd's policy does not contain any terms inconsistent with the relinquishment of control to the primary insurer. Nor does it preserve the right to question or second-guess the primary insurer's motivations for entering into a good-faith settlement with a third-party claimant which results in the exhaustion of the primary policy limits. *See, infra*, at 11-14. Simply stated, as a follow-form insurer, Lloyd's is bound by the fact of exhaustion and cannot contest "whether"

exhaustion of the primary limits should have occurred. *See, infra, id.*

Any other result would unjustifiably reduce the value of follow-form multilayered excess insurance programs. *See, infra* at 31-43. If a follow-form insurer were not required to pay the benefits of the excess policy upon the good-faith exhaustion of the primary limits and, instead, even in the absence of fraud or bad faith, were permitted to contest the intent of the primary policy and/or coverage decisions of the primary insurer, it would have *carte blanche* to upset the multi-layered coverage program that the policyholder had paid for. *See, infra,* at 43-48. Allowing such open-ended second-guessing would do violence to the public policy interest of encouraging good faith settlements and discouraging protracted litigation. Likewise, claimants would be deprived of the prompt and full payment of settled claims and policyholders unfairly would be exposed to personal liability for contested portions of settled claims. *See, infra, id.* In addition, coverage litigation would spawn at each

and every layer of a multilayer-follow-form program where disgruntled excess insurers could raise either the same arguments or new and creative arguments to avoid or delay the payment of excess policy benefits. *See, infra, id.*

Affirming the trial court's decision would frustrate one of the primary purposes of follow-form insurance, *viz*, achieving the peace of mind and confidence that consistent and predictable coverage exists throughout each follow-form layer. *See, infra, id.*

In short, allowing the follow-form excess insurer to attack the good-faith coverage and/or third-party settlement decisions of the only party with the "right" to make those decisions would deprive a third-party claimant of the full benefit of its good-faith settlement with the policyholder; expose policyholders to personal liability that the follow-form insurer promised to pay; and encourage a litigious and chaotic environment where a policyholder could not achieve the bargained-for peace of mind, certainty and predictability which

it sought by designing a multilayered follow-form insurance program. *See, infra* at 31-43; 43-48.

IV. ARGUMENT

A. Lloyd's Duty To Pay Is Triggered By The Exhaustion Of The Underlying Primary Policy.

As a follow-form excess insurer, Lloyd's assumed the risk that there would be a judgment or settlement that exhausted the combined amount of the policyholder's self-insured retention and CNA's primary policy limit.[2] Lloyd's policy simply provides, in pertinent part, as follows:

> 2. The Underwriters' Liability to pay under this Policy shall attach only when the Underlying Insurer(s) shall have paid or have been liable to pay, the full amount of the Underlying Limit(s) shown in Item 6 of the schedule and then for no more than the Limit of Liability shown in Item 5 of the Schedule subject, however, to Condition 3 of this Policy.
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> . . .

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[2] *See* Windt *Insurance Claims and Disputes: Representation of Insurance Companies and Insureds*, §6:45A (4th Ed. 2001, Supp. 2006) at 157. at p. 157. ("The risk that the primary carrier would make a mistake is a risk that the excess carrier assumed under the terms of its contract.")

> 3. In the event of exhaustion of the Underlying Limit(s) by payment of claims this Policy shall:
>
> . . .
>
> (b) If exhaustion be complete, continue in force in place of such Policy(ies) of Underlying Insurers;
>
> Subject always to the Limit of Liability as stated in Item 5 of the Schedule.

A 781, A855.[3]

Lloyd's did not condition its "Liability to pay" upon its agreement with the way in which CNA controlled the defense, determined coverage, or achieved settlement. Lloyd's policy does not say that its "Liability to pay" is triggered only if it concurs with CNA's coverage determinations, or how CNA controlled the defense, or the reasons why the underlying limits were exhausted. Rather, the

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[3] The terms "pay" and "exhaustion" are not defined by Lloyd's policy. The ordinary meaning of those terms, however, are clear and simple. In the context of an insurance policy, the word "pay" means "to satisfy the claims of (a person, organization, etc.) as by giving money due:" Dictionary.Com Unabridged (V.1.1); the term "exhaustion" means "the total consumption of something:" *Id.*

plain structure and language of Lloyd's policy unequivocally requires it to pay upon the occurrence of one and only one condition - the exhaustion of the primary policy limits.

The fact that primary-limit exhaustion is the single event that triggers Lloyd's obligation to pay is reinforced by the "drop-down" provision set forth in "Condition 3(b)" of Lloyd's policy. That provision obligates Lloyd's to continue in force as primary insurance in the event of the complete exhaustion of the underlying primary policy in excess of the self-insured retention. *See Times-Picayune Pub. Corp., v. Zurich Am. Ins. Co.*, 421 F. 3d 328, 335 (5th Cir. 2005) (held that the most straightforward construction of a follow-form policy's insuring agreement and "drop down" provision is that the excess insurer's "duty to pay is triggered by a single condition: the exhaustion of the underlying primary policy by actual payment of benefits").

The self-imposed deference that a follow-form excess insurer agrees to give to the primary insurer has been described as the excess insurer

being "at the mercy" of the primary insurer's "judgment." "The excess carrier usually does not have the *right* to exercise *control* in the investigation and legal handling, and is, to a large degree, much 'at the mercy' of the primary's judgment (or lack thereof). The primary is, in fact, 'almighty' through the course of the claim and trial - until the 'doomsday' of excess judgment - when the roof and other things fall in." *Hardies, Guiding Principles (And Principals) in Primary and Excess Problems*, 655 *Insurance Law Journal 469, 473 (August, 1977)*.

These sentiments were echoed by the Sixth Circuit Court of Appeals in Amway *Distribs. Benefits Ass'n v. Northfield Ins. Co.*, 323 F.3d 386 (6th Cir.2003), where the court stated: "The real question, then, is whether an excess carrier . . . is bound as a matter of law by the underlying carrier's failure to comply with the renewal rule. We believe that the answer is 'yes' because *the 'follow-form' linkage between an excess insurer and the primary insurer should logically apply to procedural as well as*

substantive obligations to their common insured. In effect, an excess insurer who lives by the sword must die by the sword." *Id.* at 393 (emphasis added).[4]

Thus, Lloyd's cannot, on the one hand, agree to coverage upon exhaustion of the underlying limits and, on the other, challenge the good-faith reasons for such exhaustion when Lloyd's is called upon to perform its contractual obligation to pay.

B. Lloyd's Agreed To "Subject" Itself To All Good-Faith Decisions Made By The Primary Insurer Concerning The Defense, Settlement And Coverage Of The Underlying Action.

Because Lloyd's agreed to pay upon the exhaustion of CNA's primary policy limits and voluntarily relinquished control of decisions

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[4] The "Renewal Rule" referred to by the court is a rule under Michigan Law imposing upon a primary insurer the affirmative obligation to notify its insured of any change in coverage in its renewal policy; where notice of a reduction in coverage is not given, the primary insurer is bound to the more extensive coverage in the earlier policy. In *Amway*, the Court found that like the primary insurer, a follow-form excess insurer also was bound as a matter of law by the application of the "Renewal Rule" to the primary insurer.

concerning the defense, settlement and, by necessary implication, coverage, Lloyd's irrevocably bound itself to all good-faith decisions made by CNA that culminated in triggering Lloyd's obligation to pay. One respected commentator who has examined an excess insurer's limited ability to contest a settlement that exhausts the primary policy and pierces the excess layer concludes that, absent fraud or bad faith, an excess insurer is unalterably bound by the exhaustion of the primary limits, including all decisions such as the coverage determinations leading to that exhaustion.

In his often-quoted treatise, *Windt, Insurance Claims and Disputes: Representation of Insurance Companies and Insureds,* Windt concludes that a follow-form insurer cannot contest a primary insurer's good-faith motivation for resolving a claim on behalf of its policyholder because "excess insurers are bound by what they agreed to do under the terms of their insurance contracts", *viz*, pay upon the exhaustion of the primary limits. *Id.* at 153-154.

First, Windt observes that typical follow-form policies, like the Lloyd's policy at issue here, do not allow an excess insurer to challenge the basis upon which the primary insurer decides to exhaust its primary limits. Instead, the excess insurer is bound by the fact of exhaustion. *Id.* at 153-154.

Second, Windt concludes that because of: (1) the "far-reaching" duties owed by the primary insurer to its policyholder; (2) the discretion with which the primary insurer is vested; and (3) the primary insurer's absolute right to use its own money to make settlement payments, a follow-form insurer "cannot challenge the [primary insurer's] judgment" to exhaust its limits in the settlement of a claim. *Id.* at 155-56.

Here, the primary policy vests the primary insurer, Columbia Casualty Company ("CNA"), with the right to control the defense and settlement of any claim above the self-insured retention. A804.[5]

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[5] CNA is defined as the "Insurer" and is "the Insurer designated in the Declarations…". CNA's

(continued . . .)

Although CNA is not obligated to provide a defense as such, its policy preserves CNA's right to control the defense and settlement of claims. For example, CNA's primary policy forbids the policyholder from, among other things, admitting to any liability, consenting to any judgment, agreeing to any settlement or incurring any defense costs without CNA's prior written consent. *Id.* CNA's primary policy also preserves CNA's right to consent to the policyholder's selection/retention of defense counsel, the right to associate itself in the defense and settlement of claims, and the right to recommend that the

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(continued . . .)

policy subjects the policyholder to the provisions of the Policy. See CNA Policy at p. 3, **"Insurance Company Executive Risk Policy"** which states "In consideration of the payment of the premium and in reliance upon all statements made in the **Application** furnished to the Insurer designated in the Declarations . . . and subject to the provisions of the Policy, the Insurer and the **Allmerica Financial Insureds** agree as follows:")(A789). Lloyd's is not a party to the primary policy and is not the "Insurer" under that policy.

policyholder accept an offer or proposal to settle. *Id.*[6]

Nothing in Lloyd's policy is inconsistent with the rights preserved by CNA. Instead, Lloyd's, like the policyholder, is expressly "subject to" and bound by the terms and conditions of the primary policy, including all rights preserved by CNA as the primary insurer. Lloyd's policy states: "This Policy is **subject to** the same conditions, limitations and other terms (except as regards the premium, the amount and limits of liability and the renewal agreement, if any and except as otherwise provided herein) as are contained or may be added to the Policy(ies) of the Primary Insurer(s)." *See* Lloyd's Policy at p. 3, §1 "Conditions" (emphasis added). A781 and A855.

As explained by Windt, since the primary insurer's preservation of the right to control the defense and settlement of claims vests it with the

[6] CNA, in fact, exercised its right to associate itself in the defense and settlement of the claim brought against Allmerica. A1004-1017.

absolute right to pay its own money to resolve claims on behalf of its policyholder, "[i]t should go without saying, . . . that those primary policy provisions are also enforceable against excess insurers . . . especially since (a) failing to enforce the provisions as written against an excess insurer could serve to penalize the insured, and (b) neither the insured nor the primary insurer entered into a contract with the excess insurers that contained a provision inconsistent with the provision vesting the primary insurer with the right to use its money to enter into settlements on behalf of the insured." *Id.* at 156. *See also Diamond Heights Homeowners Ass'n v. National Am. Ins. Co.*, 227 Cal. App. 3d 563, 579(primary insurer's duty to defend gives it the right to control the defense in an action based on a claim under its policy, and this right extends to all aspects of the defense, including the good-faith negotiation of a settlement prior to trial).

Moreover, Lloyd's agreement to incorporate and be "subject to" the terms and conditions of

CNA's policy precludes Lloyd's from now contesting the good-faith decisions made by CNA in exercising its right to control the defense and settlement of the underlying litigation, including its decision to exhaust its primary limits. When each policy is read together, it is inescapably clear that, as between them, CNA was solely responsible for controlling the defense and settlement of claims made against the policyholder.[7] The exercise of that responsibility necessarily required CNA to make coverage determinations under its primary policy. In discharging that responsibility, CNA

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[7] Because the Lloyd's excess policy "follows" and incorporates the terms and conditions of CNA's primary policy, the two policies must be read together as if forming a single contract. *See Samuel Williston & Richard A. Lord, A Treatise on the Law of Contracts* §30:25 at 232-33(4th Ed. 1999) ("Generally, all writings which are part of the same transaction are interpreted together." citing Restatement (Second) of Contracts §202(2)). Massachusetts courts have followed this rule of incorporation. For example, *Boston Ins. Co. v. Fawcett,* 357 Mass. 535, 258 N.E. 2d 771 (1970) involving the inter-relation between two different but related insurance policies); and *Travelers Cas. & Surety Co. v. Long Bay Management Co.*, 58 Mass. App. Ct. 786, 792 N.E. 2d 1013 (2003) (involving the incorporation of a construction contract's arbitration provision into the terms of a surety bond agreement).

in good faith determined that coverage existed. A1010-17. It exercised its rights to associate itself in the defense, to participate in structuring a settlement (a settlement judicially determined to be "fair, adequate and reasonable"), and to pay to exhaustion the $20 million limit of its primary coverage. A700-A738.

Because Lloyd's, like the policyholder, agreed to subject itself to the good-faith exercise of CNA's control, it has no basis upon which to challenge or second-guess any good faith decision made by CNA in the exercise of that control, including the coverage determinations that led to the exhaustion of the primary coverage.[8] There is no evidence that CNA did not

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[8] An excess insurer stands in the shoes of the policyholder *vis a vis* the policyholder's relationship with the primary insurer and assumes the rights as well as the obligations of the policyholder in that position. *See Hartford Cas. Ins, Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 124-125, 638 N.E.2d 14 (1994) (held that the rights of an excess insurer against a primary insurer are derivative of, an no greater than the rights of the insured); *see also* Anthony M. Lanzone and Stephen G. Ringel, *Duties of a Primary Insurer to an Excess Insurer,* 61 Neb. L. Rev. 259,

(continued . . .)

act in complete good faith in approving the settlement and agreeing to pay its policy limits.

Simply stated, Lloyd's is not a party to the primary insurance contract between the policyholder and CNA; had no contractual relationship with CNA; was owed no contractual duties by CNA; and had no right to control any aspect of CNA's good-faith discharge of its obligation to the policyholder to reasonably find

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265-266 (1982) (citing *Continental Cas. Co., v. Reserve Ins. Co.* 307 Minn. 5, 238 N.W.2d 862, 864 (1976)) ("Where there is no excess insurer, the insured becomes its own excess insurer, and his single primary insurer owes him a duty of good faith in protecting from an excess judgment and personal liability. *If the insured purchases excess coverage, he in effect substitutes an excess insurer for himself. It follows that the excess insurer should assume the rights as well as the obligations of the insured in that position").* (emphasis added); *See also Driggs Corp. v. Pennsylvania Mfrs' Ass'n Ins. Co.*, 3 F. Supp. 2d 657, 660 (D. Md. 1998, aff'd, 181 F.3d 87 (4th Cir. 1999) (court declined to rewrite insurance policy so as to have the effect of allowing a policyholder to "second-guess" and engage in "secondary litigation" over the decisions made by its primary insurer in exercising its control of the defense of a claim brought against the policyholder).

coverage and settle claims.[9] Thus, because Lloyd's agreed to subject itself to CNA's control of the underlying defense and settlement, it is bound by and has no basis upon which to challenge CNA's good-faith decision to exhaust its primary limits.

Lloyd's should not be permitted to rewrite its follow-form policy so as to enable it to condition its obligation to pay on any condition other than the exhaustion of the primary limits. Although the Lloyd's policy is "subject to" the same conditions, limitations, and other terms as are contained in CNA's primary policy, and although Lloyd's policy obligates Lloyd's to pay when CNA has paid its policy limits, Lloyd's argues in its brief (at page 43) that its policy is "separate and distinct" from CNA's primary policy and that Lloyd's is entitled to raise its

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[9] See *United States Fid. & Guar. Co.v. Tri-State Ins. Co.*, 285 F.2d, 581 (10th Cir. Okla.1960) (observing that the obligation of the primary insurer to the excess insurer "is not contractual and is based only upon the duty of the primary carrier to perform the obligation which it alone has assumed, that is, provide primary coverage.")

own policy defenses. In effect, Lloyd's would like to rewrite its policy to add a provision that would read something like the following:

> "Notwithstanding the fact that this policy incorporates by reference the same terms as are in the Policy of the Primary Insurer, this policy is a separate and distinct policy. Upon the Primary Insurer's payment of the Underlying Limit, Underwriters shall have the right to make their own independent determination as to whether the Primary Insurer's Limit should have been paid in view of the exclusions and other terms of the Primary Insurer's Policy. The payment of the Primary Insurer's Limit, even if made in good faith, shall not affect the right of Lloyd's to independently apply the exclusions or other terms of the Primary Insurer's Policy to disclaim coverage of the settlement or judgment in excess of the Primary Insurer's Limit."

No reasonably prudent buyer of excess insurance coverage would accept an excess policy that expressly stated the payment contingencies that

Lloyd's now says are inherent in its follow form excess policy.[10]

C. Prevailing Case Law Supports The Proposition That A Follow-Form Excess Insurer Is Bound By The Primary Insurer's Coverage Determinations.

Although we have found no decisions squarely addressing the precise question posited by this Court, our exhaustive review of the case law reveals that those courts which have been called upon to address similar issues are uniformly aligned in holding that a follow-form insurer is obligated to follow the "intent" of the primary

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[10] In its amicus brief (at p. 11), CICLA asserts that a primary insurer's decision to "settle" with the policyholder is irrelevant in determining an excess carrier's duties to the policyholder. This assertion and the three cases on which it is based, however are not applicable to the instant case. *See Koppers Co. v. Aetna Cas. & Sur. Co.*, 98 F.3d 1440, 1454 (3d Cir. Pa. 1996); *UMC/Stamford, Inc. v. Allianz Underwriters Ins. Co.*, 647 A.2d 182 (N.J. Super. Law Div. 1994; *Gould, Inc. v. Continental Casualty Co.*, 401 Pa. Super. 219, 585 A.2d 16 (1991). These cases all involved policyholders who settled coverage disputes with their primary insurer for less than the primary policy's limits. These cases are thus not applicable to the instant case, in which the primary carrier acknowledged coverage and paid its full policy limits. A1004; A1014-17; A1365 n. 5.

insurer and its insured.[11] We have found no decision that excuses a follow-form insurer from its duty to pay upon the exhaustion of the primary policy limits because it disagrees with the results of the good-faith coverage determinations made by the primary insurer in achieving a settlement that pierces the excess layers.[12]

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[11]Several of those cases have been cited and discussed in the Appellant's submissions to this Court and will not be re-examined here. *See Playtex FP, Inc. v. Columbia Casualty Co.*, 609 A.2d 1087, 1093-94 (Del. Super. Ct. 1991; *L. E. Myers Co. v. Harbor Ins. Co.*, 77 *Ill. 2d* 4, 394 N.E.2d 1200, 1203-04 (1979); *R.W. Beck & Assoc. v. City & Borough of Sitka*, 27 F.3d 1475, 1482-83 (9th Cir. Alaska 1994); and *Great Atlantic Ins. Co. v. Liberty Mut. Ins. Co.*, 773 F.2d 976, 980-81 (8th Cir. Mo. 1985) , cited at pages 45-46 of Appellant's Opening Brief; *see also* "Reply Brief of Appellants" and the cases cited therein at pp. 2-7.

[12] It is important to distinguish disputes involving **whether** primary limits have been exhausted from disputes, like here, in which the follow-form excess insurer disputes the reasons **why** exhaustion occurred. Questioning **whether** exhaustion has occurred is a legitimate issue to be raised by an excess insurer whose coverage is triggered by the event of exhaustion. *See e.g. Massachusetts Elec. Co. v. Travelers Cas. & Sur. Co.*, 2002 WL 31677203 (Mass. Super.) (involving dispute under an excess umbrella policy [not a follow-form policy] regarding whether the underlying primary limits had been exhausted);

(continued . . .)

The paucity of case law directly addressing the question raised is not surprising. As discussed in Part D below, the custom and practice in the insurance industry is that a follow-form excess insurer is bound by the primary insurer's good-faith decision to exhaust its limits, including all determinations leading to that exhaustion.

One court that was called upon to decide whether an excess follow-form insurer could

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(continued . . .)

Allstate Ins. Co. v. Dana Corp. 759 N.E.2d 1049, 1058-60 (Ind. 2001) (same). Questioning the reasons **why** a primary insurer decided to exhaust its limits, however, is not a right reserved by a follow-form insurer whose policy is triggered by the single event of the good-faith exhaustion of primary limits. *See* Windt, *supra*. Cases such as *Massachusetts Electric* and *Dana* are also distinguishable because the exhaustion issue in those cases depended on whether the primary policy contained aggregate limits, which in turn depended on how the policy was "Rated" - a factual issue that those courts held made summary judgment inappropriate. In addition, unlike the instant case, where the interests of the primary carrier (CNA) and the follow-form excess carrier (Lloyd's) are aligned, the interests of the primary and excess insurers in *Massachusetts Electric* and *Dana* were adverse on the key issue of whether the primary policy contained aggregate limits.

object, on coverage grounds, to a settlement that pierced the excess layers determined that it could not. In *Associated Wholesale Grocers v. Americold Corp.*, 261 Kan. 806, 934 P.2d 65 (1997), the Kansas Supreme Court addressed an issue of first impression concerning the effect of a "hostile fire 'exception endorsement'" on an "absolute pollution exclusion" clause of a primary liability insurance policy. That issue was set in the context of a multilayered-follow-form insurance program where coverage under the primary policy was seemingly inconsistent with the follow-form policy.

There, two follow-form insurers declined, on coverage grounds, to participate in the settlement of a liability suit arising from a long-burning and very smoky fire at an underground storage facility owned and operated by the policyholder. The estimated amount of third-party damage totaled $66 million. The policyholder carried liability protection through a follow-form insurance program with total limits of $41 million consisting of primary limits of $1 million and two follow-form

excess layers with limits of $25 million and $15 million respectively. *Id.* at 810.

The primary policy contained an absolute pollution exclusion clause. The scope of that exclusion, however, was limited by a hostile fire exception endorsement providing that the pollution exclusion did not apply to injury or damage caused by the heat, smoke or fumes of a hostile fire - a fire that becomes uncontrollable or breaks out from where it was intended to be. *Id.* at 822.

Each of the follow-form policies also were endorsed with absolute pollution exclusion endorsements. *Id.*at 822. Unlike the primary policy, neither excess policy contained a hostile fire exception endorsement. Coverage under each excess policy was triggered upon exhaustion of the primary policy limits. *Id.* at 816.

Following a court-ordered settlement conference, the primary insurer exhausted its limits in response to a policy-limits settlement demand. Neither excess insurer agreed to participate in the settlement and instead, relying upon their respective pollution exclusion clauses,

contested coverage. The policyholder thereafter negotiated a settlement significantly in excess of its available policy limits.

The Kansas Supreme Court concluded that the hostile fire amendment endorsement was part of the primary policy's coverage agreement and that the follow-form policy neither deleted that endorsement from its scope nor contained language saying that its terms, conditions and exclusions controlled over conflicting or inconsistent terms of the primary policy. *Id.* at 825. Accordingly, the court held that the follow-form excess policy included the same hostile fire coverage as did the primary policy. The court also found that the "reasonable expectations doctrine" was applicable and that the policyholder's coverage intent controlled. *Id.* at 825.[13]

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[13] Although it affirmed the trial court's coverage decision, the Kansas Supreme Court remanded the case to the trial court for a factual determination as to whether the excess insurer denied coverage in bad faith.

Associated Wholesale Grocers, supra, is consistent with the *Playtex* line of cases and supports the principle that a follow-form excess insurer is bound by the primary policy's coverage intent in the context of a settlement that invades the excess layers. Industry custom and practice also supports this proposition.

D. Industry Custom And Practice Confirms That A Follow-Form Excess Insurer Is Bound By The Primary Insurer's Good-Faith Coverage Determinations.

Follow-form excess insurance was created approximately seventy years ago in response to a spike in the frequency of catastrophic losses and the lack of adequate domestic capacity to address those losses.[14] At that time, the U.S. insurance market was protective of its domestic insurers.

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[14] See Randolph M. Fields, *The Underwriting of Unlimited Risks: The London Market Umbrella Liability Policy - 1950-1970*, Coverage, July-August, 1995 at 36-38. The term "capacity" is "the largest amount of insurance or reinsurance available from a company or from the market in general. An insurer's capacity to write business is often measured and/or limited by its premium-to-surplus ratio." International Risk Management Institute Inc., *Glossary of Insurance and Risk Management Terms*, 30 (6th Ed. 1996).

It restricted market participation by foreign insurers to the limited situation where a domestic insurer could not or would not provide insurance to domestic insureds.[15] That protectionism, however, collided with a growing demand for additional capacity. Domestic insurers could not satisfy that demand; foreign insurers could. The foreign market eagerly responded to that demand by creating the "excess market". The products developed by that emerging market included, among others, two types of excess insurance - excess follow-form insurance and stand-alone excess insurance.[16]

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[15] Fields, *supra* at 36.

[16] Stand-alone excess insurance was specifically developed and designed to provide coverage over a self-insured retention. Because there was no underlying contract or form which the stand-alone excess policy could follow, it contained its own insuring agreement, terms and conditions and provided coverage for multiple risks on a broad occurrence basis with few exclusions. *See* James A. Robertson, *How Umbrella Policies Started, Parts 1 and 2: The First Umbrella Forms*, available at "http://www.irmi.com/Expert/Articles/2000/Robertson -04.Aspx."(hereinafter "Robertson"). A stand-alone excess policy, in certain respects,

(continued . . .)

From its inception, the sole purpose of follow-form excess insurance has been to provide additional liability limits over a specific primary policy while retaining the primary policy's scope of coverage.[17] It is designed to protect the policyholder against the possibility that a claim will exceed the primary policy limits by providing a seamless web of consistent coverage as dictated by the intent of the primary policy.[18]

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is antithetical to a follow-form policy - a follow-form policy does not have an independent insuring agreement. Instead it is subject to the scope of coverage provided by the primary policy it is to "follow".

[17] Mitchell F. Dolin, Excess Defense Coverage and Long-Tail Liabilities, 32 Tort & Ins. L.J. 875, 886 (Spring, 1997)(hereinafter "Dolan") ("[T]he insured would want to be certain that this multilayered program provided a seamless web of consistent coverage."); see also *Commercial Union Assurance Cos. v. Safeway Stores, Inc.*, 26 Cal. 3d 912, 919, 610 P.2d 1038, 164 Cal. Rptr. 709 (1980) ("The object of the excess insurance policy is to provide additional resources should the insured's liability surpass a specified sum.")

[18] Dolin, supra at 886; Scott M. Seaman, *Excess Liability Insurance: Law and Litigation*, 32 Tort & Ins. L.J. 653, 657-658 (1997); ("[E]xcess insurance generally is written by design. This

(continued . . .)

To this day, the advantages of a seamless web of consistent coverage is regularly touted by the insurance industry in promoting follow-form excess policies. For example, the Zurich Insurance Company advises that its "following form excess liability policy locks right into each insureds' underlying trigger points to help eliminate coverage gaps, so insureds [can] sidestep conflicts with the controlling policy."[19] Chubb promotes its follow-form policy by explaining that it "[p]rovides you with excess limits of insurance

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type of insurance commonly is referred to as "following form" or "specific" excess coverage. Most major corporate insureds now obtain multiple layers of excess insurance to cover losses aggregating in the hundreds of millions of dollars . . . A "pure" following form excess contract, in essence, expands the limits of the underlying contract. "All it protects the insured against is the possibility that a claim will exceed the limits of the primary policy. [Citation omitted]").

[19] See *Excess Casualty - Commercial Umbrella & Following Form Excess Liability Insurance,* available at http://www.zurichna.com/zus/ZSource.nsf/print?-openForm&id=411&. (Copy attached at Addendum 2 for the Court's convenience).

that apply in the same manner as your underlying policy . . . [It]protects you whenever controlling underlying insurance protects you."[20]

Insurance industry publications likewise reinforce the promise of seamless consistency between the primary policy and the follow-form excess policies above it. For instance, one publication advises that to achieve multilayered coverage continuity, the policyholder "should require the [follow-form] excess policy to provide coverage on the same terms and conditions of the underlying policy(ies), including any endorsements."[21] Another industry publication explains that with a follow-form policy, "whatever is covered by the primary insurance will be

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[20] See *Excess Liability: Chubb Commercial Insurance,* available on-line at www.chubb.com/businesses/cc/chubb1655.html(Copy attached at Addendum 3 for the Court's convenience).

[21] *See* The Umbrella Book: Analysis of Commercial General Umbrella and Excess Liability Forms, Vol. I at p. 14 (Gary W. Griffin, ed., Griffin Communications, Inc. 2000) (1979) (hereinafter the "Umbrella Book").

covered by the excess [policy] as well."[22] These types of representations have created the expectation that "the duties of the following form excess insurer are determined by the intent of the underlying primary policy, unless specific provisions to the contrary exist in the excess policy."[23]

As a matter of industry custom and practice, the promise of a "seamless web of consistent coverage" is relied upon by policyholders and insurers alike in structuring multilayered follow-form risk management programs. Typically, most major corporations purchase multiple layers of follow-form insurance through a carefully-planned insurance program designed to protect against catastrophic loss.[24] "Large businesses purchase

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[22] *See* W. Jeffrey Woodward, *IRMI's CGL and Umbrella Insurance Guide,* Chpt 7 at p. 135 (Int'l Risk Mgmt. Inst. Inc. 1998).

[23] *See* Eugene R. Anderson, Insurance Coverage Litigation, §13.07[b] (Aspen 2006 Supp.) (Citations omitted).

(continued . . .)

liability insurance in 'layers' that begin with either primary liability insurance or a self-insured 'retention' . . . Businesses then purchase additional 'layers' of excess liability insurance . . . It is not unusual for the nation's large businesses to have excess 'programs' that provide a total of several hundred million dollars of liability insurance."[25] "[W]hen an excess policy is explicitly follow form . . . the policyholders' insurance program has obviously been designed with inter-policy consistency." (Citation omitted). *Id. at 226.*

A carefully designed follow-form insurance and risk management program is specifically structured to avoid "gaps" caused by differences

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[24] Michael M. Marick, Excess Insurance: An Overview of General Principals and Current Issues, 24 Tort & Insurance L.J. 715, 718(1989).

[25] Kenneth S. Abraham, *Environmental Liability Insurance Law: An Analysis of Toxic Tort and Hazardous Waste Insurance Coverage Issues (1991)*, Chpt. 6: Excess Coverage and Reinsurance Issues at p. 223.

in policy language.[26] Such programs are designed to assure that multiple insurance policies will respond to covered claims in an explicit sequential order pursuant to their respective attachment points.[27]

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[26] John F. O'Connor,, *Insurance Coverage Settlements and the Rights of Excess Insurers,* 62 Md. L.R. 30, 39 (2003) ("Indeed, in order to avoid gaps in coverage caused by differences in policy language, many excess insurance policies are 'following form' policies. . ." (citation omitted); *see also* Jeffrey W. Stemple, *Stemple on Insurance Contracts,* §16.01 at 16-5 (3d ed. 2006) ("The excess insurers' rights and responsibilities are then defined by the underlying policy except to the extent that the excess policy has specific wording differentiating one or more of its coverage provisions from the underlying policy. [citations omitted]. **This not only means following the language of the underlying policy, but also may mean the excess insurer is bound to any specific understanding between the primary insurer and policyholder unless the excess insurer has relied to its detriment on specific primary policy language at odds with the understanding of the policyholder and primary insurer.")** (Citations omitted) (emphasis added).

[27] O'Connor, *supra* at 40. (Explaining that with a multilayered-follow-form insurance program, "the multiple insurance policies in effect for a given year respond to covered claims in an explicit, sequential order. Once the primary policy exhausts its applicable policy limit(s) for a covered claim or type of covered claim, the first-layer excess policy or umbrella policy must respond. Once the umbrella policy has exhausted

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The purpose and structure of a multilayered follow-form program was scrutinized by the Delaware Superior Court in *Monsanto v. Am. Centennial Ins. Co.*, 1991 WL 35714 (Del. Super. Feb. 20, 1991)[28]. *Monsanto* is instructive because it examines the considerations of a policyholder in designing a multilayered-follow-form program so as to achieve the consistent and predictable coverage promised by follow-form insurance.

Monsanto involved a declaratory judgment action initiated to determine whether a follow-form insurer was obligated to follow the intent of the lead umbrella policy concerning coverage for and payment of defense costs. There, the excess insurer, American Centennial Insurance Company ("ACIC"), declined defense cost coverage for a

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(continued . . .)

its applicable policy limits, the next lowest excess policy responds, and so on.")

[28] *Monsanto* is an unpublished decision that was cited and relied upon by the Delaware Superior Court in *Playtex FP, Inc. v. Columbia Casualty Co.*, *supra* at note 10, page 23 .

claim that reached and exceeded its coverage layer. The policyholder contended that in establishing its multilayered-multi-million dollar program, it sought to assure consistent follow-form coverage, including defense cost coverage, through each tier of that program. The excess insurer thereafter issued a single-page policy specifying coverage simply as: "Excess Umbrella Liability - Following Form." *Id.* at p. 4.

To establish the intent of its follow-form program, the policyholder presented the testimony of its broker who testified that the goal of that program was to "make absolutely certain that they had continuity of coverage". *Id.* at p. 2. He explained, "[v]ery simply, if the policyholder is going to have a catastrophic loss, [it] wants to make sure that [it is] covered for the very many millions of dollars that it is going to represent, and there is no way that he [sic] wants anything other than the complete continuity of coverage." *Id.*

Significantly, in presenting his testimony, the policyholder's broker explained how a follow-

form program typically is presented to the excess market and the steps taken by excess insurers to determine whether to participate in such programs. It was explained that a follow-form program is presented to the market as a "monolithic block of coverage" in which excess insurers are given the opportunity to participate. *Id.* at p. 2. That "monolithic block" was aptly likened to a loaf of sliced bread standing vertically on its axis. *Id.* The loaf's ingredients, *viz* coverages, are decided upon by its bakers - the policyholder and its primary insurer. Once baked, the primary insurer takes the primary slice which, for purposes of this analogy, is the first slice at the bottom of the vertically standing loaf. The loaf is then presented to the excess market, leaving the excess insurers to decide which slice above the primary slice they wish to take.

A follow-form insurer is not free to change the loaf's basic ingredients. With minor exceptions, it either must accept those ingredients or decline to participate. If it participates, it cannot later complain about the

recipe, or question the bakers' choice of ingredients. Nor may it argue that it intended for different ingredients to be included in the slice it has chosen. Instead, if the primary slice is devoured, the excess insurer must be prepared to follow the primary insurer's lead and eat the slice it purchased.[29]

The *Monsanto* court found that the policyholder "intended" and "had every reason to expect . . .following form coverage" which the court equated with "continuity of coverage," including "coverage for defense cost in each layer." Id. at pp.2-5 (Findings of Fact 2-8). *Monsanto* confirms that insurance-industry custom

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[29] If a follow-form insurer declines to participate as an excess insurer in any of the underlying primary coverages, it must expressly identify coverages in which it is not participating. Typically, this is accomplished through the "except as otherwise provided" language of the follow-form policy and by attaching exclusion endorsement to the policy. Here, the only coverages that Lloyd's specifically excluded from its follow-form participation in the policyholder's insurance program was coverage for "Nuclear Incidents" and "Radioactive Contamination". A782-784, and A856-859. Neither exclusion is relevant here.

and practice mandates that an excess follow-form insurer be bound by the intent of the underlying primary insurer and the good-faith coverage determinations of the underlying primary insurer. Public policy considerations require the same outcome.

E. Public Policy Considerations Mandate That A Follow-Form Excess Insurer Be Bound By The Primary Insurer's Good-Faith Decision To Exhaust Its Primary Policy Limits.

The business of insurance is infused with a public purpose. Insurance is an economic necessity. It enables anyone from lone individuals to huge, multi-national corporations to plan for financial protection against the risk inherent in living and conducting business in a complex society. It provides for a safe harbor against losses that otherwise would individually or collectively disrupt our lives and financial security. It promotes a peace of mind, instilled

by a sense of certainty and predictability, that enables us as a society to plan and progress.[30]

"[C]ertainty - or rather, the quest for certainty - is the main reason for insurance . . . [W]e continue to buy insurance because it makes us feel more secure."[31] "With the certainty effect, buyers attach a greater-than proportional weight and value to eliminating a risk versus merely reducing it . . . From the buyer's perspective, the known premium now, in return for a larger payment later, if a loss occurs, is at the heart of insurance." *Id.* at 43. The purchase of an insurance policy provides a peace of mind and an expectation against loss.[32]

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[30] Roger C. Henderson, *The Tort of Bad Faith in First-Party Insurance Transactions: Refining the Standard of Culpability and Reformulating the Remedies by Statute*, 26 U. Mich. J.L. Reform 1, 10-14 (1992).

[31] Eugene R. Anderson, Esquire *Insurance - Foolproof or Fool's Gold?*, Environmental Claims Journal, 16 (1/Winter): 41, 42 (2004).

[32] Douglas R. Richmond, *Rights and Responsibilities of Excess Insurers*, 78 Denver Law Review 29, 34 (2000).

As demonstrated by *Monsanto*, supra, the "certainty" and "peace of mind" sought by a policyholder who designs a multilayered follow-form program is that consistent and continuous coverage exists throughout each excess layer; the promise of consistent and continuous coverage is the essence of follow-form insurance.

If a follow-form insurer whose coverage is triggered by the exhaustion of the underlying policy's limits were allowed to contest the good-faith coverage decisions which resulted in that exhaustion, the policyholder's bargained-for certainty and peace of mind would be worthless. Instead of being able to reliably predict and plan for the financial contingencies of potential liabilities, policyholders would be left only to guess at the novel interpretations each of its several follow-form insurers would attempt to impart to the primary policy language so as to avoid the obligation to pay upon exhaustion. A policyholder is entitled to rely on the intent of the parties as expressed in the language contained in its insurance contracts and should not have to

guess about the scope of coverage provided by its follow-form policies. *See In re Healthsouth Corp. Ins. Litig.*, 308 F. Supp. 2d 1253, 1284 (N.D. Ala. 2004)., .

If "follow-form" meant that each insurer could impose its own interpretation of the language to be followed, the purpose of follow-form insurance would be thwarted; and the promise of consistency, predictability and peace-of-mind would be hollow and misleading. Instead, the only thing a policyholder could predictably rely upon would be frequent secondary litigation in which follow-form insurers at each layer of a multilayer program could challenge the coverage intent of the policyholder and its primary insurer.

Permitting such after-the-fact second-guessing would expose both the policyholder and the claimant to additional litigation in violation of Massachusetts public policy in favor of ensuring prompt recovery to injured claimants. *See Bergstresser v. Cooke,* 12 Mass. L. Rep. 466, 2000 WL 1909784 at 7 (Mass. Super.Ct. 2000) (The public policy of ensuring recovery to injured

claimants is "[t]he very purpose of liability insurance - to shield the [policyholder] from the consequences of its fault."); *Mission Ins. Co., v. United States Fire Ins. Co.*, 401 Mass. 492, 517 N.E.2d 463 (1988) (Massachusetts public policy favors the reimbursement of injured parties); *U.S. Fire Ins. v. Peerless Ins. Co.*, 18 Mass. L. Rep. 64, 2004 WL 1515591 (Mass. Super. Ct. 2004) (Addressing the right of a primary insurer to seek reimbursement from a triggered excess policy so as to encourage insurers to promptly protect their insureds and to resolve disputes among themselves afterwards).

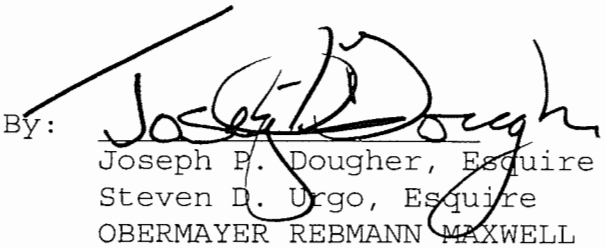
Moreover, secondary litigation against policyholders' insurance brokers and/or risk management consultants would be more likely. For instance, a policyholder who purchased follow-form insurance based on a broker's and/or risk management consultant's representation that "follow-form" meant that excess benefits would be paid upon the single event of primary-limits exhaustion, most likely would join that broker and/or risk management consultant in any

litigation where a follow-form insurer adopted Lloyd's tact of arguing that its agreement "to pay" upon "exhaustion" really meant that it would pay only if it agreed with the reasons why primary-limits exhaustion occurred.

V. CONCLUSION

The explicit language of Lloyd's "follow-form" policy, case law, industry custom and practice, and public policy considerations mandate that the trial court's grant of summary judgment in favor of Lloyd's be reversed and that Lloyd's do what it promised to do - "pay" upon exhaustion of the underlying limits.

Respectfully submitted:

By: 

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April 17, 2007

ADDENDUM ONE

COMMONWEALTH OF MASSACHUSETTS

WORCESTER, ss. SUPERIOR COURT
CIVIL ACTION
NO. 02-2075

ALLMERICA FINANCIAL CORPORATION, SMA FINANCIAL CORPORATION, FIRST ALLMERICA FINANCIAL LIFE INSURANCE COMPANY, and ALLMERICA FINANCIAL AND LIFE INSURANCE AND ANNUITY COMPANY,

vs.

CERTAIN UNDERWRITERS AT LLOYD'S LONDON Who are Members of SYNDICATES 1212, 435, 1173, 79, 1207, and 623,

MEMORANDUM OF DECISION AND ORDER ON DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND PLAINTIFF'S CROSS MOTION FOR SUMMARY JUDGMENT

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The plaintiff, Allmerica Financial Corporation, SMA Financial Corporation, First Allmerica Financial Life Insurance Company, and Allmerica Financial and Life Insurance and Annuity Company (Allmerica), filed this action alleging breach of contract against the defendant, Certain Underwriters at Lloyd's London Who are Members of Syndicates 1212, 435, 1173, 79, 1207, and 623 (Underwriters), arising from the excess insurance policy that Underwriters issued to Allmerica. The matter is before this court on the defendant's motion for summary judgment under Mass. R. Civ. P. 56 on the issue of liability. The plaintiff has filed a cross motion for summary judgment. For the reasons discussed below, the defendant's motion for summary judgment is ALLOWED, and Allmerica's cross motion for summary judgment is DENIED.

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BACKGROUND

The parties appear in agreement that there are no disputed facts material to the resolution of this case. The undisputed facts set forth in the summary judgment record are as follows.

Allmerica is engaged in selling life insurance policies. In 1992, D.P. Jowers filed a lawsuit[1] (Jowers) against an affiliate of Allmerica alleging that the affiliate and/or its agent had engaged in "a pattern or practice of fraud or other intentional wrongful conduct" and its agent had made misrepresentation regarding the performance of Jowers' policy. Allmerica's affiliate ultimately reached a settlement agreement in the Jowers case.

In 1996, Columbia Casualty Insurance Company (CNA) issued insurance policy number 16180518 to Allmerica for coverage of $20 million dollars during the period of August 29, 1996 through July 1, 1997, relating to professional services liability. This policy was subject to a single $2.5 million dollar retention for each "claim" under the policy. In addition, Allmerica obtained an excess insurance policy, number 757/FD961641, of $10 million dollars through Underwriters for coverage during the same policy period. With this policy, Underwriters provided coverage in excess of the primary policy issued by CNA. The Underwriters' policy was a "follow form" policy, which means that it incorporated the terms set forth in CNA's primary policy. The following year, CNA and Underwriters provided Allmerica with renewed policies for the period of July 1, 1997 through July 1, 1998. These policies were practically mirror images of the policies that CNA and Underwriters had issued to Allmerica the year before.

In October 1997, a group of individuals filed a class action lawsuit in the Federal District Court of Massachusetts (Bussie Class Action) alleging improper sales practices by Allmerica

[1] D.P. Jowers v. SMA Life Assurance Co., Civ. No. 92-1908-G (Ala. Super. Ct. filed Aug. 26, 1992).

"directly and through their nationwide sales force of agents, representatives and brokers" arising from alleged misrepresentations during the sale of life insurance policies. Among its complaints, the Bussie Class Action alleged that Allmerica had made misrepresentations, directly or through its agents, regarding the future value or performance of the policies. In addition, the Bussie Class Action claimed that Allmerica made misrepresentations, directly or through its agents, pertaining to a "vanishing premium" scheme.[2] Since 1990, Allmerica received about 700 complaints from its customers, 300 of which pertained to the actions alleged in the Bussie Class Action.

After discovery and negotiations, Allmerica and the Bussie plaintiffs reached a settlement in November of 1998. On March 19, 1999, Judge Gorton of the Federal District Court of Massachusetts issued a memorandum decision certifying the class and approving the settlement as fair, adequate, and reasonable. The settlement provided the approximately 400,000 members of the Bussie Class Action the option of General Policy Relief or Individualized Relief, which involved an alternative dispute resolution process to determine the level of relief that a class member was entitled to under criteria set forth in the settlement agreement. Allmerica incurred costs of approximately $39.4 million dollars arising from settlement payments, attorneys' fees, administrative costs, and implementation of the Individualized Relief Plan.[3] After discussions between CNA and Allmerica, CNA agreed to pay the full amount of its policy to Allmerica, indicating that it interpreted the policy as covering the Bussie Class Action.

Upon review of the settlement agreement, Underwriters notified Allmerica that it

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[2] A "vanishing premium" policy relies upon interest rates to generate income that will cover the policy premiums so that the policyholder is not required to pay any further premiums.

[3] The motions for summary judgment before this court pertain to liability only. The issue of damages is not at issue and is, therefore, not decided by this decision.

interpreted the Bussie Class Action as not falling within the policy's coverage. In particular, Underwriters drew attention to provisions III.b. and III.g. as the exclusions that it believed to be applicable. The language of the two provisions are set forth below:

> III "In addition to the Common Exclusions Applicable to All Liability Insuring Agreements, the Insurer shall not be liable to pay any Loss under this Insuring Agreement in connection with and Claim made against the Allmerica Financial Insureds . . .
>
> b. based upon, directly or indirectly arising out of, or in any way involving:
> (1) any Wrongful Act or any matter, fact, circumstance, situation, transaction or event which has been the subject of any Claim made against the Allmerica Financial Insureds prior to the Original Effective Date as stated in Item 8 of the Declarations; or
> (2) any other Wrongful Act whenever occurring, which, together with a Wrongful Act which has been the subject of such Claim, would constitute Interrelated Wrongful Acts, provided, however, this exclusion shall not apply to a Claim for a Wrongful Act involving claim handling and adjusting; . . .
>
> g. based upon, directly or indirectly arising out of or in any way involving any of the Allmerica Financial Insureds' actual or alleged oral or written representation, promise or guarantee of the past performance or future value of any insurance product or investment product, provided this Exclusion shall not apply to any Claim arising out of a representation, promise or guarantee of a Contract Agent acting independent of the Allmerica Financial Insureds including representations not authorized by the Allmerica Financial Insureds and made by the Contract Agent in conjunction with the Allmerica Financial Insureds' authorized marketing materials; . . . ."[4]

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[4] The terms Claim, Wrongful Act, and Contract Agent are defined in the policy as follows:

"'Wrongful Act' means any actual or alleged error, misstatement, misleading statement, act, omission, neglect or breach of duty."

"'Claim' means

(1) a civil or criminal proceeding, or an administrative adjudicatory proceeding commenced by the filing of a notice of charges or a formal investigative order;

(2) an arbitration or mediation proceeding; or

(3) a written demand for monetary damages,

In light of Underwriters' determination that the Bussie Class Action did not fall within coverage of the policy, Allmerica instituted this action for breach of contract.

In its motion for summary judgment, Underwriters sets forth the following theories upon which it seeks judgment as a matter of law: 1) Underwriters is not bound by CNA's interpretation that the Bussie Class Action fell within coverage of the policy; 2) exclusions III.g. and III.b. are unambiguous and should be interpreted to preclude coverage of the Bussie Class Action; 3) the doctrine of "known loss" precludes the coverage of the Bussie Class Action based on Allmerica's prior knowledge of a substantial probability that the claim would arise.

Allmerica challenges Underwriters' reliance on the above theories and further asserts that Allmerica should be entitled to judgment as a matter of law because Underwriters is bound by CNA's interpretation and the unambiguous exclusions do not apply to the Bussie Class Action. Allmerica has set forth two additional theories upon which it seeks summary judgment. Allmerica contends that the Bussie Class Action constituted a single proceeding, requiring a single retention under the policy, and that Underwriters previously made assurances of payment, which bars Underwriters from now contesting coverage.

DISCUSSION

Summary judgment shall be granted when there are no genuine issues of material fact, and the moving party is entitled to judgment as a matter of law. Mass. R. Civ. P. 56(c); Opara v.

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against the Allmerica Financial Insureds, including any appeal therefrom."

"'Contract Agent' means a duly licensed life or accident and health agent, general or managing agent, or duly licensed Registered Representative while under valid contract with the Allmerica Financial Insureds."

Mass. Mutual Life Ins. Co., 441 Mass. 539, 544 (2004). The burden of affirmatively demonstrating the absence of a triable issue and entitlement to judgment as a matter of law lies with the moving party. Pederson v. Time, Inc., 404 Mass. 14, 16-17 (1989). The moving party can satisfy this burden by setting forth affirmative evidence negating an essential element of the opposing party's case or by demonstrating that the opposing party has no reasonable expectation of proving an essential element of its case at trial. Flesner v. Technical Communications Corp., 410 Mass. 805, 809 (1991); Kourouvacilis v. Gen. Motors Corp., 410 Mass. 706, 716 (1991). Once the moving party has met its burden, the non-moving party then must "respond by set[ting] forth specific facts showing that there is a genuine issue for trial." Kourouvacilis, 410 Mass. at 716, citing Mass. R. Civ. P. 56(e).

Underwriters contends it is not bound by CNA's determination that the Bussie Class Action fell within the primary policy's coverage and likewise fell within the excess insurance policy issued by Underwriters.[5] Underwriters further contends that CNA's interpretation of exclusions III.b. and III.g. are incorrect and a proper interpretation of the policy's language would exclude the Bussie Class Action from coverage. Allmerica counters that CNA, as drafter of the policy, had interpreted the language as covering the Bussie Class Action following the settlement, and Underwriters, as a follow form excess insurer, is bound by CNA's determination of the policy's applicability. This appears to be an issue of first impression in the Commonwealth.

A brief discussion of follow form excess insurance policies may be instructive to the

[5] Before addressing the parties arguments, it is necessary to determine whether Allmerica has exhausted the limits of the primary policy with CNA. Allmerica points to Underwriters' Answer and Counterclaim as demonstrating Underwriters' challenge of whether Allmerica exhausted the limits of the CNA policy. Underwriters, however, has not disputed this issue in its memoranda for summary judgment or during its argument before this court. It, therefore, is conceded that Allmerica's primary policy limits were exhausted.

principles underlying this case. An excess insurance policy provides coverage of claims that are over and above the coverage under the primary insurance policy. When a policyholder reaches the limits of its primary policy under a claim, the excess policy typically covers the additional amounts provided by its coverage. In addition, a follow form policy "provide[s] coverage in accordance with the terms and provisions of the . . . primary [or underlying] policy." Metropolitan Leasing, Inc. v. Pacific Employers Ins. Co., 36 Mass. App. Ct. 536, 543 n. 6, quoting Industrial Risk Insurers v. New Orleans Pub. Serv., Inc., 666 F. Supp. 874, 876 (E.D. La. 1987).

I. **Whether Underwriters is Bound by CNA's Interpretation of the Policy Language**

Although a follow form excess insurer incorporates the terms set forth in the underlying primary policy, it does not necessarily follow that the excess insurer is subject to the primary insurer's interpretation of those policy terms.[6] Under the principles of issue and claim preclusion, a final judgment involving the same parties is a requirement for precluding a party from raising a particular issue or claim. See Fireside Motors, Inc. v. Nissan Motor Corp., 305 Mass. 366, 372-373 (1985). It follows from that principle that a party not involved in the prior action cannot be precluded from arguing and defending its position. Id. Underwriters was not a party to the Bussie Class Action settlement and did not have a prior opportunity to defend its position. As a result, it should not be precluded from challenging the policy interpretation simply because CNA and Allmerica reached an agreement between themselves.

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[6] Allmerica cites to a Delaware case as supporting its position on this issue. See Playtex FP Inc. v. Columbia Casualty Co., 609 A.2d 1087, 1094 (Del. Super. 1991). That case is distinguishable from this one because the excess insurer in Playtex did not challenge whether the action fell within coverage but at what point the excess policy would be triggered. In this case, however, Underwriters disputes whether coverage even exists under the language of the policy.

It is also well established that a "judgment" is a term of art, and a settlement does not qualify as a judgment, particularly for purposes of preclusion analysis. See Clegg v. Butler, 424 Mass. 413, 424-425 (1997).[7] Parties may choose to settle a claim for a variety of reasons wholly unrelated to liability. Here, Allmerica disputes its liability arising from the Bussie Class Action but chose to settle the claims for various business and practical considerations such as time, expense, and business efficiency.[8] Requiring a party to follow the practical business decisions of other parties would be contrary to the principle and policy of issue and claim preclusion. CNA's concession of coverage in settling the Bussie Class Action could just have easily been made for a business decision rather than the true application of the policy language.[9] It is contrary to the underlying principles and policies of settlements, arbitration, and preclusion to bind Underwriters to a decision made between CNA and Allmerica as business entities rather than a determination by a judgment of a court to which Underwriters was a party.[10] Pursuant to this interpretation, Underwriters has carried its burden of showing that it should not be bound by CNA's interpretation. For the same reasons articulated above, Underwriters' attempt to invoke issue

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[7] Several cases have drawn the clear distinction between the operation of a judgment and a settlement or an arbitration. See e.g., Mongeon v. Arbella Mut. Ins. Co., Civ. No. 02-0154B (Worcester Super. Ct. April 23, 2004); Goodman v. Seaver, Civ. No. 99-2085 (Essex Super. Ct. Aug. 28, 2000).

[8] See Bussie et al v. Allmerica Financial Corp., No. 97-40204-NMG, at 7 (D. Mass. May 19, 1999) (mem.); Aframe Aff. para 18.

[9] In furtherance of this point, Underwriters point to another policy that CNA issued (Policy Number 132040762) to Allmerica that appears to provide coverage for losses resulting from "a Wrongful Act attributed solely to an Insured/Agent and not due to any independent negligence or bad faith of Allmerica Financial Corporation."

[10] A proper judicial determination is necessary to bind a third party. David A. Hoffman & David E. Matz, Massachusetts Alternative Dispute Resolution §§ 4.16, 4.28 (1996) (discussing the lack of binding effect that arbitration has on third parties). Under this principle, any determinations made during the Individualized Relief Plan would have no precedential value against Underwriters' position.

and/or claim preclusion against Allmerica based on its settlement is equally unavailing, particularly because the federal court made no findings as to the merits or defenses of the parties.

II. **The Interpretation of the Challenged Policy Provisions**

Underwriters bears the burden of proving that the exclusions apply, but upon that showing, Allmerica must prove that an exception to that exclusion is applicable. Highlands Ins. Co. v. Aerovox Inc., 424 Mass. 226, 230-231 (1997).

Having determined that Underwriters is not bound by CNA's interpretation of the policy language, the court now addresses the arguments regarding the interpretation of the challenged clauses. The interpretation of insurance policy language is a question of law that the court determines. Chemard v. Commerce Ins. Co., 440 Mass. 444, 445 (2004); Cody v. Conn. Gen. Life Ins. Co., 387 Mass. 142, 146 (1982). In this case, the parties agree that the policy language is unambiguous; they simply differ in their respective positions regarding the interpretation of that language.[11] See Lumbermens Mut. Casualty Co. v. Offices Unlimited, Inc. & Fed. Ins. Co., 419 Mass. 462, 466 (1995) (noting that an ambiguity is not created by the parties favoring different interpretations).

If either exclusion applies to the Bussie Class Action, then Underwriters would not owe a duty to make payments under the policy and would be entitled to judgment as a matter of law.

A. **Interpretation of Provision III.g.**

When interpreting the provisions of an insurance policy, every word is presumed to have purpose and should be analyzed as such whenever practicable. Wrobel v. Gen. Accident Fire &

[11] Allmerica asserts that the policy is unambiguous in its favor, but it alternatively argues that the language would at most be ambiguous as to coverage, requiring a review of its negotiations and other extrinsic evidence.

Life Assurance Corp., 288 Mass. 206, 209-210 (1934). In the absence of ambiguity, terms in a contract, particularly exclusion clauses, are to be interpreted according to their plain and ordinary meaning. Hakim v. Massachusetts Insurers' Insolvency Fund, 424 Mass 275, 281-282 (1997). This court finds the language of provision III.g. unambiguous and as such strictly construes the policy from the plain meaning of its terms. Id. As this provision is unambiguous, this court will not consider extrinsic evidence in determining the policy's application. See Somerset Savings Bank v. Chicago Title Ins. Co., 420 Mass. 422, 428 (1995); Herson v. New Boston Garden Corp., 40 Mass. App. Ct. 779, 791-792 (1996).

Provision III.g. excludes claims of "actual or alleged oral or written representations, promise or guarantee" by Allmerica concerning the performance of its insurance products and policies.[12] In Massachusetts, it is well settled that an insurer is liable for the actions of its agents within the scope of the agent's authority. See Shumway v. Home Fire & Marine Ins. Co., 301 Mass. 391, 393-394 (1938). Allmerica concedes that its agents had apparent authority to make the misrepresentations that are at issue in this case. Unless the exception applies, the claim in the Bussie Class Action would fall within the exclusion to the policy. The exception provides coverage for claims arising from "a representation, promise or guarantee of a Contract Agent acting independent" of Allmerica "including representations not authorized" by Allmerica which were made in conjunction with Allmerica's marketing materials. The ultimate issue of whether these representation by Allmerica's sales agents were authorized by Allmerica is a material

[12] The term "Allmerica Financial Insureds'" is defined in the policy glossary as pertaining to the Allmerica corporation itself, any subsidiary, and any officers or directors.

question of fact that remains unanswered.[13] As a result, this material issue of fact precludes summary judgment for either party on this issue.

B. **Interpretation of Provision III.b.**

The relevant language of provision III.b. is as follows:

> "In addition to the Common Exclusions Applicable to All Liability Insuring Agreements, the Insurer shall not be liable to pay any Loss under this Insuring Agreement in connection with and Claim made against the Allmerica Financial Insureds . . .
>
> b. based upon, directly or indirectly arising out of, or in any way involving:
>
> (1) any Wrongful Act or any matter, fact, circumstance, situation, transaction or event which has been the subject of any Claim made against the Allmerica Financial Insureds prior to the Original Effective Date as stated in Item 8 of the Declarations; or
>
> (2) any other Wrongful Act whenever occurring, which, together with a Wrongful Act which has been the subject of such Claim, would constitute Interrelated Wrongful Acts, provided, however, this exclusion shall not apply to a Claim for a Wrongful Act involving claim handling and adjusting . . .

Provision III.b. is also unambiguous. As such, it will be interpreted according to the plain and ordinary meaning of its terms. Hakim, 424 Mass. at 281-282. The plain language of provision III.b. provides an exclusion from coverage of any claim brought against Allmerica that

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[13] In certifying the class and accepting the settlement, Judge Gorton did not rule on the merits or defenses of either party to the settlement. Allmerica submits an affidavit of Lisa Shunkwiler, a paralegal for Allmerica's counsel, in support of its argument that it was the Allmerica's agents and not Allmerica itself that made the misrepresentations. Affidavits must rest on personal knowledge, not conclusory statements or statements of belief. Key Capital Corp. v. M&S Liquidating Corp., 27 Mass. App. Ct. 721, 727-728 (1989); Mass. R. Civ. P. 56. On this basis, this court does not credit Shunkwiler's analytical breakdown of whether individual class members were claiming misrepresentations by Allmerica or its sales agents because her analysis does not answer the ultimate question of whether Allmerica had authorized the representations at issue. In addition, the court is not bound by the determinations made during the Bussie Class Action, which involved alternative dispute resolution in the Individualized Relief Process. See Butler, 424 Mass. at 425; David A. Hoffman & David E. Matz, supra, § 4.28. Underwriters was not a party to that prior action and as discussed supra is not precluded from challenging those issues.

"directly or indirectly [arose] out of, or in any way [involved]" a wrongful act that had been the subject of a claim prior to the policy or if any claim against Allmerica was interrelated with any prior claim. Although exclusions are narrowly construed, the very language of this provision is broad in its application. This provision excludes claims that are connected in some way to "any matter, fact, circumstance, situation, transaction or event" of a claim that Allmerica had faced previously.

Allmerica contends that the Jowers action from 1992 is not related in any way to the Bussie Class Action claim.[14] The policy defines an interrelated wrongful act as "any Wrongful Acts which are logically or casually connected by reason of any common fact, circumstance, situation, transaction or event." Underwriters has presented evidence in the form of the Jowers complaint which sets forth allegations of fraud and misrepresentation by one of Allmerica's affiliates and/or its sales agent as to the future performance of the policy. The situation and allegations in Jowers are very similar to the ones presented in the Bussie Class Action regarding allegations of misrepresentation by Allmerica and/or its sales agents as to past or future values of policies. Allmerica asserts that the Jowers case was based on alleged representations by its agent and not by Allmerica itself. This is the very same argument that Allmerica raised with regard to the inapplicability of provision III.g., claiming that the agents alone were the cause of these misrepresentation. Although Allmerica asserts that the Jowers case involved "a different policyholder, a different agent, a different transaction, and different events" than the Bussie Class Action, such factual nuances disregard the actual terms of the provision, which has broader

[14] Allmerica listed the Jowers action in its applications for coverage with CNA and Underwriters (Ex. 14 of Plaintiff's Memorandum), but Allmerica's inclusion of a case name and brief description within its application does not effect the court's analysis on these issues.

application as evidenced by its "in any way involving" language. The mere fact that a different agent was involved is of no consequence to the actions' commonalities.

Also immaterial to the application of III.b. is the fact that the Jowers case and the Bussie Class Action were both settled without specific findings of facts. The policy defines a "Loss" as "damages, settlements, judgments and Defense Costs for which the Allmerica Financial Insureds' are obligated to pay." The definitions of the policy also provide for exclusion if the claims are logically or causally connected in any way. The fact that the plaintiff in Jowers would likely have been a class member of the Bussie Class Action but for the settlement in the Jowers case is quite telling of the relationship between the two cases. The multitude of similarities between these two actions place the Bussie Class Action squarely within the exclusion language of III.b. The parties also dispute whether multiple retentions[15] should apply based on their respective interpretations of provision III.b.[16] Based on the unambiguous language of provision III.b., however, a determination of whether a single or multiple retentions apply is unnecessary to the resolution of this case. Therefore, Underwriters is entitled to judgment as a matter of law on the issue of its liability.

III. Application of the "Known Loss" Doctrine

Even if provision III.b. were inapplicable to the Bussie Class Action, the "known loss"

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[15] A self-insured retention is defined as the "amount of an otherwise-covered loss that is not covered by an insurance policy and that [usually] must be paid before the insurer will pay benefits . . . ." Black's Law Dictionary 1391 (8th ed. 2004).

[16] The relevant provision sets forth that "[a] Single Retention shall apply to any one Claim or more than one Claim involving the same Wrongful Act or Interrelated Wrongful Act (which shall be considered as one Claim)." If multiple retentions were applicable, the Underwriters' excess policy would not be triggered because Allmerica's obligation to pay a portion ($2.5 million) of each "claim" plus CNA's payment would already cover the costs associated with the Bussie Class Action.

doctrine would exclude coverage and entitle Underwriters to judgment as a matter of law. This doctrine follows the basic principle of insurance as aiming to protect against risks, not certainties. SCA Servs. Inc. v. Transp. Ins. Co., 419 Mass. 528, 532-533 (1995). The doctrine, therefore, eliminates coverage of a loss that had already happened or the insured knew was highly probable to occur. Id. The "known loss" doctrine requires an initial determination as to whether there are any factual questions as to Allmerica's knowledge of the existence of claims under the Bussie Class Action at the time it purchased the policy. Id.

The burden lies with Underwriters to show that Allmerica subjectively knew of a probable loss when it sought coverage under the policy. See id. Underwriters points to a number of letters, produced by Allmerica in discovery, that Allmerica received from customers regarding deficiencies in their policies, pointing to representations made when they purchased the policies. In addition, Underwriters presents a letter dated July 27, 1998, addressed to Allmerica's Vice President of Risk Management, Ms. Patricia Coyle, from CNA's counsel that discusses the Bussie Class Action. On this letter is a handwritten notation acknowledging that, since 1990, Allmerica had received about 700 complaints, 300 of which were "of the type in the [Bussie Class Action]." Id. Allmerica disputes this notation on the grounds that Underwriters has not pointed to any specifics regarding these complaints, but Underwriters need only show that Allmerica subjectively knew of these complaints and that a probable loss would occur.

Underwriters also highlights that the Bussie Class Action was filed against Allmerica only a few weeks after the effective date of the renewal policy. Allmerica admits that litigation concerning improper sales practices by insurers and agents were "widely known in the insurance industry," and that Allmerica sought additional insurance coverage for those exact types of claims.

Allmerica's characterization of the approximately 300 complaints as "minuscule" in comparison to the approximately 400,000 class members is unconvincing. The facts presented by Underwriters show that Allmerica knew of this probable loss when it sought coverage, making it a substantial probability that Allmerica would face lawsuits arising from these complaints. See SCA Servs., 419 Mass. at 532-533. In addition, Allmerica has failed to set forth specific facts that raise a genuine issue as to its knowledge of the probability of a loss stemming from the complaints. See Kourouvacilis, 410 Mass. at 716. This court, therefore, finds there are no factual questions as to Allmerica's knowledge. Under the "known loss" doctrine, the Bussie Class Action is precluded from coverage, entitling Underwriters to summary judgment.

IV. Underwriters' Assurances of Coverage

Aside from the contractual issues addressed supra, Allmerica asserts an equitable claim based on alleged assurances of payment that Underwriters gave to Allmerica, which it argues should bar Underwriters from now denying coverage. See Boylston Devel. Group Inc. v. 22 Boylston St. Corp., 412 Mass. 531, 542 n.17 (1992) (discussing elements of estoppel theories). Allmerica relies on a letter, dated November 4, 1998, from Underwriters as assurance that Underwriters would provide coverage under the Bussie Class Action. Allmerica points specifically to the statement that Underwriters "would expect to make an indemnity payment in connection with [the Bussie Class Action]." Underwriters points to the full context in which the statement was made and the conditional language immediately preceding this statement as negating Allmerica's contention. The preceding language states that "assuming that there is a covered loss in excess of both the limits of the primary policy and the applicable retention, and

assuming that CNA has paid its full policy limits of $20 million, Underwriters would expect to make an indemnity payment in connection with the [Prossie Class Action]." Additional language in the letter expresses Underwriters' reservation of rights as to coverage issues.[17] Based on the plain reading of the language, Allmerica has failed to meet its burden of establishing that no genuine issues of material fact exist regarding this issue. Cf. Somerset Savings Bank v. Chicago Title Ins. Co., 420 Mass. 422, 428 (1995) (holding that the absence of ambiguity requires an interpretation of the plain language of the document); Herson v. New Boston Garden Corp., 40 Mass. App. Ct. 779, 791-792 (1996).

[17] The second to last paragraph of this letter states:

"While, at this time, Underwriters lack sufficient information to consent to the proposed settlement and/or advise you of Underwriters' position regarding the scope of coverage for the settlement, given the fact that Allmerica is under court imposed time constraints to conclude the settlement agreement, and pursuant to the broker's recent request, Underwriters agree that they will not assert that the failure to obtain Underwriters' prior consent to the settlement constitutes a separate defense to coverage. As such, Underwriters fully reserve their rights to object to the reasonableness of the terms of the settlement and fully reserve their rights regarding coverage issues presented, including, but not limited to the allocation of settlement amounts, costs and defense expenses between covered and non-covered claims."

ORDER

For the foregoing reasons, it is hereby **ORDERED** that the defendant Underwriters' motion for summary judgment pursuant to Mass. R. Civ. P. 56 on the issue of liability is **ALLOWED**. It is further **ORDERED** that the plaintiff Allmerica's cross motion for summary judgment is **DENIED**.

Peter W. Agnes Jr.
Justice of the Superior Court

Dated: September 27, 2004

ADDENDUM TWO

Excess Casualty - Commercial Umbrella & Following Form Excess Liability Insurance

overview | customer profile | coverages | coverage options | minimum premium

Overview

Our Commercial Umbrella Policy and Following Form Excess Liability Policy provides security for the long-term. These policies can offer an approach for your excess liability coverage, a fit just right for each and every insured.

Zurich's Commercial Umbrella Policy is custom-built upon a sound foundation of ISO 1998 terms and keeps insureds a step ahead of both typical and atypical risks.

Zurich's Following Form Excess Liability policy locks right into each insureds' underlying trigger points to help eliminate coverage gaps, so insureds sidestep conflicts with the controlling policy.

Customer Profile

- manufacturers
- construction operations including wrap-ups
- real estate, including habitational and non-habitational, hotels, motels, apartments
- service industry, such as fast food, processing, wholesale/retail stores
- conglomerates and diversified companies
- most customers that buy high-excess casualty limits

Coverages

- aggregate limits follow underlying policy and apply annually on long-term policies

- occurrence or claims-made basis

Coverage Options

- blended time element pollution

Minimum Premium

Please contact your broker or a Zurich representative for details.

Product Information Last Updated: 10/20/2006

ADDENDUM THREE

CHUBB

Excess Liability

Chubb Commercial Insurance

Chubb Excess insurance is additional liability protection above an Umbrella Liability policy that follows the terms and conditions of the Umbrella, whether or not it is placed with Chubb. This policy can provide significant limits that enable a company to construct an excess liability program with fewer carriers and consequently less concern over potential coverage differences.

Chubb's Commercial Excess Liability policy affords a variety of benefits:

- Consistency by following the provisions of the policy designated by the insurer regardless of its position in the layered excess program.
- The application of limits is consistent with the underlying program. For example, if all underlying insurance limits apply per location, per jobsite or per policy, so will the Chubb excess.
- Pays on behalf of the insured, it is not a reimbursement policy.
- Failure to maintain underlying insurance does not invalidate the policy.
- Coverage responds directly over reduced or exhausted underlying insurance limits when all other applicable underlying insurance does the same.

OTHER SOLUTIONS

Umbrella Liability

Where primary policies end, Chubb's Umbrella Liability begins, providing flexible protection with two separate insuring agreements.

Learn More ›

Customarq General Liability

General Liability insurance is an essential element of any comprehensive insurance program. Chubb's *Customarq* policy has kept pace with today's risks.

Learn More ›

Service and Strength

At Chubb, we deliver more than solid insurance products. We support our customers through our renowned services, extensive global network and financial strength.

Chubb's reputation for outstanding service is built on a consistent track record of performance by its global network of loss control and claim professionals. Our loss control and risk consulting professionals are experienced in making risk assessments and proposing practical remediation to help mitigate or prevent losses. Should a loss occur, our exceptional claim service is available anytime/anywhere in more than 140 languages through a toll-free number or via the Internet.

Our financial strength continues to earn high ratings from A.M. Best, Standard & Poor's and Moody's, leading evaluators of insurance companies. Financial strength, combined with our underwriting expertise and claim service, means you can count on Chubb to be there when you need us most.

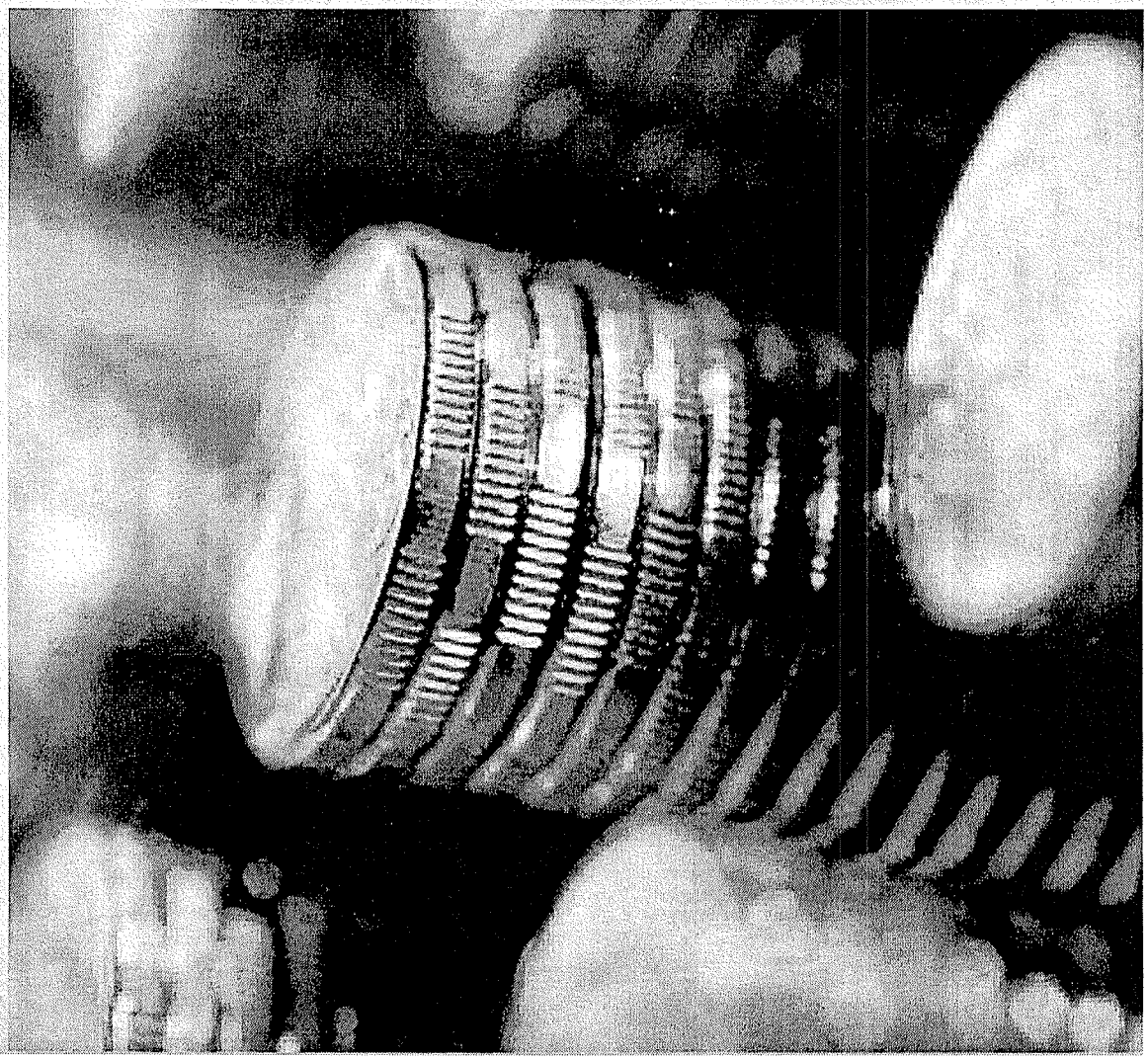
Additional Information

Commercial Excess Follow Form Insurance - Features & Benefits

Commercial Excess Follow Form Insurance - The Risks are Real

For more information about Excess Liability from Chubb, contact your insurance agent or broker, or write to **cci-marketing@chubb.com**.

CHUBB



A litigious environment. Multimillion-dollar jury awards. Escalating defense costs. You need an insurance program that helps provide protection against these threats to your company's balance sheet. It's never been more important to insure your business with an insurance company that understands today's complex risks and can offer a strong Excess liability program. You need Chubb. We've been providing casualty and property insurance solutions since 1882, and we continue to earn high ratings from leading independent evaluators of the insurance industry for our financial stability and claim service.

When selecting an Excess insurer, it's important to consider the policy's terms and conditions. Chubb's Commercial Excess Follow Form insurance policy is a cut above the rest. In addition to writing over other carriers, our Excess policy can be written in combination with a suite of integrated liability products from Chubb — including our hallmark *Customarq* General Liability, Umbrella and Errors & Omissions contracts. Take a look at what our Excess policy offers.

Features	Benefits
Follow form policy adopts the provisions of the controlling underlying insurance, with limited exceptions.	Provides responsive excess insurance for exposures covered by policies you designate, regardless of their position in your layered excess program. Offers greater flexibility by adapting to various or unique primary and excess insurance policies, such as miscellaneous professional/errors and omissions, global, aviation, marine and others. Adopts the varied triggers of controlling underlying insurance such as occurrence, claims made and reported occurrence.
Protection is not restricted by the exclusions, definitions or other provisions of intervening layers of insurance.	Responds to the loss at our attachment point based on our provisions and those of the controlling underlying insurance.
Pays on behalf of the insured.	Less disruptive to your cash flow. Avoids your having to pay losses first and seek reimbursement afterward.
Defense and supplementary payments are provided in addition to the limits of insurance when such is the case with all underlying insurance.	Preserves your policy limits for payment of claims.
Supplementary payments include pre- and post-judgment interest.	Provides a more complete response to judgments against you.

Application of limits is consistent with your underlying program.	Provides you with excess limits of insurance that apply in the same manner as your underlying policies. If, for example, all underlying insurance limits apply unaggregated per location, per job site or per policy, ours will too.
No "Other" (non-products) aggregate limit if none is applicable to all underlying insurance.	Puts unrestricted limits at your disposal to meet non-products claims.
No requirement for reinstatement or replacement of eroded or exhausted underlying limits.	Frees you from the necessity and expense of rebuilding your underlying insurance program should it be eroded or exhausted by claims.
Insurance will respond directly over reduced or exhausted underlying limits of insurance when all other applicable underlying insurance does the same.	Provides potential first-dollar protection for successive losses occurring within our policy period.
Recognizes underlying limits erosion for coverage that is broader than ours.	Could provide you with first-dollar drop-down insurance protection for your next loss.
Financially solid capacity.	Provides peace of mind that the insurance you purchase from us today will be there to pay future liability claims.
Follow form protection.	Protects you wherever controlling underlying insurance protects you.
All insureds in controlling underlying insurance are protected.	Helps maintain continuity of insurance protection in your excess liability program.
Failure to maintain underlying insurance or insolvency of underlying insurer(s) will not invalidate the policy.	Ensures that the insurance you purchased will be available as if underlying insurance was maintained.
Return premiums are calculated pro-rata (not short-rate).	No premium penalty should you need to cancel the insurance.

Includes broadened notice and knowledge of occurrence, offense, claim or suit.	Does not hold you responsible for failing to notify us, unless your officer knows. Notice to our licensed agent is notice to Chubb.
Waivers of subrogation are recognized, if executed before loss.	Honors your business decision to waive the liability of others for loss.
Adopts definitions and exclusions of controlling underlying insurance.	Helps maintain consistent scope of insurance protection in your excess liability program.
Policy does not exclude punitive damages.	Insures punitive damages if controlling underlying insurance does (if such damages are insurable).
Policy contains few definitions.	More closely follows the controlling underlying insurance.

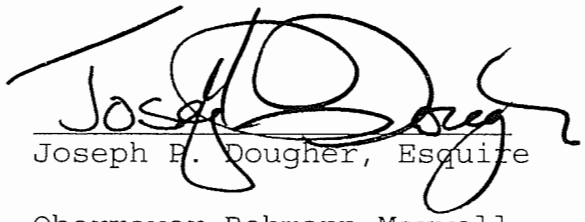
For an insurance company that truly understands the complexity of excess liability protection, look to Chubb. Contact your agent or broker to inquire about Chubb's Excess Follow Form insurance policy.

Form 07-01-0080 (Rev. 11/05)

Chubb Group of Insurance Companies
Whitehouse Station, New Jersey 08889
www.chubb.com

CERTIFICATION

In accordance with Rule 16(k) of the Massachusetts Rules of Appellate Procedure, I hereby certify that the attached brief complies with the rules of the Court that pertain to the filing of briefs.



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April 17, 2007

PROOF OF SERVICE

I, Steven D. Urgo, hereby certify that on April 17, 2007, two copies of the Amicus Curiae Brief of United Policyholders, Inc. for Leave to File Amicus Curiae Brief was served upon counsel or Plaintiff/Appellant Allmerica Financial Corps., et al; and counsel for Defendant/Appellee Lloyd's of London, Syndicate 1212, et al., by First Class Mail, postage prepaid, to the following addresses:

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Signed under penalties of perjury this 17th day of April, 2007.

Steven D. Urgo

April 17, 2007

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