COLORADO SUPREME COURT Court Address: 101 West Colfax, Suite 800 Denver, Colorado 80202	COURT USE ONLY
Certification of Question of Law United States Courts of Appeals 10th Circuit, D.C. No. 1:13-CV-00448-RPM District of Colorado	Case No. 2014SA43
***Plaintiff-Appellant*:** DEAN CRAFT, v. ***Defendant-Appellee*:** PHILADELPHIA INDEMNITY INSURANCE COMPANY, A FOREIGN CORPORATION	
Attorneys for *Amicus Curiae* United Policyholders James M. Davis (#33594) REED SMITH LLP 10 S. Wacker Drive, 40th Floor Chicago, Illinois 60606 Phone: (312) 207-3899 Email: jdavis@reedsmith.com Timothy P. Law REED SMITH LLP Three Logan Square, Suite 3100 1717 Arch Street Philadelphia, PA 19103 Main: 215.851.8100 Facsimile: 215.851.1420 **Of Counsel** Amy Bach UNITED POLICYHOLDERS 381 Bush Street, 8th Floor San Francisco, California 94104 Telephone: 415.393.9990 Facsimile: 415.677.4170	

BRIEF OF *AMICUS CURIAE* UNITED POLICYHOLDERS IN SUPPORT OF APPELLANT

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

I. CERTIFICATE OF COMPLIANCE

Pursuant to Colorado Appellate Rule 32(a)(3), the undersigned certifies that the Brief of Amicus Curiae United Policyholders contains 5,389 words, excluding this certificate of compliance, the table of contents, the table of authorities, and the appendices. To the best of the undersigned's knowledge, this brief also complies with C.A.R. 28.

James M. Davis (#33594)
REED SMITH LLP
10 S. Wacker Drive, 40th Floor
Chicago, Illinois 60606
Phone: (312) 207-3899
Email: jdavis@reedsmith.com

Attorney for *Amicus Curiae* United Policyholders

II. INTEREST OF AMICUS CURIAE

United Policyholders ("UP") is a non-profit 501(c)(3) organization founded in 1991 that is a voice and an information resource for insurance consumers in Colorado and throughout the United States. The organization assists and informs disaster victims and individual and commercial policyholders with regard to every type of insurance product. Grants, donations, and volunteers support our work. UP does not accept funding from insurance companies.

UP's work is divided into three program areas: *Roadmap to Recovery*™ (disaster recovery and claim help), *Roadmap to Preparedness* (insurance and financial literacy and disaster preparedness), and *Advocacy and Action* (advancing pro-consumer laws and public policy). UP hosts a library of tips, sample forms and articles on commercial and personal lines insurance products, coverage, and the claims process at www.uphelp.org.

In partnership with El Paso, Boulder, and Larimer counties, UP has been engaged in long term wildfire and flood recovery work in Colorado since 2010. UP works closely with the Colorado Department of Insurance and has participated in legislative proceedings in Denver.

State insurance regulators, academics, and journalists throughout the United States routinely seek UP's input on insurance and legal matters. We have been

appointed for six consecutive years as an official consumer representative to the National Association of Insurance Commissioners.

UP seeks to assist courts as *amicus curiae* in appellate proceedings throughout the United States. UP has appeared as *amicus curiae* in two Colorado Supreme Court cases: Mountain States Mutual Casualty Co. v. Roinestad (2010SC853, 2011) and Board of Directors Metro Wastewater vs. Nat'l Union Fire (03SC846, 2004). A complete listing of all cases we've weighed in on can be found in our online Amicus Project library.

III. STATEMENT OF THE ISSUES

1) Whether Colorado's notice-prejudice rule applies to claims-made liability insurance policies?

2) And if so, whether the rule applies to both types of notice requirements in those policies?

IV. STATEMENT OF THE CASE

United Policyholders adopts the Statement of the Case contained in the brief of the Plaintiff-Appellant, Dean Craft.

V. SUMMARY OF ARGUMENT

The notice-prejudice rule is black-letter law. It supports insurance consumers by avoiding disproportionate forfeiture. Insurance serves the public interest by ensuring a source of recovery for victims and by protecting businesses and individuals from the risks of litigation. The public interest would be harmed by a rule that allows an insurance company to avoid responsibility for a covered claim whenever an insured reports that covered claim later than the policy requires. The better rule, and the one embedded deeply in the common law, is to allow the forfeiture of coverage only when late notice causes substantial prejudice to the interests of the insurance company. Claims-made policies should be no exception.

Claims-made insurance policies contain traps into which even sophisticated policyholders can fall. Indeed, Philadelphia Indemnity (the defendant here) once sued its own professional liability insurance company alleging that Philadelphia Indemnity's "technical" violation, if any, of the notice provision in its claims-made policy was inconsequential. In that case, Philadelphia Indemnity received payment ($350,000) for the full amount of coverage – except to the extent that the carrier had been prejudiced by the late notice ($600,000 in extra money Philadelphia Indemnity paid in settlement because it refused to accept an earlier, lower

settlement offer, which Philadelphia Indemnity's carrier could have accepted had it been on notice).

Philadelphia Indemnity was outraged at the treatment it received and brought a lawsuit for bad faith, feeling that it should have been paid everything. Here, United Policyholders asks this Court to adopt a rule that treats policyholders no better than how Philadelphia Indemnity was *actually treated* by its own carrier under its own claims-made professional liability policy. Payment should not be required *to the extent* the carrier proves substantial prejudice as a result of the late notice. In other words, if the cost of a claim was $1 million, and the carrier can prove that the claim would have only cost $500,000 if notice had been provided in a timely manner (similar to what Philadelphia Indemnity's carrier did in that prior case), then the carrier should only be required to pay $500,000. However, if the carrier is unable to prove that the late notice had any material effect on the claim, then there is no basis for imposing any forfeiture of coverage.

VI. ARGUMENT

A. An Insurance Company's Allegation of Late Notice Is an Affirmative Defense That Should Not Be Adjudicated on a Motion to Dismiss.

Notice provisions are coverage limitations, whether they are expressed as conditions, exclusions, or some other limitation of coverage. As the Texas Supreme Court noted, "[e]xclusions and conditions are in effect two sides of the same coin; exclusions avoid coverage if the insured does something, and conditions avoid coverage unless an insured does something." Paj, Inc. v. Hanover Ins. Co., 243 S.W.3d 630, 635 (Tex. 2008). Philadelphia Indemnity is attempting to affirmatively assert facts and circumstances that would avoid coverage for a loss. It must plead and prove late notice as an affirmative defense. This case should not have been resolved on a motion to dismiss.

B. The Notice-Prejudice Rule Is a Rule of Law, Not a Rule of Insurance Policy Interpretation.

As an essential element of its burden of proof on its affirmative defense of late notice, an insurance company must prove that the notice was late and that the insurance company suffered substantial and material prejudice as a result of the delay. The notice-prejudice rule is not affected by how clearly the insurance company drafts a requirement for the policyholder to notify the insurance company of an accident, occurrence, or claim. In Friedland, the policy required notice of an

occurrence "as soon as practicable" and "if a claim is made or suit is brought against the Insured, the Insured shall immediately forward" the process received by the Insured initiating the claim. Friedland v. Travelers Indem. Co., 105 P.3d 639, 642 (Colo. 2005). In the present case, the policy required written notice "as soon as practicable after any of the directors, officers, governors, trustees, management committee members, or members of the Board of Members first become aware of such Claim, but, not later than 60 days after the expiration date of this Policy, Extension Period, or Run-Off Policy, if applicable." The policy requirements in this case and Friedland are largely the same, except that instead of "immediate" notice of the claim required in Friedland, the policy in this case includes a more specific means of calculating when notice will be deemed late.

Policy drafting tactics of insurance companies cannot supplant the rule of law. An insurance company should no more be permitted to draft its way out of the notice-prejudice rule than to draft a provision requiring a policyholder to prove the inapplicability of all exclusions, which would violate a similarly well-established rule of insurance law. Even when insurance policies are drafted to require a policyholder to report a claim to the insurance company within the policy period or within a certain number of days thereafter, the insurance company still

should be required to prove both that notice was provided late and that the insurance company was materially prejudiced by the delay.

C. Claims-Made Policies Create Traps for the Unwary.

The duty to provide notice under a claims-made policy typically arises when a "claim" is made. What constitutes a "claim" may be undefined, unclear or unknown to the corporate policyholder or most of its staff. Accordingly, a policyholder may not immediately recognize that a letter it receives or some demand made upon it could be considered a "claim." The policyholder could be completely unaware that it should inform its carrier of the letter or demand within a defined period of time. The policyholder also may not recognize the potential liability as something that is, or may be, covered by insurance. Later, when that letter or demand evolves into a lawsuit, the notice provisions in claims-made policies may prompt the insurance company to deny coverage based solely on the basis that the policyholder did not inform the insurance company of the initial letter or demand when first received, even though notice of the lawsuit was provided promptly. The insurance company on the risk for the following policy period would deny coverage on the ground that the "claim" was made prior to the policy it issued, leaving the victim without access to insurance assets and the insured without coverage.

Insurance companies have been known to take inconsistent positions about what constitutes a "claim" in order to use notice as a trap. For example, insurance companies sometimes argue that a subpoena is a claim (so if it is not promptly reported, coverage is forfeited) and that a subpoena is not a claim (so if notice if given, the insurance company will say it's not a demand for monetary damages or nonmonetary relief and no amounts are due for responding to the subpoena).

Philadelphia Indemnity Insurance Company, unfortunately, is a poster-child for this type of sharp practice. On January 30, 2001, Philadelphia Indemnity was sued by its insured (Insureon.com) for denying coverage under a directors and officers liability insurance policy in tortious violation of its duty of good faith and fair dealing. Philadelphia Indem. Ins. Co. v. Federal Ins. Co., No. Civ. A. 02-CV-7247, 2004 WL 1170525, at *2 (May 26, 2004), aff'd, 143 Fed. Appx. 419 (3d Cir. 2005). Philadelphia Indemnity did not notify its professional liability carrier until May 13, 2002 – nearly 16 months later. Id. at *4. Philadelphia Indemnity settled the case on or about June 7, 2002, for $1.2 million.

Philadelphia Indemnity's professional liability insurance company (Federal Insurance Company) did not deny all coverage, but instead delivered a check to Philadelphia Indemnity for $350,000, with a letter explaining that Federal's refusal to pay the full amount was due to its belief that had it received timely notice,

Federal could have accepted an earlier settlement offer of $600,000. Id. Thus, it appears that Federal believed it was prejudiced to the extent that the settlement could have been $600,000, if accepted earlier, instead of $1.2 million. Federal did not deny all coverage due to Philadelphia Indemnity's late notice under the claims-made policy; instead, it paid the $600,000, minus the retention of $250,000.

Nevertheless, Philadelphia Indemnity sued Federal on the theory that notice was not late, arguing that while its general counsel had received the Complaint when it was filed, he had not read it, and thus did not know it presented a claim for a wrongful act. Philadelphia Indemnity alleged that Federal was acting in bad faith and sought not only full payment of the $1.2 million settlement, but also punitive damages. In its Brief to the Third Circuit in support of its bad faith claim, Philadelphia Indemnity asserted that its own breach of a notice provision under a claims-made policy was merely a "technical breach":

> Federal made a determination of a "technical breach" without investigation. Its "investigation" consisted of one telephone call to Philadelphia after notice was provided. Federal then asserted a "technical breach" of the notice requirement while lacking the information needed to make that determination.

See Brief of Plaintiff Appellant, Philadelphia Indem. Ins. Co., No. 04-2667, 2004 WL 5322564 at 16 (3d Cir. Dec. 6, 2004).

A few years later, Philadelphia Indemnity failed to follow the golden rule – treating a policyholder far worse under a claims-made policy than Philadelphia Indemnity had itself been treated. See SNL Financial, LC v. Philadelphia Indem. Ins. Co., 455 Fed. Appx. 363, 366 (4th Cir. 2011). In that case, the policyholder was sued on October 3, 2008, received a copy of the complaint by mail on October 20, 2008, and provided notice of the complaint to Philadelphia Indemnity on October 27, 2008. Philadelphia Indemnity denied on the basis of late notice. The Fourth Circuit rejected Philadelphia Indemnity's arguments that letters in January 2008 contained written demands for monetary or non-monetary relief, as they simply reflected a "desire" to meet and a "hope" for an amicable resolution. Although the insured was shown an unsigned draft complaint in July 2008, no demand was made. Id. at 368. The policyholder had to endure the expense and delays of litigation to get its covered claim paid.

As another of many examples, a school district also fell into a notice trap. "*Tardy Insurance Claim May Cost Roslyn Schools Millions*," N.Y. Times, December 5, 2005. In October, 2002, the school district learned that a business manager had stolen money; they thought she had stolen $250,000. The Board of Education decided against filing a claim or making public disclosures because the business manager promised to return the money and the Board wanted to avoid

publicity. When the scheme was revealed to be much larger, and notice was given, the crime policy carrier denied due to late notice. When new Board members came in and sued the old Board members for failing to give notice, the directors and officers liability insurance carrier balked at covering the old Board members, also claiming late notice. The old Board members claimed they relied on professional auditors and lawyers in settling quietly with the business manager. They pursued the district's former general counsel, among others. The malpractice carrier for the general counsel received adequate notice and assumed the defense of the lawyer.

While it may be tempting to blame the Board for its own stupidity, just as Philadelphia Indemnity suffered when it foolishly failed to provide notice, the school district paid public funds to insure itself against crime and against the negligence of its Board members. Notice requirements created a trap that resulted in forfeiture. It allowed the insurance companies who assumed the risk that a District employee would commit a theft (the crime policy) and that the Board members would act wrongfully or negligently (the directors and officers liability policy) to avoid paying on the one occasion when that insurance was most needed. Technical forfeitures like these are highly disfavored for good reason. Requiring the insurance company to prove substantial prejudice allows the insurance company to avoid liability *only* when, and to the extent, the late notice truly and

materially harmed its legitimate interests. That's the treatment Philadelphia Indemnity received from its own carrier when Philadelphia Indemnity breached a notice provision in its own claims-made professional liability insurance policy. Mr. Craft should receive no worse treatment from Philadelphia Indemnity, and all policyholders should be treated with the same level of fairness.

D. The Breach of a Notice Provision in a Claims-Made Policy Should Not Invariably Lead to the Forfeiture of Coverage for a Covered Claim.

1. The Notice-Prejudice Rule is an Anti-Forfeiture Rule.

Colorado strongly disfavors the "forfeiture" of insurance coverage. O'Connor v. Proprietors Ins. Co., 696 P.2d 282, 285 (Colo. 1985) ("Public policy does not favor the forfeiture of insurance coverage based on the insured's technical violation of the insurance policy."); Grooms v. Rice, 429 P.2d 298, 300 (Colo. 1967) ("Forfeitures are not favored and Courts should be liberal in construing the transaction in favor of avoiding a forfeiture."); Moorman Mfg. Co. v. Rivera, 395 P.2d 4, 6 (Colo. 1964) ("Forfeitures are not looked upon with favor and the right thereto must clearly appear before a forfeiture will be upheld."); Genesis Ins. Co. v. Crowley, 495 F.Supp. 2d 1110, 1115 (D.Colo. 2007) ("Colorado law reflects the general disfavor of forfeiture and therefore appears to require substantial, not strict, compliance with a notice provision.").

Black letter law fully supports Colorado's anti-forfeiture precedent:

> To the extent that the non-occurrence of a condition would cause disproportionate forfeiture, a court may excuse the non-occurrence of that condition unless its occurrence was a material part of the agreed exchange.

Restatement (Second) of Contracts § 229 (1979). Indeed, while insurance companies often focus on notice as a "condition" of coverage, conditions can be excused not only on account of disproportionate forfeiture, but also due to impracticability, which is particularly relevant under the facts of this case. Mr. Craft could not give notice because he had no idea the policy existed. Once he learned of the policy's existence, he *immediately* gave notice.

Under black-letter law, Mr. Craft's performance of the notice condition was "temporarily impracticable" because he did not know about the policy. Once notice was provided, the insurance company's duty to pay arose. So long as the insurance company's performance at that later time would not be "materially more burdensome" to the insurance company than earlier performance, the late notice should be excused:

> Impracticability of performance or frustration of purpose that is only temporary suspends the obligor's duty to perform while the impracticability or frustration exists but does not discharge his duty or prevent it from arising unless his performance after the cessation of the impracticability or frustration would be materially more burdensome than had there been no impracticability or frustration.

Restatement (Second) of Contracts § 269 (1979). The "materially more burdensome" standard of Section 269 of the Restatement is identical to the notice-prejudice rule, which requires the insurance company to prove that "its significant interests were prejudiced by the delayed notice." See Friedland, 105 P.3d at 643 ("In Clementi, we concluded that the insurer has the burden of demonstrating by a preponderance of the evidence that its significant interests were prejudiced by the delayed notice."). Accordingly, in the absence of material and substantial prejudice, or harm, or burden, to the insurance company, there is no legal basis for excusing the insurance company from its fundamental obligation to pay a covered claim.

2. Colorado Has a Strong Public Policy in Favor of Protecting Tort Victims.

This Court in Friedland stated that "[i]n Colorado, there is a strong public policy in favor of protecting tort victims." 105 P.3d at 646. Insurance coverage exists, in part, to protect tort victims by providing a source of recovery. Indeed, the protection of tort victims "is a fundamental purpose of insurance coverage, whether or not the state makes the particular coverage mandatory to obtain." Id.

Directors and officers liability insurance provides coverage that is critical to shareholders and to other victims of mistakes and alleged misdeeds perpetrated by corporate officers and directors. The insurance limits, and the damages, in such

cases can be massive. It is not unusual for companies to have insurance limits approaching $100 million. "*More Paid to Shield Directors, Officers from Lawsuits*," Wall St. J. Online, March 7, 2012 (400 companies surveyed reported an average policy limit of $87 million, up from $80 million in 2010). The damages alleged in the downfall of Qwest, a Denver-based phone company, were in the billions, and the costs to defend the officers from those allegations were in the tens of millions. Andy Vuong, *Nacchio's Legal Tab Picked Up By Bylaws Require Qwest to Pay for ex-CEO's Defense*, Den. Post, Jan. 26, 2007. Likewise, the settlements in WorldCom reportedly exceeded $6 billion. Gretchen Morgenson, *Ex-Directors at WorldCom Settle Anew*, N.Y. Times, March 19, 2005. Large damage awards are not uncommon. See Eric Morath, *Ex-Lehman Officers Seek $90 Million to end Lawsuit; Ex-CEO Fuld, Other Former Bank Executives Want Release of Insurance Funds*, Wall St. J. Online, Aug. 26, 2011 (reporting on $90 million settlement of class action lawsuit); Victoria McGrane, *FDIC Reaches $64 million Settlement with WaMu Ex-Officials*, Wall St. J. Online, Dec. 13, 2011 (reporting on $64 million settlement of litigation); Gretchen Morgenson, *10 Ex-Directors from WorldCom to Pay Millions*, N.Y. Times, Jan. 6, 2005 (reporting on $54 million settlement of class action lawsuit).

Almost all professional liability insurance is written on a claims-made basis. Commentators have noted since the 1980's that "claims-made policies dominate the corporate directors' and officers' liability market" and that it is essentially the only type of insurance available to architects, engineers, accountants, and corporate officers and directors. *"Claims Made" Liability Insurance: Closing the Gaps With Retroactive Coverage*, 60 Temp L.Q. 165, 178 (1987).

The availability of directors and officers liability insurance provides a critical source of recovery for tort victims. In addressing this issue in its Certification of Question of State Law, the Tenth Circuit implied that a rule of forfeiture "arguably" allows more people to secure liability insurance. There is absolutely no proof to support that statement. Insurance companies do not set their premiums by counting on a forfeiture windfall caused by insureds reporting claims belatedly. Rather, insurance companies are the only parties who benefit when courts forfeit coverage as a result of late notice.

Allowing the easy forfeiture of coverage for liability claims involving directors and officers will mean that many victims of wrongdoing will have no source of recovery. It will also mean that well-meaning professionals, like doctors, nurses, engineers, architects, and attorneys will find their personal assets at risk even though insurance was purchased to protect their individual assets and provide

a source of recovery for the victims of their negligence. Allowing an insurance company to collect full premiums yet refuse coverage based on a mistake or technicality where the insurance company cannot demonstrate that it would have acted materially differently had it received notice earlier or that its costs will now be materially higher is unduly severe and inequitable.

3. Typically, Policyholders Have No Ability To Select Between Claims-Made and Occurrence Insurance Policies.

Policyholders usually do not have the option to purchase an "occurrence" form instead of one that is "claims-made." A critical part of virtually any business's risk management program is insurance coverage such as D&O,[1] E&O,[2] and EPL[3] insurance policies. Businesses that are publicly traded on a stock exchange, as well as many others (even non-profit entities), have D&O insurance. A vast array of companies that provide services as well as professionals (doctors, lawyers, accountants, insurance brokers, architects, engineers, etc.) purchase E&O insurance to protect themselves, as well as their patients, clients and customers who may be harmed by professional negligence. EPL coverage is also

---

[1] Directors and officers liability insurance.

[2] Errors and omissions liability insurance.

[3] Employment practices liability insurance.

commonplace in the business world to protect against employment practices liability, such as sexual harassment and age discrimination.

While commercial general liability coverage is still written on an occurrence form, these other types of policies are written almost exclusively on a "claims-made" form. See 23 Appleman on Insurance § 146.4 ("A small percentage of professional liability policies . . . consists of occurrence-based policies"). A policyholder cannot simply shop around or agree to pay more in premiums in order to purchase D&O, E&O and EPL coverage on an occurrence rather than on a claims-made basis.

E. The Differences Between "Occurrence" and Claims-Made Policies Do Not Support A Harsher Rule of Forfeiture In the Claims-Made Context.

1. Prompt Notice Is No More Important in the Claims-Made Context Than in the Occurrence Context.

The purpose of a notice provision is to alert the insurance company to the claim so that the insurance company can both assess and provide coverage, as well as protect its own interests. That is true, regardless of whether the insurance policy is written on a "claims made" or "occurrence" form. Insurance companies sometimes argue that notice is more important in the claims-made context because notice defines the coverage parameters. However, *the date the claim is made* defines the coverage parameters of a claims-made policy, not the date notice is

given. Indeed, the policy at issue in the present case requires the *claim* to be made in the policy period. Notice need not be given within the policy period. If a claim were made a day *prior to the beginning* of the policy period, and notice were given a few days later, during the policy period, there would be no coverage. Likewise, if a claim were made the day *prior to the end* of the policy period, and notice were given a few days later, after the policy period, there would be coverage. The assertion of a "claim" by a third party against the insured is the "trigger" of coverage for a claims-made policy.

Furthermore, while prompt notice of a claim may allow insurance companies to better compute premiums for successive policy periods, that is equally true for "occurrence" policies. If an insurance company knows about a loss, it can use that loss to compute premiums for future policies. The notice prejudice rule does not foreclose the argument that notice was particularly important to the carrier in the particular situation, but merely requires that it be *proven* and that it be *material*. It should be obvious that an unproven and immaterial allegation of prejudice (like "maybe we could have charged more premium to someone sometime") cannot be the basis for a forfeiture of all coverage for a covered claim. Indeed, prompt notice is often, perhaps even usually, more important under occurrence policies than under claims-made policies because occurrence policies typically provide (1) a

duty to defend; (2) first-dollar coverage; and (3) the possibility the multiple policies could be triggered for a single loss.

First, occurrence policies typically include a duty to defend, in which the insurance company assumes the defense – selecting counsel and controlling many strategic litigation decisions. In contrast, claims-made policies often do not include a duty to defend, leaving the choice of counsel and the strategic legal decisions in the hands of the insured. The insurance company pays the attorneys' fees as an element of loss under a claims-made policy, but often has neither the right nor duty to defend the lawsuit. The insurance company may be only minimally involved in the defense, receiving only periodic updates. Under an occurrence policy, the insurance company has *more* interest in prompt notice because prompt notice facilitates the insurance company's assumption of the defense and control of the claim. In the claims-made context, when there is no duty to defend, the insurance company loses nothing by reimbursing the defense expenses later instead of sooner.

Second, claims-made policies often have self-insured retentions that require the insured to bear the first portion of the loss. Only after such self-insured retentions are exhausted must the insurance company pay any defense costs or indemnity for any settlement or judgment. So, it can be months or years, if at all,

after a claim is noticed (even if noticed timely) before the insurance company actually faces financial exposure.

Third, with claims-made policies, the insurance company is exposed only under the policy issued in the year the claim was first brought against the policyholder. Under occurrence policies, which are triggered by the date of bodily injury or property damage, the same insurance company may be exposed under policies that span several years if the property damage or bodily injury continues over time. See Hoang v. Assurance Co. of America, 149 P.3d 798, 802 (Colo. 2007); Public Service Co. of Colorado v. Wallis and Companies, 986 P.2d 924, 939 (Colo. 1999). Applying the notice-prejudice rule to a claims-made policy will not subject the claims-made insurance company to increased exposure to so-called "long-tail" claims. Rather, it requires the insurance company to pay for the risk it assumed – the risk that a covered claim would be asserted against the policyholder in that one particular policy period.

2. Claims-Made Policies Typically Cover Individual Insureds Who Have No Bargaining Power and Who Do Not Even Receive the Insurance Policy.

Claims-made policies often cover individuals who have no role in purchasing the coverage. A hospital's medical malpractice policy insures many doctors, nurses, and other medical professionals. A law firm's legal malpractice

policy insures many lawyers and perhaps other professionals. A company's directors and officers liability insurance policy covers many individual executives. In each of these examples, the individual insureds are not named on the policy, do not receive a copy of the policy, and may not even know an insurance policy exists. It may be that, even if a particular individual insured generally knows a policy exists, or should exist, the insured has no idea which insurance company issued the coverage or how to give notice.

Mr. Craft had absolutely no bargaining power or options with regard to the terms and conditions of insurance. Insurance companies sell form insurance policies to corporations. Those notice provisions are dictated by the insurance company to the policyholder in almost all instances. Just as in automobile liability or general liability policies written on an "occurrence" form, those "notice" or "reporting" terms are non-negotiable. Colorado courts "have long viewed insurance policies with a critical eye" because:

> although they may not technically qualify as contracts of adhesion...[they] are not ordinary, bilateral contracts, either; they are "not the result of bargaining" and are often imposed on a "take-it-or-leave it basis...." Because of the unequal bargaining position between insurers and insureds, and because insureds are generally not "highly sophisticated in the art of reading insurance policies...," an increased risk exists that insurers may intentionally, or inadvertently, exploit insureds.

Bailey v. Lincoln Gen. Ins. Co., 255 P.3d 1039, 1049 (Colo. 2011) (internal citations omitted). Individuals who are insured under commercial policies do not negotiate the terms and conditions of coverage.

3. Colorado Insurance Law Treats Claims-Made Policies Like a Hazardous Product.

The Legislature enacted a statute requiring, as a condition for issuance of claims-made insurance to "any person in this state" that (1) the insurer defines the nature of risks or exposures to be insured on the claims-made policy; (2) the policy contain "clear and adequate disclosure and alerts the insured to the fact that the policy is a claims-made policy and explains the unique features distinguishing it from an occurrence policy"; (3) the policy "clearly defines the events and conditions which trigger coverage and defines when and how a claim is deemed to be made or is deemed made"; (4) the policy offers, "at the insured's option," the purchase of an extended reporting period; (5) the policy requires the insurance company to provide loss information; (6) any exclusions for known occurrences, products or locations be included only upon signature by the insured; and (7) all persons engaged in the sale, consultation, or adjustment of the claims-made policy be trained and certified. C.R.S.A. § 10-4-419.

Implementing the statute, Colorado insurance regulations contain special requirements for persons who will be handling the claims-made insurance product.

The Commissioner of Insurance has promulgated and adopted regulations "to establish standards for the training of all persons engaged in the sale or consultation of claims-made policies . . . or in adjusting claims under such policies." 3 C.C.R. 702-5:5-1-8.

In addition, the regulations "provide minimum disclosure standards for claims-made insurance policies." Id. The required warnings are extensive, focusing on the coverage gaps that can be created. Mr. Craft never received the policy. He never received the warnings. Mr. Craft had no opportunity to purchase an extended reporting period option, just as he had no knowledge of his coverage. If an insurance company is not going to provide a copy of the insurance policy to each of the individuals it is insuring, then the insurance company cannot expect strict compliance with the terms and conditions of the insurance policy by those individual insureds, under penalty of forfeiture.

F. Insurance Companies Can Waive the Right to Assert Late Notice.

"An insurer should raise (or at least reserve) all defenses within a reasonable time after learning of such defenses, or those defenses may be deemed waived or the insurer may be estopped from raising them." U.S. Fidelity & Guar. Co. v. Budget Rent-A-Car Systems, Inc., 842 P.2d 208, 210 n. 3 (Colo. 1992). Here, Philadelphia Indemnity complains of late notice, but when it received notice, it did

nothing. It did not reserve its rights. It did not assert late notice. It did nothing for several *months*. Philadelphia Indemnity should be deemed to have forfeited any forfeiture. Unlike Mr. Craft who acted as promptly as he possibly could, Philadelphia Indemnity sat on its rights. It has unclean hands and cannot now complain of any delayed notice, particularly not without proving substantial prejudice.

VII. CONCLUSION

United Policyholders respectfully requests that this Court answer the questions presented in the affirmative. Colorado's notice-prejudice rule does, and rightfully should, apply to "claims-made" liability insurance policies just as it applies to "occurrence" liability insurance policies. This Court drew no distinction between the various types of liability insurance policies in Friedland, and no distinction is warranted, particularly not on the facts of this case in which the individual insured had no knowledge of the insurance policy and gave notice as soon as practicable.

Mr. Craft's coverage should not be forfeited as a remedy for late notice unless Philadelphia Idemnity proves that it was materially prejudiced.

Dated: March 20, 2014

AMICUS CURIAE UNITED POLICYHOLDERS

By: 

James M. Davis (#33594)
REED SMITH LLP
10 South Wacker Drive
40th Floor
Chicago, IL 60606-7507
Main: 312.207.1000
Facsimile: 312.207.6400

Timothy P. Law
REED SMITH LLP
Three Logan Square, Suite 3100
1717 Arch Street
Philadelphia, PA 19103
Direct: 215.241.1262
Main: 215.851.8100
Facsimile: 215.851.1420

- and –

Amy Bach
UNITED POLICYHOLDERS
381 Bush Street, 8th Floor
San Francisco, California 94104
Telephone: (415) 393-9990
Facsimile: (415) 677-4170

CERTIFICATION OF SERVICE

I hereby certify that on the 20th day of March, 2014, a true and correct copy of the foregoing BRIEF OF *AMICUS CURIAE* UNITED POLICYHOLDERS IN SUPPORT OF APPELLANT was sent to the following counsel via prepaid first class mail:

Heather R. Hanneman
RECHT KORNFELD PC
1600 Stout Street, Suite 1000
Denver, CO 80202

Scott R. Larson
SCOTT LARSON PC
1580 Lincoln Street, Suite 500
Denver, CO 80203

Bethany Culp
Suzanne J. Jones
HINSHAW & CULBERTSON
333 S.7th Street, Suite 2000
Minneapolis, MN 55402

Dated: March 20, 2014

AMICUS CURIAE UNITED POLICYHOLDERS

By: 

James M. Davis (#33594)