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The Policy

The newsletter of the Illinois State Bar Association's Section on Insurance Law

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From the editor

BY JAMES T. NYESTE

This issue of The Policy summarizes every insurance opinion applying Illinois law decided in January through March 2019 by the Illinois appellate court (7) and the seventh circuit (1).

Additionally, this issue contains an extensive article by Mark Rouleau on the insured's duty to give timely notice to its insurer of a covered event or claim. Keep this useful article handy for its many citations.

This will be my last issue of The Policy as the managing co-editor. It has been 10 years and 45 issues, with many articles and many hundreds of case summaries, plus the Words and Phrases Index of every issue. And, who can ever forget the Great Illinois Insurance Law Quiz in the 2014 issues? Many thanks go to those of you who have contributed articles and case summaries. My apologies if I have omitted anyone:

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Insured's duty of notice

BY MARK ROULEAU

An insured's duties to the insurer are covered in three principal concepts; (a) the duty to give notice to the insurer; (b) the duty to cooperate; and (c) the duty of good faith and fair dealing. This installment covers the first of these duties, the duty of an insured to give notice of a covered event to the insurer.

There are basic governing concepts that apply to all relationships between insureds and insurers. For the most part (excepting governmental intervention), these governing concepts define the nature, extent and scope of an insured's duties to the insurer.

Insurance Policies are Contracts

General: The language of an insurance policy is construed so as to determine and give effect to the intentions of the parties as expressed by the words of the policy.[1] An insurance policy, like any other contract, must be construed as a whole, giving effect to every provision.[2] In construing the policy, the court should take into account the type of insurance purchased, the nature of the risks involved, and the contract's overall purpose.

Public Policy: One form of governmental intervention in the contract of insurance is the application of public policy. Recall that all insurance contracts are enmeshed with the concept of public policy from the outset. This relationship with public policy is obvious when one considers the insurable interest requirement. Nearly one-hundred fifty years ago, the Illinois Supreme Court repeated, "[a] policy obtained by a party who has no interest in the subject of insurance, is a mere wager policy."[3] Although the concept of what constitutes an insurable interest has expanded over the years, the public policy requirement that there must be an insurable interest persists to this day.[4] Insurance agreements embody more than just a private agreement between the insured and the insurer.[5] The public policy informing insurance contracts affords protection to members of the public, generally innocent third parties.[6] The

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As always, if any readers have articles that they would like to submit for publication, please contact any member of the Insurance Law Section Council. Likewise, please don't hesitate to contact us with any suggestions for improvement of The Policy newsletter.

Contributing to this issue

Alexander Baker
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Insured's duty of notice

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statutes and regulations that govern insurance contracts will be considered when construing the policy. To determine whether a provision within an insurance agreement violates public policy, courts consider whether the contract is so capable of producing harm that its enforcement would be contrary to the public interest.[7] A contract will not be invalidated unless it is obviously contrary to the public policy in Illinois declared by the constitution, the statutes, or the decisions of the courts, or unless it is obviously injurious to the public welfare.[8] The specific facts and circumstances of an individual case determine whether an insurance clause violates public policy.[9]

UM & UIM: Public policy concerns underpin the statutorily required uninsured motorist (UM) coverage and underinsured motorist coverage (UIM) in automobile policies. The full extent of these coverages and the accompanying statutory rights and duties are beyond the scope of this article excepting

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the issue of the insured's duty to provide notice.

The fundamental rule in Illinois is that when an insurer seeks to place limits on the uninsured motorist provisions of its insurance policy, the limitations must be construed in favor of the policyholder and "most strongly against the insurer."[10] Section 143a of the Illinois Insurance Code (215 ILCS 5/143a (West 2014)) specifically requires an insurer to provide uninsured motorist coverage for the benefit of persons who may be entitled to recover from persons who own and operate uninsured motor vehicles.[11] The purpose of this statute is to place the injured party in substantially the same position had the uninsured driver carried the minimum required liability insurance. 215 ILCS 5/143a (West 2014)."[12]

Ambiguity: "Whether an ambiguity exists turns on whether the policy language is subject to more than one reasonable interpretation."[13] Unambiguous words in the policy are to be given their plain, ordinary, and popular meaning.[14] "Where competing reasonable interpretations of a policy exist, a court is not permitted to choose which interpretation it will follow.[15] Rather, in such circumstances, the court must construe the policy in favor of the insured and against the insurer that drafted the policy.[16]

Duties

Insured's Duties to Insurer: The terms and conditions of an insurance policy control the insured's duties.[17] An insured that breaches a condition precedent to policy coverage should not be permitted to invoke the coverage provisions of that policy.[18]

Duty to Give Notice: The Illinois cases discuss two kinds of notice – notice of an *occurrence*[19] and notice of a *lawsuit or claim*.[20] Insurance policies often have separate notice provisions addressing these.

When an insurance contract includes a provision requiring the insured to notify the insurer of an *occurrence* or a *claim* against it, the notice provision is a "condition precedent to the triggering of the insurer's contractual duties."[21] Where an insurance policy requires the insured to notify the insurer of an *occurrence* "as soon as practical," the test is whether notice was given within a reasonable time.[22] "[T]he insured has a duty to give timely notice to the insurer if the circumstances of an *occurrence* would suggest to a reasonably prudent person a claim for damages covered by the policy might be asserted against the insured."[23] When an insured fails to comply with the notice provision, the insurer may be relieved of its duty to defend the insured under the policy.[24]

Purpose of Notice Provision: The purpose of a notice requirement in an insurance policy is to enable the insurer to make a timely and thorough investigation of the insured's claim.[25]

- **Valid Condition Precedent to Coverage:** Notice provisions are considered valid conditions precedent to coverage, and should not be considered mere technical requirements for the convenience of the insurer.[26] The notice requirements of a policy apply not only to the named insured but also to unnamed additional insureds under an omnibus or permitted user clause.[27]
  Providing notice to an insurer is not excused based upon the insured's fear of criminal prosecution.[28]
  Notice is a condition precedent to the insurer's duties to defend and indemnify and without giving proper notice there is no duty on the part of the insurance company.
- **Timeliness of Notice:** The timeliness of the notice given is generally a question of fact, but it may be properly determined as a matter of law where the material facts are not in dispute.[29] In *West Am. Ins. Co. v. Yorkville Nat'l Bank*, 238 Ill.2d 177, the insured did not give written notice of the suit until approximately 27 months after the underlying lawsuit was filed. Overturning the appellate court, our Supreme Court found that the trial court's holding that this delay was reasonable was not against the manifest weight of the evidence. Referencing its decision in *Country Mutual Ins. Co. v. Livorsi Marine*, 856 N.E.2d 338, 222 Ill.2d 303, 305 Ill.Dec. 533 (Ill., 2006) the court identified five factors that may be considered "in determining whether notice to an insurer has been given within a reasonable time:
  (1) the specific language of the policy's notice provision;
  (2) the insured's sophistication in commerce and insurance matters;
  (3) the insured's awareness of an event that may trigger insurance coverage;
  (4) the insured's diligence in ascertaining whether policy coverage is available; and
  (5) prejudice to the insurer."[30]

Cases Applying the Five Factors from *Livorsi*

- The specific language of the policy's notice provision:
  - Immediate or reasonable: "The term "immediate," in the context of insurance policy notice provisions, has been interpreted in a similar manner to the phrase "as soon as practicable."[31]
  - Written notice within 120 days of occurrence (Auto): A 120-day notice provision in an auto policy is a dilution or diminution of the uninsured motorist statute and is therefore against public policy.[32] Although the notice provision is not ambiguous; the court applied the reasonableness factors found in *Country Mut. Ins. Co. v. Livorsi Marine, Inc.*,[33] as guidelines to determine whether the notice provision violates public policy of the uninsured motorist statute.
  - Terms such as "may involve" and "likely to involve" grant "the insured some discretion in evaluating the case" before triggering notice duties.[34] This is particularly true in excess coverage policies "Excess insurers are not interested in every accident, but only in those that may be serious enough to involve [them]. [Citation.] Since excess coverage is contingent on exhaustion of primary or underlying policies, excess insurers generally do not require

notification of occurrences until the excess policy is reasonably likely to be implicated. [Citation.] Consequently, insurance policies for excess coverage generally grant the insured some discretion in evaluating the case."[35]

- The insured's sophistication in commerce and insurance matters: This factor was found to weigh against the insured where the insured "was savvy enough to have both primary and excess/umbrella coverage, it retained a part-time and later a full-time general counsel . . . it had the benefit of local litigation counsel . . . it retained coverage counsel, and it had cash on hand to pay its litigation expenses and its share of settlement".[36]

  Similarly this factor went against a general contractor of a construction project. In her deposition, the contractor's general counsel testified the insured had previously made multiple claims under the same policy and that she understood the importance of timely notifying the contractor's insurer of any lawsuits naming the contractor. Counsel also stated she notified the contractor's president that claims should be made within certain specified periods to meet the contractor's obligations to comply with the notice terms of the insurance policy. The record showed that the contractor, as an additional insured, had tendered notice to other insurers within one month after their respective primary insureds were named as defendants in the underlying action, thus the court found the contractor to be sophisticated in commerce and insurance.[37]
- The insured's awareness of an event that may trigger insurance coverage: Where an insured is undeniably aware of an injury that may trigger insurance coverage, this factor is to be decided in favor of the insurer.[38] Even where there is confusion of what was the triggering event in a UIM claim (i.e., the crash or learning that the defendant driver lacked sufficient coverage) waiting until settlement of the claim against the at-fault UIM motorist was too late.[39]

  "It cannot be plausibly said that by the notice provision the insurer intended that every occurrence or accident had to be reported to it."[40] "An insured is not required to report every injury it is aware of, it is only required to report those injuries which a reasonable person would understand is likely to lead to a claim."[41] One can see how this analysis is connected to the policy language containing the notice provision where the language grants the insured some discretion.

  A paintball injury which takes place outside the playing arena, which is the same injury likely to occur in the playing arena, that is believed by the insured not to require reporting is not unreasonable as a matter of law.[42] Likewise, an insured's belief that an incident may not be covered under insurance policy, though erroneous, may excuse a delay in notice.[43] An insured's conclusion that no claim would be filed was not an unreasonable determination, even though erroneous and where the insured's management was experienced in safety litigation.[44]
- The insured's diligence in ascertaining whether policy coverage is available: A lengthy delay in giving notice is not an absolute bar to coverage provided the insured's reason for the delay is justifiable under the circumstances.[45] Courts have recognized that an insured's reasonable belief of noncoverage under a policy may be an acceptable excuse for the failure to give timely notice, even where the delay is lengthy.[46] One court excused a two and one-half year delay in giving notice because the 19–year–old insured could not have reasonably known that the occurrence would have been covered by his mother's homeowner's policy.[47] Another court held a two-year delay excused as the insured did not reasonably believe that an accident in her boyfriend's Jeep was covered by her father's excess coverage insurance policy.[48] Still another court found a two-year delay excusable where the insureds did not reasonably believe that an accidental shooting occurring outside their home would be covered by their homeowner's policy.[49]
- Whether the insured, acting as a reasonably prudent person, believed the occurrence or lawsuit was not covered by the policy is a question of fact, which the court reviews under the manifest weight standard.[50] Where the insured is informed by its agent (independent but approved by the insurer) that the policy afforded no coverage, a reasonably prudent party in the situation of the insured would not continue to pursue coverage under the policy.[51]
- Where an insured initially looked to the policy for primary coverage, then determined primary coverage was subject to a policy exclusion for professional liability, and subsequently looked no further in the policy, the insured's further inaction was not excusable. An insured's abandonment of its reliance on that primary coverage exclusion is an indication that it did not exercise reasonable diligence in ascertaining whether policy coverage was available.[52]
- Although general contractor did not know the identity of the employer of a negligent worker, the delay by general contractor in providing notice as an additional insured under subcontractor's policy was not excusable because general contractor was charged with knowledge of identity of subcontractor contractually responsible to perform the allegedly defective work alleged in plaintiff's complaint.[53]
- Notice to Agent Upon Receiving

Motion for Default: Where the insured testified that he did not recall receiving a summons, who when receiving a motion for default contacted his agent before a default order was entered and 77 days before a judgment was entered created a question of fact regarding the insured's diligence which cannot be determined as a matter of law on a motion for summary judgment, as the court cannot make a credibility determination regarding the insured's statements.[54]

- Prejudice to the insurer: "The presence or absence of prejudice to the insurer is one factor to consider when determining whether a policyholder has fulfilled any policy condition requiring reasonable notice."[55] In evaluating whether the insured breached the notice provisions of the policy, Illinois courts consider whether the insurer was prejudiced.[56] Prejudice has been found to be established as a matter of law under circumstances where an insurer was prevented from participating in the underlying lawsuit until after judgment has been entered.[57]

  Actual prejudice was shown where (1) the insured had exhausted its arguments through motion practice and was facing an impending trial date; (2) insured's litigation counsel had advised that a trial and postjudgment appeal was foolhardy; (3) the judge and insured's litigation counsel advised that, without question, a jury would give the party suing the insured a substantial, multimillion dollar judgment; (4) discovery was nearly complete and the insured's litigation counsel was adamant that the party suing the insured would realize the real strength of her case if she were able to depose insured's psychologists, who were scheduled for depositions; and, (5) finally, insured was actively negotiating a settlement with the plaintiff suing insured. Such facts indicate that the insurer was deprived of any meaningful participation in the defense until the case was in the last possible stage.[58]

Insurer's actual notice from other sources: The Supreme Court has stated:

> "[c]ontrary to the appellate court's statement that actual notice has "no bearing" on whether notice was given within a reasonable time, actual notice to an insurer is relevant to whether the insurer has been prejudiced by a delay in receiving written notice as specified by the policy. "[W]here the insurance company has actual notice of the loss or receives the necessary information from some other source, there is no prejudice to the insurer from the failure of the insured to give notice of the claim. (*citations omitted*). An insurance company is deemed to have "actual notice" of a lawsuit where it has sufficient information to locate and defend the suit. (*citations omitted*). [I]n order to have actual notice sufficient to locate and defend a suit, the insurer must know both that a cause of action has been filed and that the complaint falls within or potentially within the scope of the coverage of one of its policies. (*citations omitted*). [59]

Notice by claimant (injured party): Frequently, where the injured party or claimant knows of the defendant's insurer, the injured party will provide notice of the claim to the defendant's insurer. However, mere statements threatening the possibility of suit are not sufficient for "actual notice" purposes.[60] "[A]ctual notice can arise from a letter or phone call to the insurer from an injured party or an attorney asserting a claim under the insurance policy."[61]

UM and UIM Notice: Providing sufficient and timely notice of an uninsured or underinsured motorist claim is a trap for the unwary. Frequently attorneys do not know (1) if the at-fault drivers have adequate coverage (potential excess and secondary policies that might be stacked); or (2) if the coverage available to the defendant will be exhausted with other claims (multiple injured parties). There are multiple cases discussing the difference between placing an insurer on notice of the occurrence or incident and placing them on notice of the UM or UIM claim.[62] Likewise, simply notifying the insurer of a UM or UIM claim is not the same thing as demanding arbitration.[63] Most insurance policies have a time period during which arbitration must be demanded. Providing notice of a UM/UIM claim is not the same thing as demanding arbitration and naming an arbitrator.[64] Waiting until the underlying claim against the at-fault party is resolved to determine whether the at-fault driver is actually underinsured is too late under the terms of the policy.[65] Given these cases, it is extremely important that counsel representing an individual with a potential UM or UIM claim immediately place the client's insurance company on notice (1) of the claim, (2) the demand for arbitration, (3) the name of her client's appointed arbitrator, and (4) her attorney lien. Failure to notify the carrier of each of these things may cause the attorney's client to lose their contract rights, possibly replacing them with a claim against her counsel.

Surviving Summary Judgment: In order to survive summary judgment where the insurer asserts a lack of notice, an injured party (or the insured) can present evidence of (a) a telephone call to the insurer advising it of the lawsuit;[66] (b) sending a letter to insurer advising it of the lawsuit,[67] or (c) forwarding a copy of the complaint and/or summons to insurer.[68] Best practice would suggest that unless an insurance company has acknowledged representation of a defendant in writing, plaintiff's counsel should send a copy of the complaint to the insurer. This also applies to any amended complaints which seek to plead into the policy coverage. The notice should be sent by certified mail, return receipt requested, to avoid any dispute as to whether the notice was received by the insurer.

Conclusion

Apart from paying for the coverage, notice is the first duty owed by an insured to the insurance company. Without timely and proper notification to the insurer of the occurrence, claim, or suit, none of the other rights or duties matter. Where an attorney represents a client (plaintiff or defendant)

where potential insurance coverage for the event exists, it is extremely important that the attorney notify all of the insurers possibly affording coverage for the event. ■

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1. *Crum & Forster Managers Corp. v. Resolution Trust Corp.*, 156 Ill.2d 384, 391, 189 Ill.Dec. 756, 620 N.E.2d 1073 (1993).
2, *Central Illinois Light Co. v. Home Insurance Co.*, 213 Ill.2d 141, 153, 290 Ill.Dec. 155, 821 N.E.2d 206 (2004).
3, *Guardian Mutual Life Insurance Co. of New York v. Hogan*, 80 Ill. 35, 1875 WL 8703, 22 AmericanRep. 180 (Ill., 1875) quoting *Reese v. The Mutual Benefit Life Insurance Co.*, 23 N. Y. 516.
4, See Peter N. Swisher, *Wagering on the Lives of Strangers: The Insurable Interest Requirement in the Life Insurance Secondary Market*, 50 Tort Trial Insurance Prac. L.J. 703 (2015).
5, *M.F.A. Mutual Insurance Co. v. Cheek*, 66 Ill.2d 492, 500–01, 6 Ill.Dec. 862, 363 N.E.2d 809 (1977).
6, *Id*.
7. *Phoenix Insurance Co. v. Rosen*, 242 Ill.2d 48, 54, 350 Ill. Dec. 847, 949 N.E.2d 639 (2011).
8. *Phoenix*, 242 Ill.2d at 55, 350 Ill.Dec. 847, 949 N.E.2d 639.
9. *Kleinwort Benson North America, Inc. v. Quantum Financial Services, Inc.*, 181 Ill.2d 214, 226, 229 Ill.Dec. 496, 692 N.E.2d 269 (1998).
10. *Hartford Accident & Indemnity Co. v. LeJeune*, 114 Ill.2d 54, 59, 101 Ill.Dec. 876, 499 N.E.2d 464 (1986).
11. *Severs v. Country Mutual Insurance Co.*, 89 Ill.2d 515, 518, 61 Ill.Dec. 137, 434 N.E.2d 290 (1982).
12. *Smith v. American Heartland Insurance Co.*, 2017 IL App (1st) 161144, 72 N.E.3d 789 (Ill. App., 2017).
13. *Hobbs v. Hartford Insurance Co. of the Midwest*, 214 Ill.2d 11, 17, 291 Ill.Dec. 269, 823 N.E.2d 561 (2005).
14. *Country Mutual Insurance Co.*, 222 Ill.2d at 311, 305 Ill. Dec. 533, 856 N.E.2d 338.
15. *Outboard Marine Corp. v. Liberty Mutual Insurance Co.*, 154 Ill.2d 90, 108-09, 180 Ill.Dec. 691, 607 N.E.2d 1204 (1992).
16. *American States Insurance Co. v. Koloms*, 177 Ill.2d 473, 479, 227 Ill.Dec. 149, 687 N.E.2d 72 (1997); *Outboard Marine Corp.*, 154 Ill.2d at 108-09, 180 Ill.Dec. 691, 607 N.E.2d 1204." *Employers Insurance of Wausau v. Ehlco Liquidating Trust*, 708 N.E.2d 1122, 186 Ill.2d 127, 237 Ill. Dec. 82 (Ill., 1999).
17. *American Country Insurance Co. v. Bruhn,* 289 Ill. App. 3d 241, 247, 682 N.E.2d 366, 370 (1997); *Erie Insurance Exchange v. Nieman*, 2014 IL App (4th) 130792-U (Ill. App., 2014); and *Northbrook Prop. & Casualty Insurance Co. v. Applied Systems, Inc.*, 729 N.E.2d 915, 313 Ill. App.3d 457, 246 Ill.Dec. 264 (Ill. App., 2000).
18. See *City of Chicago v. U.S. Fire Insurance Co.*, 124 Ill. App.2d 340, 347, 260 N.E.2d 276, 280 (1970); *International Environmental Corp. v. National Union Fire Insurance Co.,* 860 F.Supp. 511 (N.D.Ill.1994); *La Salle National Trust, N.A. v. Schaffner, 818 F.Supp. 1161 (N.D.Ill.1993)*; and *Employers Insurance of Wausau v. Ehlco Liquidating Trust*, 687 N.E.2d 82, 292 Ill.App.3d 1036 (Ill. App., 1997).
19. *Motorola Solutions, Inc. v. Zurich Insurance Co.*, 2017 IL App (1st) 161465, 83 N.E.3d 1063 (Ill. App., 2017).
20. *Maier v. CC Services, Inc.*, 2019 IL App (3d) 170640-U (Ill. App., 2019) finding that a notice of attorney's lien did not constitute notice of a UIM claim.
21. *Northbrook Property & Casualty Insurance Co. v. Applied Systems, Inc.,* 313 Ill. App. 3d 457, 464, 729 N.E.2d 915, 920-21 (2000).
22. *Northern Insurance Co. of New York v. City of Chicago,* 325 Ill. App. 3d 1086 1091, 759 N.E.2d 144, 149 (2001).
23. *National Bank of Bloomington v. Winstead Excavating of Bloomington,* 94 Ill. App. 3d 839, 842, 419 N.E.2d 522, 524 (1981), emphasis added.
24. *Northern Insurance*, 325 Ill. App. 3d at 1091, 759 N.E.2d at 149; *Erie Insurance Exchange v. Nieman*, 2014 IL App (4th) 130792-U (Ill. App., 2014).
25. *Safeway Insurance Co. v. Ebijimi*, 2018 IL App (1st) 170862 (Ill. App., 2018); *Allstate Insurance Co. v. Carioto*, 194 Ill. App. 3d 767, 780 (1990); *INA Insurance Co. v. City of Chicago*, 62 Ill.App.3d 80, 19 Ill.Dec. 519, 379 N.E.2d 34 (1978). (*Barrington Consolidated High School v. American Insurance* (1974), 58 Ill.2d 278, 319 N.E.2d 25; *McFadyen v. North River Insurance Co.* (1965), 62 Ill.App.2d 164, 209 N.E.2d 833).
26. See *Kerr v. Illinois Central Railroad Co.*, 283 Ill.App.3d 574, 219 Ill.Dec. 81, 670 N.E.2d 759 (1996) (stating that compliance with notice provision is a condition precedent to coverage and if breached, the insurer will not be liable under the policy); *Industrial Coatings Group, Inc. v. American Motorists Insurance Co.*, 276 Ill.App.3d 799, 213 Ill.Dec. 317, 658 N.E.2d 1338 (1995) (stating that the requirement of timely notice is a condition precedent of the policy). See also *Millers Mutual Insurance Ass'n v. Graham Oil Co.*, 282 Ill.App.3d 129, 218 Ill.Dec. 60, 668 N.E.2d 223 (1996); *American Country Insurance Co. v. Cash*, 171 Ill.App.3d 9, 120 Ill.Dec. 834, 524 N.E.2d 1016 (1988); *Equity General Insurance Co. v. Patis*, 119 Ill.App.3d 232, 74 Ill.Dec. 846, 456 N.E.2d 348 (1983); *INA Insurance Co.*, 62 Ill.App.3d 80, 19 Ill.Dec. 519, 379 N.E.2d 34; *City of Chicago v. United States Fire Insurance Co.*, 124 Ill.App.2d 340, 260 N.E.2d 276 (1970).
27. *Mt. Hawley Insurance Co. v. Robinette Demolition, Inc.*, 2013 IL App (1st) 112847, 994 N.E.2d 973, 374 Ill. Dec. 36 (Ill. App., 2013) citing *International Harvester Co. v. Continental Casualty Co.,* 33 Ill.App.2d 467, 472, 179 N.E.2d 833 (1962).
28. *Farmers Auto. Insurance Ass'n v. Burton*, 2012 IL App (4th) 110289, 967 N.E.2d 329, 359 Ill.Dec. 599 (Ill. App., 2012) See also *American Country Insurance Co. v. Bruhn,* 289 Ill.App.3d 241, 249, 224 Ill.Dec. 805, 682 N.E.2d 366, 371 (1997); *American Standard Insurance Co. of Wisconsin v. Slifer,* 395 Ill.App.3d 1056, 1062–63, 335 Ill.Dec. 653, 919 N.E.2d 372, 377–78 (2009).
29. *Williams v. BNSF Railway Co.*, 29 N.E.3d 1097 (Ill. App., 2015)*; Northbrook Property & Casualty Insurance Co. v. Applied Systems, Inc.,* 313 Ill.App.3d 457, 465, 246 Ill.Dec. 264, 729 N.E.2d 915 (2000).
30. *West American Insurance Co. v. Yorkville National Bank*, 238 Ill.2d 177 citing *Country Mutual,* 222 Ill.2d at 313.
31. See *Zurich Insurance Co. v. Walsh Construction Co. of Illinois, Inc.,* 352 Ill.App.3d 504, 512, 287 Ill.Dec. 834, 816 N.E.2d 801 (2004) ("'Immediate' in this context 'has been uniformly interpreted to mean within a reasonable time, taking into consideration all the facts and circumstances' "), quoting *Kenworthy v. Bituminous Casualty Corp.,* 28 Ill. App.3d 546, 548, 328 N.E.2d 588 (1975)." *West American Insurance Co. v. Yorkville National Bank*, 238 Ill.2d 177, 2010 WL 3704985, 939 N.E.2d 288, 345 Ill.Dec. 445 (Ill., 2010).
32. *Smith v. American Heartland Insurance Co.*, 2017 IL App (1st) 161144, 72 N.E.3d 789 (Ill. App., 2017).
33. 222 Ill.2d 303, 313, 305 Ill.Dec. 533, 856 N.E.2d 338 (2006).
34. *Kerr v. Illinois Cent. R. Co.*, 670 N.E.2d 759, 283 Ill. App.3d 574 (Ill. App., 1996).
35. *American States Insurance Co. v. National Cycle, Inc.*, 260 Ill.App.3d 299, 311, 197 Ill.Dec. 833, 631 N.E.2d 1292, 1301 (1994).
36. *MHM Services, Inc. v. Assurance Co. of American*, 2012 IL App (1st) 112171, 975 N.E.2d 1139 (Ill. App., 2012).
37. *AMCO Insurance Co. v. Erie Insurance Exchange*, 49 N.E.3d 900 (Ill. App., 2016).
38. *AMCO Insurance Co. v. Erie Insurance Exchange*, 49 N.E.3d 900 (Ill. App., 2016).
39. *United National Insurance Co. v. Kemper*, 2014 IL App (1st) 122877 (Ill. App., 2014).
40. *Barrington Consolidated High School,* 58 Ill.2d at 282-83, 319 N.E.2d 25 (1974).
41. *Efficient Construction,* 225 Ill.App.3d at 181-82, 167 Ill. Dec. 458, 587 N.E.2d 1073 (1992).
42. *Berglind v. Paintball Bus. Ass'n*, 402 Ill.App.3d 76, 930 N.E.2d 1036, 341 Ill.Dec. 522 (Ill. App., 2010).
43. See, e.g., *Rivota v. Kaplan,* 49 Ill.App.3d 910, 7 Ill.Dec. 176, 364 N.E.2d 337 (1977).
44. *Commercial Underwriters Insurance Co. v. Aires Environmental Services, Ltd.,* 259 F.3d 792, 798 (7th Cir.2001).
45. See *Northbrook Property & Casualty Insurance Co. v. Applied Systems, Inc.,* 313 Ill.App.3d 457, 465, 246 Ill.Dec. 264, 729 N.E.2d 915 (2000); *McFarlane v. Merit Insurance Co.,* 58 Ill.App.3d 616, 619, 16 Ill.Dec. 176, 374 N.E.2d 951 (1978).
46. See, *e.g., Allstate Insurance Co. v. Carioto,* 194 Ill.App.3d 767, 780, 141 Ill.Dec. 389, 551 N.E.2d 382 (1990).
47. *Id*.
48. *Grasso v. Mid-Century Insurance Co.,* 181 Ill.App.3d 286, 290, 129 Ill.Dec. 927, 536 N.E.2d 977 (1989).
49. *Brotherhood Mutual Insurance Co. v. Roseth,* 177 Ill. App.3d 443, 449, 126 Ill.Dec. 669, 532 N.E.2d 354 (1988).
50. *Farmers Automobile Insurance Ass'n v. Hamilton,* 64 Ill.2d 138, 142–43, 355 N.E.2d 1 (1976).
51. *West American Insurance Co. v. Yorkville National Bank*, 238 Ill.2d 177, 2010 WL 3704985, 939 N.E.2d 288, 345 Ill. Dec. 445 (Ill., 2010)
52. *MHM Services, Inc. v. Assurance Co. of American*, 2012 IL App (1st) 112171, 975 N.E.2d 1139 (Ill. App., 2012)
53. *AMCO Insurance Co. v. Erie Insurance Exchange*, 49 N.E.3d 900 (Ill. App., 2016)
54. *Berglind v. Paintball Bus. Ass'n*, 402 Ill.App.3d 76, 930 N.E.2d 1036, 341 Ill.Dec. 522 (Ill. App., 2010). *AYH Holdings, Inc. v. Avreco, Inc.* 357 Ill.App.3d 17, 31, 292 Ill. Dec. 675, 826 N.E.2d 1111 (2005); *Pietruszynski v. McClier Corp., Architects and Engineers, Inc.,* 338 Ill.App.3d 58, 67-68, 272 Ill.Dec. 778, 788 N.E.2d 82 (2003).
55. See *Country Mutual,* 222 Ill.2d at 317, 305 Ill.Dec. 533, 856 N.E.2d 338.
56. *Country Mutual Insurance Co. v. Livorsi Marine, Inc.,* 222 Ill. 2d 303, 312, 856 N.E.2d 338, 343 (2006).
57. See *Vega v. Gore,* 313 Ill. App. 3d 632, 634-35, 730 N.E.2d 587, 589 (2000); *American Country Insurance Co. v. Cash,* 171 Ill. App. 3d 9, 10-11, 524 N.E.2d 1016, 1017-18 (1988)." *Erie Insurance Exchange v. Nieman*, 2014 IL App (4th) 130792-U (Ill. App., 2014).
58. *MHM Services, Inc. v. Assurance Co. of American*, 2012 IL App (1st) 112171, 975 N.E.2d 1139 (Ill. App., 2012).
59. *West American Insurance Co. v. Yorkville National Bank*, 238 Ill.2d 177, 2010 WL 3704985, 939 N.E.2d 288, 345 Ill. Dec. 445 (Ill., 2010).
60. See *Johnson v. Samuels*, 40 Ill.App.2d 417, 419-20, 189 N.E.2d 780, 781-82 (1963).
61. *Illinois Founders Insurance Co. v. Co. v. Barnett*, 304 Ill. App. 3d 602, 607 (1999).
62. *Maier v. CC Services, Inc.*, 2019 IL App (3d) 170640-U (Ill. App., 2019) Maier v. CC Services, Inc., 2019 IL App (3d) 170640-U (Ill. App., 2019).
63. See *Buchalo v. Country Mutual Insurance Co.*, 83 Ill. App. 3d 1040 (1980) (holding that the insured's letter to the insurer concerning arbitration failed to make an unequivocal demand for arbitration and failed to name an arbitrator as required under the policy); see also *Shelton v. Country Mutual Insurance Co.*, 161 Ill. App. 3d 652 (1987) (holding that an insured's notice of attorney's lien did not serve to commence the arbitration process).
64. See *Rein v. State Farm Mutual Automobile Insurance Co.*, 407 Ill. App. 3d 969 (2011). Which uniformly stands for the proposition that mere notice of a UIM claim is not synonymous with an arbitration demand.
65. "See, *e.g., Parish v. Country Mutual Insurance Co.* , 351 Ill. App. 3d 693, 699, 286 Ill.Dec. 516, 814 N.E.2d 166 (2004) (affirming dismissal of complaint where the insured did not become aware of the extent of her damages until after the two-year period for beginning dispute resolution proceedings against the insurer had expired); *Vansickle v. Country Mutual Insurance Co.* , 272 Ill. App. 3d 841, 842–43, 209 Ill.Dec. 528, 651 N.E.2d 706 (1995) (affirming dismissal of complaint where the other driver tendered payment more than two years after the accident, after the two-year time limitation for beginning dispute resolution proceedings under the insurance policy had expired); *Hannigan v. Country Mutual Insurance Co.* , 264 Ill. App. 3d 336, 343, 201 Ill.Dec. 465, 636 N.E.2d 897 (1994) (affirming dismissal of complaint where the insured did not become aware that the other motorist was underinsured until after the two-year contractual time limitation for beginning dispute resolution proceedings had expired)." *Sweis v. Founders Insurance Co.*, 2017 IL App (1st) 163157, 98 N.E.3d 485 (Ill. App., 2017).
66. *Rice v. AAA Aerostar, Inc.*, 690 N.E.2d 1067, 294 Ill. App.3d 801, 229 Ill.Dec. 20 (Ill. App., 1998).
67. See *Gregory v. Highway Insurance Co.*, 24 Ill.App.2d 285, 297, 164 N.E.2d 297, 303 (1960).
68. See *Olivieri v. Coronet Insurance Co.*, 173 Ill.App.3d 867).

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Cooke v. Jackson National Life Insurance Co., Nos. 18-3527 & 18-3583 Cons. (7th Cir. March 26, 2019).
HOLDING: Section 155 (215 ILCS 5/155) does not provide a basis for awarding sanctions for an insurance company's conduct in federal court, as federal rules apply to penalize any unreasonable conduct in federal litigation.

Corbin v. The Allstate Corp., 2019 IL App (5th) 170296 (January 29, 2019).
HOLDING:
Auto insurance rates are not afforded any protection under the filed rate doctrine as the Department of Insurance does not have authority to approve or disapprove rates. For the same reason, the court need not defer to the Department under the doctrine of primary jurisdiction but may determine whether insurer's rating practices constitute deceptive and unfair business practices in violation of the Consumer Fraud and Deceptive Business Practices Act.

Hess v. The Estate of Klamm, 2019 IL App (5th) 180220 (February 11, 2019).
HOLDING: Liability limits of $100,000 per person and $300,000 per accident, listed twice on the three pages of policy Declarations, would be stacked, providing total limits of $200,000 per person and $600,000 per accident.

Sanders v. Illinois Union Insurance Co., 2019 IL App (1st) 180158 (January 19, 2019). **HOLDING:**
Coverage for the "offense" of malicious prosecution is triggered when the offense is complete, that is, when there has been exoneration. Exoneration occurred within policy period, triggering potential coverage for malicious prosecution.

State Farm Mutual Auto. Insurance Co. v. Murphy, 2019 IL App (2d) 180154 (March 29, 2019). **HOLDING:** Driver, who was permissive user of vehicle, was not covered as an insured by umbrella liability policy; and the insured owner of the vehicle, who was a passenger at the time of the accident, was not using the vehicle in a manner sufficient to trigger coverage for the driver.

State of Illinois ex rel. Leibowitz v. Family Vision Care, LLC, 2019 IL App (1st) 180697 (March 12, 2019). **HOLDING:** Under Insurance Claims Fraud Protection Act (740 ILCS 92/1 *et seq.*), a whistleblower or relator who has personal, nonpublic information of possible wrongdoing is an "interested person" under the Act and need not have a personal injury to have standing; nor does the State need to have suffered any monetary damages to confer standing on the relator.

Travelers Property Casualty Co. v. ArcelorMittal USA Inc., 2019 IL App (1st) 180129 (March 11, 2019). **Holding:** Summary judgment in favor of insurer on its subrogation action was affirmed where contract between defendant and the insured did not require insured to obtain a subrogation waiver under insurer's policy.

West Bend Mutual Insurance Co. v. TRRS Corp., 2019 IL App (2d) 180934 (March 1, 2019). **HOLDING:** Circuit court had no authority to stay worker's compensation claim while declaratory judgment action was pending. Because claimant's 19(b) petition before the Worker's Compensation Commission seeks to determine only whether he is entitled to receive medical services, staying the proceedings is contrary to purpose of expeditious resolution of such issues. ■

Case summaries

Cooke v. Jackson National Life Insurance Co., Nos. 18-3527 & 18-3583 Cons. (7th Cir. March 26, 2019).

Norma Cooke, the widow of Charles Cooke, sued Jackson National Life Insurance Company for the death benefit under her husband's life insurance policy. Jackson National contended that it did not owe the policy benefits because the policy had lapsed for non-payment of premiums. The trial court determined that the policy was valid and in effect and ordered Jackson National to pay $191,000 on the policy of life insurance. The trial court also determined that Jackson National had a good faith (although erroneous) basis for denying the claim but found that it acted unreasonably *during the course of the litigation* by failing to attach the complete insurance policy to its response to plaintiff's Rule 12(c) motion for judgment on the pleadings. That failure prolonged the course of the litigation, and the court ordered Jackson National to reimburse the plaintiff's legal fees ($42,835 plus interest). The court premised its authority for the sanction on Illinois Insurance Code Section 155 (215 ILCS 5/155). Jackson National appealed the award of attorney's fees.

The seventh circuit reversed. The court stated, "The district court assumed that §5/155 governs the conduct of litigation in federal court. It did not explain why. Many cases hold that federal, not state, rules apply to procedural matters—such as what ought to be attached to pleadings—in all federal suits, whether they arise under federal or state law. Federal rules and doctrines provide ample means to penalize unreasonable or vexatious conduct in federal litigation. The district court's decision to rely on state rather than federal law was a mistake."

The court then examined whether there was any basis to affirm the sanction based on federal rules, but found none. There is no obligation on the defendant in responding to a Rule 12(c) motion for judgment on the pleadings to attach documents. And the other alternative grounds suggested by plaintiff—Rules 11, 26(g)(3), and 37(b)(2)(C), plus 28 U.S.C. §1927—likewise did not provide any basis for sanctioning the insurance company under the facts of the case.

The decision teaches that the federal court's power to penalize unreasonable litigation conduct must be based on federal rules and not on section 155.

Corbin v. The Allstate Corp., 2019 IL App (5th) 170296 (January 29, 2019).

Plaintiffs filed a class action complaint in Madison County alleging that Allstate engaged in deceptive and unfair business practices in violation of the Consumer Fraud and Deceptive Business Practices Act and was unjustly enriched by charging long-time customers higher auto insurance premiums than other customers with the same risk factors—in other words, by imposing an undisclosed customer loyalty surcharge. According to the complaint, Allstate had for years collected and analyzed data and determined that loyal policyholders were willing to pay higher premiums than the risk they presented. Plaintiffs claimed that since 2012, Allstate began charging its longtime policyholders higher premiums than it charged new customers who presented the same risk but were less willing to tolerate a price increase. Plaintiffs alleged that Allstate did not disclose this practice in its rate filings with the Illinois Department of Insurance or in its communications with existing customers upon renewal of their auto policies. Plaintiffs sought damages, injunctive relief, and restitution or disgorgement of ill-gotten gains from unjust enrichment.

Allstate moved to dismiss the complaint, arguing that the action was barred by the filed rate doctrine and the primary jurisdiction doctrine. Allstate argued that it is required to file its rates and underwriting manuals, as well as any rate changes, with the Director of the Department of Insurance and that it is required to calculate and charge premiums in accordance with those filed rates. Allstate further argued that the Director is vested with general oversight of the insurance industry, including automobile insurance rates, and authorized to evaluate and declare that an insurer's trade practices constitute unfair methods of competition or deceptive practices.

The circuit court denied Allstate's motion to dismiss, finding that the complaint was not barred by either the filed rate doctrine or the primary jurisdiction doctrine. The court found that, while the Department of Insurance has general oversight of the insurance industry and may find that an insurer's practices constitute unfair methods of competition or deceptive practices, the Department does not have authority to review and disapprove of filed auto insurance rates. Subsequently, the court certified two questions for appellate review under Rule 308, and the appellate court, fifth district, granted interlocutory review of those questions.

The first question concerned the applicability of the filed rate doctrine. The filed rate doctrine protects public utilities and other regulated entities from civil actions if the entity is required to file its rates with the governing regulatory agency and if the agency has the authority to set, approve, or disapprove those rates. The two principles at the core of the doctrine are (a) the need to prevent regulated entities from engaging in price discrimination as between ratepayers and (b) the preservation of the exclusive role of agencies in setting and approving uniform rates, as there is a historical aversion to rate setting by courts. However, the court explained that statutory history shows that the Illinois Department of Insurance is without authority to approve or disapprove the rates charged, either prior or subsequent to the filing of the rates. Prior to 1969, Illinois did require "prior approval" of insurance rates by the Department. Ill. Rev. Stat. 1949, ch. 73, § 1065.1 et seq. But in 1969, the General Assembly enacted an open competition rating law, which went into effect on January 1, 1970. This legislation included a sunset clause providing that the

open competition law would be "effective only until August 1, 1971, unless the General Assembly extends the term of or removes this restriction on the period during which this Article is to be applicable." However, the legislature did not renew the open competition rating law in August 1971. Nor did it reinstate the "prior approval" law or enact a new rating law. Thus, since 1971, Illinois has been left without any property, casualty, and motor vehicle insurance rating laws other than that the rates must be filed. Consequently, insurers, such as Allstate, are free to establish rates in response to their independent economic analyses, and the Department of Insurance does not have the authority to set, approve, or disapprove of those rates. Therefore, Allstate's automobile insurance rates are not afforded any protection under the filed rate doctrine.

The second certified question concerned the applicability of the doctrine of primary jurisdiction. The doctrine of primary jurisdiction proposes that a court should, in some instances, stay the proceedings before it and allow an administrative agency to decide an issue when the agency has specialized or technical expertise or when there is a need for a uniform answer or an administrative standard from the agency. The Illinois Department of Insurance has authority to investigate and determine whether a company is engaged in an unfair or deceptive practice, but except for certain defined practices in section 424 of the Insurance Code, the director has no enforcement authority other than to file, through the attorney general, a complaint in the circuit court. Further, Allstate has not shown that the Director or the Department of Insurance has any specialized knowledge or technical expertise with regard to the deceptive rating practices alleged in plaintiffs' complaint. Therefore, the Department of Insurance does not have primary or exclusive authority in the area of regulating deceptive rating practices by insurance companies. Instead, the allegations of unfair and deceptive business practices and unjust enrichment come within the experience and conventional competence of the Illinois courts.

Hess v. The Estate of Klamm, 2019 IL App (5th) 180220 (February 11, 2019)

This case, involving the issue of stacking of liability limits, arose from an automobile accident in which two individuals were killed and another was seriously injured. Following the accident, guardians and independent administrators for the decedents and injured minor (collectively, "Plaintiffs") filed suit and alleged that the accident was proximately caused by the negligent acts or omissions of the Defendant's decedent. Plaintiffs' Complaint also alleged multiple counts directed to Meridian Security Insurance Company ("Meridian"), the liability insurer for Defendant, for judicial declarations that the bodily injury liability limits listed on the auto policy could be stacked across vehicles. The Meridian policy listed four covered vehicles, and the Declarations pages included a separate premium amount paid for each of those four vehicles. The policy's Declarations pages generally identified the limits for "Liability-Bodily Injury" coverage as $100,000 per person / $300,000 per accident. Plaintiffs asked the circuit court to declare that these limits could be stacked across the four insured vehicles, for a total combined limit of $400,000 per person and $1.2 million per accident.

In contrast, Meridian argued that stacking of the liability limits was prohibited by the express terms of its policy, which provided that "[t]he limits of liability shown in the Declarations for each person for Bodily Injury Liability is our maximum limit of liability for all damages … arising out of 'bodily injury' sustained by any one person in any one accident. Subject to this limit for each person, the limit of liability shown in the Declarations for each accident for Bodily Injury Liability is our maximum limit of liability for all damages for 'bodily injury' resulting from any one auto accident. … This the most we will pay regardless of the number of: 1. 'Insureds'; 2. Claims made; Vehicles or premiums shown in the Declarations; or 4. Vehicles involved in the auto accident." Relying upon this anti-stacking language, Meridian asked the circuit court to conclude that the limits of liability coverage for this accident were $100,000 per person, and $300,000 per accident.

Following a hearing on cross-motions for summary judgment, the trial court entered a judgment finding that the coverage limits should be stacked for a total of $400,000 per person, and $1.2 million per accident. The trial court also entered a finding, pursuant to Illinois Supreme Court Rule 304(a) that there was no just reason to delay an appeal from the judgment, and Meridian appealed.

Observing that the relevant sections of the Declarations pages were on multiple pages, the fifth district appellate court noted that the first three insured vehicles were listed on the first page and that the fourth insured vehicle was listed on the second page. Further, it observed the first page identified the three separate premium amounts for each of the insured vehicles, along with identifying liability limits of $100,000 per person, and $300,000 per accident and, again, that the second page described and listed the premium amount for the fourth vehicle as $100,000 per person, and $300,000 per accident. Meridian explained that due to the number of covered vehicles, formatting required the fourth vehicle to be listed on the second page of the Declarations.

The court began its analysis by stating that the Illinois Supreme Court has considered similar stacking and Declarations page issues in *Bruder v. Country Mutual Insurance Co*. The court explained that the key difference between those Declarations pages in *Bruder* and *Hobbs* was that while the Declarations in those cases listed multiple premiums, corresponding to multiple insured vehicles, in each case, the relevant Declarations page listed the coverage limits only once. Nonetheless, in each case, the Illinois Supreme Court observed that multiple printings on a Declarations page of policy limits for various covered automobiles could create an ambiguity; this observation is known as the "*Bruder dicta*." Accordingly, the court paid attention to the fact that the policy's liability limits were listed twice—once on the first page and once on the second page of the Declarations.

In response, Meridian stated that they did *not* list the limits of liability separately for each vehicle but rather, due the number of vehicles, listed the coverage limits again on the second page for the fourth vehicle. Meridian argued that such repetition should not be construed as creating an ambiguity since it was simply necessitated by space and formatting issues. However, the fifth district disagreed.

Analyzing the Declarations pages, the court found significant the fact that,

with respect to uninsured/underinsured motorists coverage, each Declarations page simply stated "(SEE BELOW)" and that page two of the Declarations pages provided one entry:

UNINSURED/UNDERINSURED MOTORISTS – TOTAL LIMTS FOR ALL VEHICLES COVERED UNDER THIE POLICY

BODILY INJURY $100,000
EACH PERSON $300,000

EACH ACCIDENT
PREMIUM $86.00

Based upon the structure of the Declarations pages, the fifth district concluded that an ambiguity existed because the bodily injury liability limits—$100,000 per person and $300,000 per accident—were listed twice on the Declarations pages and that the anti-stacking provisions referred the reader of the policy to the Declarations pages for the applicable liability limits. Thus, an automobile insurance policy that purports to contain an anti-stacking provision but also contains a limit of liability clause that states that the limit of liability shown in the Declarations page is the maximum limit of liability, is not only ambiguous but must also be construed in favor of the insured. As a result, the Meridian bodily injury liability limits, which were listed twice on three pages of Declarations, were stacked twice for a total combined limit of $400,000 per person and $1.2 million per accident.

Sanders v. Illinois Union Insurance Co., 2019 IL App (1st) 180158 (January 19, 2019).

Rodell Sanders filed suit in federal court, alleging a claim for malicious prosecution against the City of Chicago Heights and several officers. Sanders alleged that the City manipulated and coerced witnesses, as well as fabricated evidence and withheld exculpatory information following a 1993 shooting in which he was implicated. Sanders was tried for that crime several times, with mistrials occurring or convictions being overturned. In 2014 he was tried again and finally acquitted. As a result, Sanders claimed that the City and its officers were guilty of malicious prosecution. Sanders' federal suit was settled for $15 million. The settlement agreement provided that the City would pay $2 million; that United National, the City's insurer at the time Sanders was initially charged with the crime, would pay $3 million; and that the City would assign its rights to Sanders to pursue the balance of the settlement from the City's other insurers.

Pursuant to the assignment, Sanders became a plaintiff in the state court declaratory judgment action originally filed by the City against Illinois Union Insurance Company and Starr Indemnity and Liability Company, which had issued primary and excess policies, respectively, that were in force in 2011 to 2014. The City remained a party plaintiff in the declaratory action. The insurer defendants filed a 2-619(a)(2) motion to dismiss the plaintiffs' second amended complaint, arguing that the trigger for the malicious prosecution coverage was the original filing of criminal charges, an event which took place in 1994, long prior to the effective date of the defendants' policies. They further argued that Sanders' retrials, including the 2014 retrial, did not qualify as a new or additional coverage triggers because they were merely a continuation of the original 1994 prosecution.

In response, plaintiffs argued that, because the policies provided coverage for the "offense of malicious prosecution," the coverage trigger was not the filing of the original criminal charges but the completion of the "offense" of malicious prosecution upon Sanders' exoneration in 2014. Plaintiffs alternatively argued that, even if coverage was triggered by the wrongful conduct, originally by the 1994 initial prosecution, the retrials, which occurred in 2013 and 2014, were additional coverage triggers based on wrongful conduct while the defendants' policies were in effect.

The trial court granted the defendants' motions, finding that the policy language in conjunction with applicable case law required the conclusion that the coverage trigger was the initiation of the original prosecution, not Sanders, exoneration. The court also rejected plaintiffs' argument that Sanders retrial was a coverage trigger. Plaintiffs appealed.

On appeal to the Illinois appellate court, first district, the dispute focused on when the offense was deemed to occur. Neither of the defendants' policies defined the term "offense." Relying on Black's Law Dictionary, which defined "offense" as "a violation of the law, a crime, often a minor one," the court concluded that an "offense" refers to the legal cause of action that arises from the wrongful conduct, not the wrongful conduct itself. In support of this analysis, the court noted that tort causes of action, are comprised of several elements, only one of which is the wrongful act. Therefore the cause of action was not deemed to arise until all elements had been satisfied. Thus, the court agreed with plaintiffs that only upon completion of the final element is a wrongful act transformed into a crime or tort.

The court found further support in a review of other policy language. The Illinois Union policy defined "personal injury" by reference to a list of offenses, including malicious prosecution. Nowhere in the policy was there a reference to the underlying wrongful acts. The policies' reference to the offenses by their proper legal name made it clear that coverage was triggered by the completed cause of action and not the underlying wrongful conduct.

The court rejected the defendants' reliance on the line of cases holding that the coverage trigger was the initiation of the alleged malicious prosecution. The court distinguished the cases, noting that they involved markedly different policy language. The case principally relied on by defendants was *First Mercury Insurance Co. v. Ciolino*, 2018 IL App (1st) 171532. In distinguishing *First Mercury*, the court focused on a key distinction in the two policies. The First Mercury policy required the offense to have been "committed" during the policy period, while the Illinois Union provided coverage for claims arising out of an occurrence "happening" during the policy period. Relying upon Merriam-Webster which defines "commit" as "to carry out deliberately" and "happen" as "to occur by chance," the definitions made clear that it was not unreasonable to interpret

the First Mercury policy as requiring an affirmative act, *i.e.*, the initiation of the wrongful prosecution. In contrast, "offense" in the Illinois Union policy, when read in conjunction with "happening during the policy period," should be construed to refer to the exoneration that completes the tort of malicious prosecution.

Defendants further argued that, if coverage is triggered by the completed tort of malicious prosecution, then where the same set of facts give rise to a claim for false arrest and to a claim for malicious prosecution, it is possible that one insurer would provide coverage for one claim and another insurer for the other. The court acknowledged this possibility but noted that it was incumbent upon the insurers to modify their policy language should they wish to avoid such a result. Accordingly, the court reversed the trial court's dismissal of the plaintiffs' Second Amended Complaint.

The dissent may be read to suggest that the majority opinion's focus on completion of the tort was a strained interpretation of the Illinois Union policy. Accordingly, the dissent focused on the plaintiffs' alternative argument, *i.e.*, that the retrials in 2013 and 2014 were additional coverage triggers independent of exoneration. Relying upon *St. Paul Fire & Marine Insurance Co. v. City of Waukegan*, 2017 IL App (2d) 160381, which rejected the identical argument, the dissent reached the conclusion that the initial charge and the retrials arose from the same false charges. As such the retrials were not independent occurrences triggering coverage.

State Farm Mutual Auto Insurance Co. v. Murphy, 2019 IL App (2d) 180154 (March 29, 2019).

On September 11, 2015, a multi-vehicle accident occurred at the intersection of Grove Road and U.S. Route 52. At the time of the accident, James Hollander was driving Sandra Wendland's 2015 Nissan Altima with her permission. Wendland was a passenger, as was Alyssa Guarino. In another vehicle was Cheyenne Flowers. The third vehicle was a tractor-trailer driven by Keith Keigher in the scope of his employment for J-M Transport. The accident occurred when Wendland's Nissan, driven by Hollander, collided with the tractor-trailer, which then collided with Flower's vehicle. Hollander died as a result of the accident.

Wendland, Flowers, and the guardian for Guarino each filed negligence actions against Hollander's estate. All of their complaints alleged that the collision was caused by Hollander's negligence; none alleged that Hollander was vicariously liable for any acts or omissions by Wendland or that Wendland was liable in any matter.

State Farm Mutual Automobile Insurance Company, which had issued an umbrella policy to Wendland, undertook the defense of Hollander's estate in the injury suits under a reservation of rights but filed a declaratory judgment action seeking a declaration that it had no duty to defend or indemnify the estate. State Farm acknowledged that Hollander was a "permissive user" of the Nissan but took the position that Hollander did not qualify as an "insured" under the policy. The relevant policy language was:

DEFINITIONS

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6. "insured" means:

a. you and your relatives whose primary residence is your household;

b. any other human being under the age of 21 whose primary residence is your household and who is in the care of a person described in 6.a.;

c. any other person or organization to the extent they are liable for the use of an automobile, recreational motor vehicle or watercraft by a person included in 6.a. or 6.b.

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12. "relative" means any person related to you by blood, adoption, or marriage.

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15. "you" and "your" mean the person or persons shown as "Named Insured" on the declarations page. If a named insured shown on the declarations page is a human being then you and your includes the spouse of the first person listed as a named insured if the spouse resides primarily with that named insured.

State Farm filed a motion for summary judgment arguing that Hollander did not fall within paragraph 6(c) of the umbrella policy because he was not alleged to be liable for the use of a motor vehicle by a person described in paragraph 6(a) or 6(b). The trial court initially denied the motion for summary judgment, but after hearing State Farm's motion to reconsider, the trial court reversed its original ruling and granted summary judgment in State Farm's favor.

The appellate court, second district, applied the *de novo* standard of review. In a declaratory judgment action, where the issue is whether the insurer has a duty to defend and indemnify pursuant to an insurance policy, the court ordinarily looks first to the allegations of the underlying complaint and compares those allegations to the relevant provision of the insurance policy. An insurer's duty to defend arises when: 1) the complaint is brought against an insured; and 2) the facts as alleged in the complaint fall, or potentially fall, within the policy's coverage. Where an insurer has no duty to defend, the insurer has no duty to indemnify.

When construing an insurance policy, a court's primary objective is to ascertain and give effect to the intentions of the parties as expressed in their insurance contract. If the words of the policy are clean and unambiguous, the court must afford them their plain and ordinary meaning. When ambiguity exists, the policy is to be construed strictly against the insured, who drafted the policy and liberally in favor of coverage for the insured. The courts are not to strain to find ambiguity where none exists.

Here, the defendants, the injured parties, contended that Hollander was an insured because Wendland was using her vehicle, as a passenger to visit her daughters, when the accident occurred and because the "last-antecedent rule" either provides a reasonable interpretation of paragraph 6(c) to make Hollander an insured or renders the policy language ambiguous. State Farm contended that Hollander was not an "insured" under the policy because the underlying complaints did not allege that Hollander was liable for Wendland's acts or omissions and the policy language was unambiguous.

The appellate court agreed with State Farm. None of the underlying

complaints alleged that Hollander was liable for Wendland's use of the Nissan. The underlying complaints alleged that Hollander was negligent in his own operation and use of the Nissan. None of the parties alleged that Wendland was negligent or liable in any manner. Thus, Hollander was not an insured under the policy as described above.

Defendants argued that the umbrella policy "simply required [Wendland] to be 'using' the vehicle at the time of the occurrence. The appellate court disagreed, finding that this argument ignored the connection between "liable for the use of an automobile" and "by [Wendland]" in the definition above. Thus, Wendland's use of the vehicle, without more, was not sufficient to trigger coverage for Hollander.

As to the last-antecedent rule, it is a grammatical canon providing that "relative or qualifying words, phrases, or clauses are applied to the words or phrases immediately preceding them and are not construed as extending to or including other words, phrases, or clauses more remote." Under defendants' argument, the clause "by a person included in 6.a. or 6.b." refers only to the use of watercraft, not to the use of an automobile or recreational motor vehicle. Again, the appellate court disagreed with defendants, finding that the policy language was clear and ambiguous and that the last-antecedent rule only applies to resolve ambiguities. Accordingly, the appellate court found that the trial court correctly granted State Farm's summary judgment motion and affirmed the trial court's order.

State of Illinois ex rel. Leibowitz v. Family Vision Care, LLC, 2019 IL App (1st) 180697 (March 12, 2019).

This case is one of first impression for two interrelated questions under the Illinois whistleblower statute for insurance fraud, the Insurance Claims Fraud Protection Act (Act):

whether the State can assign to a third party an injury to its sovereignty and whether the third party can derive standing from that injury absent monetary damages to the State?

Marie Cahill worked as an office administrator for Family Vision Care from October 2012 through January 2016 handling insurance billing practices. According to Cahill, roughly 90% of Family Vision Care's revenue was generated from claims it submitted to Vision Service Plan, an insurance company. In order to gain insurance payments from Vision Service Plan, an optometry practice must sign a provider agreement certifying itself as optometrist-owned and controlled. Family Vision Care is owned and controlled by Surgery Partners, Inc., not an individual optometrist.

After Cahill left her employment with Family Vision Care in January 2016, she filed for bankruptcy. The trustee of Cahill's bankruptcy estate filed a whistleblower complaint against Family Vision Care alleging a violation of the Insurance Claims Fraud Protection Act for submitting fraudulent claims to Family Vision Plan. The Estate alleged that Dr.Gula from Family Vision Care was fraudulently signing the provider agreements, falsely certifying that she was the owner of Family Vision Care. Cahill's estate also alleged that Frank Soppa, a Surgery Partners executive, instructed Cahill to lie to Vision Service Plan about Family Vision Care's true owners. The trial court dismissed the Estate's complaint under section 2-619(a)(9), finding that the estate lacked standing because Cahill was not a directly injured "interested person" under the Act and that only the insurer, Vision Service Plan, could bring a *qui tam* claim under the Act. Further, the trial court held that, even if the Estate could bring a *qui tam* action, the Estate did not allege an "injury in fact" that the State could assign to it because the State's only injury from the alleged violation was to its sovereignty, not to its treasury, which could not be assigned to a private citizen. The Estate appealed.

The Illinois appellate court, first district, held that, under the plain language of the Act and its purpose in combating insurance fraud, the State need not have suffered monetary damages to confer standing on a relator. Moreover, the court wrote, "[I]n the *qui tam* context, a whistleblower employee like Cahill, who has personal, nonpublic information of possible wrongdoing, is an "interested person" under the statute and need not have a personal injury to have standing."

The Insurance Claims Fraud Protection Act (Act), added civil penalties to existing criminal remedies for fraud against private insurance companies. Relevant to this case, subsection 5(b) creates a private cause of action against any entity that violates the Illinois criminal code relating to insurance fraud. The Act parallels the Illinois False Claims Act by including a *qui tam* enforcement provision allowing private whistleblowers with information about insurance fraud to sue for civil penalties. Section 15(a) of the Act provides that "An interested person, including an insurer, may bring a civil action for a violation of this Act for the person and for the State of Illinois."

Although a matter under the Act must be brought by an individual with standing, by definition, *qui tam* suits involve claims brought by private parties to assist the executive branch in enforcing the law, "the violation of which affects the interest of the government, not the individual relator, whose only motivation in bringing the suit is to recover a piece of the action given by statute." Standing in *qui tam* litigation under the False Claims Act has been addressed by the Illinois Supreme Court. In *Scachitti v. UBS Financial Services*, 215 Ill. 2d 484, 508 (2005), the court acknowledged that in a *qui tam* case there is "no cognizable injury in fact suffered by the relator." But, relying on the United States Supreme Court's decision in *Vermont Agency*, 529 U.S. 765, the court held that a relator has standing as a partial assignee of the State's claim. The court held, "…the plain language of the Act and its purpose support a finding that the State need not have suffered monetary damages to confer standing on a relator." The court elaborated:

Section 15(a) provides "[a]n interested person, including an insurer, may bring a civil action for violation of this Act for the person and for the State of Illinois." It does not require the State to have incurred monetary damages for an "interested person" to bring a civil action on the State's behalf. Moreover, the statute's purpose directly involves combating insurance fraud, not recouping damages. Requiring

the State to assign damages to a relator would defeat the purpose of the Act because it would preclude a whistleblower from bringing a claim on the State's behalf.

Family Vision Care argued that allowing a citizen to sue on behalf of the state would open the floodgates to litigants seeking fees without merit. The court disagreed with this argument, since the only way to bring a *qui tam* claim is if (i) the State authorizes the relator to sue on behalf of the State and the relator and (ii) the State retains control of the litigation. The Act requires that both of these be met as well.

Family Vision Care further argued that Cahill's bankruptcy estate could not be an "interested party" under the Act because Cahill had not personally suffered any damages. But there is nothing in the language of the Act requiring an "interested party" to have suffered any injury. Allowing whistleblowers, like Cahill, who have evidence of potential fraud to bring a claim, advances the Act's purpose—protection of the public from insurance fraud. Accordingly, the appellate court reversed the trial court's dismissal based on lack of standing.

Travelers Property Casualty Co. v. ArcelorMittal USA Inc., 2019 IL App (1st) 180129 (March 11, 2019).

ArcelorMittal leased lift truck tractors (essentially forklifts) from Gallo pursuant to a written equipment supply contract. The tractors were used to move steel coils at ArcelorMittal's steel fabrication mill in East Chicago, Indiana. One of the leased tractors caught fire and was destroyed. Arcelor Mittal was responsible for maintenance under the contract, and there was no dispute that it was responsible for the loss. ArcelorMittal offered to compensate Gallo for the tractor, but Gallo rejected the offer as too low. Gallo then submitted a claim to its insurer, Travelers, under an inland marine policy. Travelers settled Gallo's claim for $305,625.

Travelers then brought a subrogation action against ArcelorMittal for breach of the maintenance provisions of the supply contract. ArcelorMittal defended the claim by asserting that Gallo was in breach of the supply contract by failing to obtain a subrogation waiver from Travelers; it brought a third- party complaint against Gallo ArcelorMittal for $35,625 and also dismissed ArcelorMittal's third-party complaint against Gallo. ArcelorMittal appealed.

The appellate court, first district, construed the contract between ArcelorMittal and Gallo. The contract required both parties to have or to obtain five specific types of insurance coverage: (i) workers' compensation; (ii) employer's liability; (iii) commercial general liability; (iv) commercial auto liability; and (v) umbrella or excess liability insurance. With respect to each of these policies, the parties were to obtain from their insurers subrogation waivers for each of the coverages. Inland marine insurance, which was the type coverage from Travelers which paid for the destruction of the lift truck, was not one of the specified types of policies required by the supply contract, nor was there any catch-all clause requiring subrogation waivers under all of Gallo's insurance coverages. Accordingly, ArcelorMittal was not entitled to a subrogation waiver. Summary judgment in favor of Travelers was affirmed, as was the dismissal of ArcelorMittal's third-party complaint against Gallo.

West Bend Mutual Insurance Co. v. TRRS Corp., 2019 IL App (2d) 180934 (March 1, 2019).

Gary Bernardino sustained a shoulder injury in a forklift accident during the course of his employment with TRRS Corporation and Commercial Tire Services, Inc., which required him to undergo rotator cuff surgery. Bernardino subsequently needed a second surgery, which prompted him to file an "Application for Adjustment of Claim" with the Illinois Workers' Compensation Commission on March 29, 2018. On September 12, 2018, Bernardino filed a petition before the IWCC for an immediate hearing under Section 19(b) of the Workers' Compensation Act and for penalties for unreasonable and vexatious delay under Sections 16 and 19(k) of the Act.

West Bend Mutual Insurance Company was the workers' compensation carrier for Bernardino's employers. It filed a declaratory judgment action seeking a ruling that it had no duty to defend or indemnify TRRS and Commercial Tire against Bernardino's worker's compensation claim because the employers had violated the terms of the insurance policy by failing to provide proper notice of Bernardino's injuries to West Bend. West Bend then almost immediately filed an emergency motion asking the circuit court to stay the IWCC proceedings pending a resolution of the pending declaratory judgment action. The circuit court granted West Bend's request and entered an order staying the underlying IWCC proceedings. Bernardino then filed an emergency motion in the circuit court to vacate the stay order on the grounds that the proper venue for that request was the IWCC. The circuit court denied the motion, and Bernardino filed an interlocutory appeal. Bernardino then also filed a subsequent motion in the circuit court to vacate the stay order arguing that, at the very least, the stay should be limited to the issue of determining coverage based upon notice to West Bend. The circuit court entered and continued the second motion to vacate the stay order pending Bernardino producing certain documents. Bernardino filed a second interlocutory appeal from the circuit court's entry and continuance of the motion to vacate. The two appeals were then consolidated before the second district.

On appeal, the second district dismissed Bernardino's second appeal as the order appealed from did not "grant, modify, refuse, dissolve, or refuse to dissolve or modify an injunction and, so, was not reviewable under Rule 307(a)(1). In regards to the first interlocutory appeal, the second district agreed with Bernardino that the appropriate standard of review was *de novo* as the question presented was one of law: application of the doctrine of primary jurisdiction.

The doctrine of primary jurisdiction is a judicially created doctrine that is a matter of self-restraint and relations between the courts and administrative agencies. Under the doctrine, when a court has jurisdiction over a matter, it should, on some occasions, stay the judicial proceedings pending referral of all or part of the controversy to an administrative agency having

expertise in the area. The first question in determining if the doctrine applies is whether the legislature has vested "exclusive original jurisdiction" of the subject matter in dispute to an administrative agency. If not, then the circuit court shares concurrent jurisdiction with the administrative agency. The question then turns to whether the circuit court should "stay the judicial proceedings pending referral of a controversy, or some portion of it, to an administrative agency having expertise in the area."

The second district, following *Skilling* and *Knox County*, held that the circuit court was correct in determining that it had both concurrent and primary jurisdiction over the subject matter of West Bend's declaratory judgment claim dealing with the legal dispute as to whether coverage would apply. Since there was concurrent jurisdiction with the IWCC, the next question to be determined was whether the circuit court's jurisdiction was "paramount." The second district, relying upon *Skilling*, found that the jurisdiction of the circuit court was "paramount" because a question of law was presented to the circuit court. However, "paramount" jurisdiction does not mean that the circuit court has the ability or the authority under the doctrine of primary jurisdiction to stay the proceedings of the administrative agency.

The circuit court had agreed with West Bend that the IWCC proceedings should be stayed based upon *Hastings Mutual Insurance Co. v. Ultimate Backyard*, LLC, 2012 IL App (1st) 101751. The second district declined to follow *Ultimate Backyard* and held that the circuit court erred, as a matter of law, in staying the proceedings before the Workers' Compensation Commission. Specifically, the second district found that nothing in *Casualty Insurance Co. v. Kendall Enterprises, Inc.* (295 Ill. App. 3d 582 (1998)), or in any other case that the court was aware of, implied that the doctrine authorized a circuit court to stay the proceedings before an administrative body pending the resolution of a legal dispute in the circuit court. The second district found that "the doctrine of primary jurisdiction was not created for litigants to game the administrative system; but, rather, it was created to promote 'self-restraint and relations between the courts and administrative agencies.'" The second district found that because the Commission shares concurrent jurisdiction with the circuit court, West Bend could have argued the late notice issue before the Commission and appealed to the circuit court with any adverse ruling. Instead, West Bend chose to bring the issue straight to the circuit court. While the doctrine then requires the court to consider the issue, it does not provide that the administrative proceedings should be stayed pending resolution in the circuit court.

The court also noted that Section 19(b) of the Workers' Compensation Act provides for an employee awaiting medical services to "petition for an expedited hearing by an Arbitrator on the issue of whether or not he or she is entitled to receive payment of the services or compensation." To allow an employer and insurance provider to dispute the issue of coverage in the circuit court and suspend the expedited process made available to employees would directly contradict the legislature's clear intent.

The order of the circuit court staying the IWCC proceedings was reversed, and the cause was remanded.■

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1. 215 ILCS 5/401 (West 2012).
2. 215 ILCS 5/429 (West 2012).
3. Pub. Act 76-943 (eff. Jan. 1, 1970) (adding Ill. Rev. Stat. 1969, ch. 73, § 1065.18-1 et seq.). 1065.18-1.
4. Ill. Rev. Stat. 1969, ch. 73, § 1065.18-1.
5. 215 ILCS 424 (West 2012).
6. 215 ILCS 5/429 (West 2012).
7. See *Bruder v. Country Mutual Insurance Co.*, 156 Ill.2d 179 (1993) & *Hobbs v. Hartford Insurance Co.*, 214 Ill.2d 11 (2005).
8. 740 ILCS 92/1 *et seq*. (West 2016).
9. 740 ILCS 92/1 et seq. (West 2016)
10. *Id*. § 5(b).
11. 740 ILCS 92/15(a) (West 2016).
12. Citing *United States ex rel. Hall v. Tribal Development Corp.*, 49 F.3d 1208, 1212 (7th Cir. 1995).
13. 2019 IL App (1st) 180697 at ¶ 29.
14. *Scachitti v. UBS Financial Services*, 215 Ill. 2d 484, 494 (2005).
15. 820 ILCS 305/19(b) (West 2016).
16. *Id*. §§ 16, 19(k).
17. *Bradley v. City of Marion, Illinois*, 2015 IL App (5th) 140267 at ¶ 35.
18. *Crossroads Ford Truck Sales, Inc. v. Sterling Truck Corp.*, 2011 IL 111611 at ¶ 43; see also *Segers v. Industrial Commission*, 191 Ill.2d 421, 427 (2000); *People v. NL Industries*, 152 Ill.2d 82, 95 (1992); *Board of Education of Warren Township High School District 121 v. Warrant Township High School Federation of Teachers Local 504*, 128 Ill.2d 166, 162-63 (1989); *Kellerman v. MCI Telecommunications Corp.*, 112 Ill.2d 428, 444 (1986) (each case stating that the doctrine of primary jurisdiction allows for a stay of judicial proceedings pending referral of a controversy to an administrative agency).
19. *Employers Mutual Cos. v. Skilling*, 163 Ill.2d 284, 287 (1994).
20. *NL Industries*, 152 Ill.2d at 99.
21. *Skilling*, *supra* note 19 at 288.
22. *Continental Western Insurance Co. v. Knox County EMS, Inc.*, 2016 IL App (1st) 143083, ¶15
23. *Skilling*, *supra* note 19 at 290.
24. *Id*.
25. See, *e.g.*, *Kendall*, 295 Ill. App. 3d at 586-87.
26. *Bradley*, *supra* note 17 at ¶ 35.
27. 820 ILCS 305/19(b).