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FIDELITY LAW UPDATE 2018

Carla C. Crapster

I. INTRODUCTION

This is a survey of fidelity cases decided from April 30, 2017 through June 1, 2018. The cases discussed in this update are relatively evenly split between favoring insurers and favoring insureds. Among the cases discussed are several new important opinions that offer insight into the meaning of "Computer Fraud" coverage, and whether it covers the type of social-engineering losses that have recently become prevalent. Some of these cases addressed the perennially key question of what the word "direct" means. The author hopes that these cases will inform fidelity practitioners of the most important updates over the past year.

II. FIDELITY LAW UPDATE

A. *Fidelity Discovery Disputes*

Fidelity cases, like all coverage disputes, often involve hard-fought discovery battles. Insureds often seek all documents concerning other "similar" claims, for example, which insurance companies are usually loath to give up, both because the information sought should be irrelevant and because it is burdensome to find and produce all the relevant documents. Some recent cases shed light on these types of disputes.

In *Federal Deposit Insurance Corp. v. Arch Insurance Co.*,[1] the issue was whether the plaintiff could recover from the defendant insurance company "documents related to the insurers' handling,

[1] No. C14-545RSL, 2017 U.S. Dist. LEXIS 51520 (W.D. Wash. Apr. 4, 2017).

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adjustment, or investigation of" the claim at issue and other similar claims.[2] The defendants responded that most of the requested documents were irrelevant, privileged, or too voluminous to produce. The court held that the documents requested fell within the scope of Federal Rule of Civil Procedure 26, but reminded the plaintiff that the Rules require even requests for relevant documents to be proportional to the needs of the case. The court agreed that it would be burdensome for the defendant to have to produce all documents that "contained" the disputed policy terms, as opposed to those that would actually shed light on the meaning of those policy terms. The court also imposed a limited time-frame of four years and required the insurer to produce only documents that shed light on the meaning of the term at issue within the context of a fidelity bond like the one at issue in the case.[3]

Spear v. Westfield Insurance Co.[4] involved a dispute over three categories of documents the insurance company was seeking from the plaintiff (its insured). Those categories were: "(1) unredacted copies of all documents filed under seal in [a related] Liability Action; (2) all documents produced to the Plaintiffs in the Liability Action; and (3) the Settlement Agreement that concluded the Liability Action."[5] The court agreed with the insurer that these documents were relevant and had to be produced. The court noted that the plaintiff had destroyed some of those documents because, so it claimed, it had to do so to comply with a protective order in place in the Liability Action. The court found this assertion "preposterous," primarily because the defendant insurance company had already requested the documents in the coverage lawsuit before the plaintiffs destroyed the documents. The court believed the plaintiff would have an opportunity to recover the "destroyed" documents and ordered it to do so. The court also quickly shrugged off the argument that the plaintiff could not produce the settlement agreement that concluded the Liability Action because to do so would require obtaining consent from other parties. The court simply instructed the plaintiff to obtain whatever consent was necessary and produce the

[2] *Id.* at *2.
[3] *Id.* at *5.
[4] No. 2:15-cv-00582-RAL, 2017 U.S. Dist. LEXIS 188193 (E.D. Pa. Nov. 14, 2017).
[5] *Id.* at *6.

document.[6] The court also chastised the plaintiff for generally asserting that the attorney-client privilege protected certain documents without providing a privilege log. The court noted that it *could* have penalized this failure with a holding that the privilege had been waived, but the court found that "wholesale waiver" would be "unnecessarily harsh."[7] It therefore held instead that it would merely overrule the "existing, generalized claims of privilege."[8]

In *National Retail Systems v. Markel Insurance Co.*,[9] the insurer sought to compel the production of documents that it believed would prove that an officer of the insured knew that an employee now accused of theft had previously been charged with "theft of company time." The insurer wanted the insured to (1) answer interrogatories on this topic, (2) produce the personnel file of the officer who purportedly knew of the dishonest employee's previous theft of time, and (3) produce payroll documents that would clarify whether there had been a theft of company time. The court granted the motion to compel in part and denied in part. It held that the scope of the interrogatories and document request had to be more narrowly tailored to reference the relevant time frame.

B. Discovery of Loss Issues

In *National Credit Union Administration Board v. Cumis Insurance Society, Inc.*,[10] the court analyzed whether a fidelity bond had terminated before it incepted due to knowledge of employee dishonesty. The insured was a credit union who had the misfortune of appointing as its CEO Anthony Raguz, who accepted over $ 1 million in bribes in exchange for making fraudulent loans. Raguz's dishonest conduct had cost the credit union nearly $73 million over the course of many years. The National Credit Union Administration (NCUA) became suspicious in 2010, and shortly thereafter confirmed its suspicions and placed St. Paul in conservatorship.[11] NCUA sued Cumis seeking a declaration that a fidelity bond that took effect in February 2010 provided coverage. Cumis

[6] *Id.* at *15.
[7] *Id.* at *18.
[8] *Id.*
[9] No. 17-672, 2018 U.S. Dist. LEXIS 69891 (E.D. Pa. Apr. 25, 2018).
[10] 689 F. App'x 428 (6th Cir. May 18, 2017).
[11] *Id.* at 429.

defended on the grounds that the Bond's termination provision applied. Raguz had, for approximately five years, been submitting a report to the credit union's board boasting of a *zero* delinquency rate. Raguz believed that reporting zero loan defaults would cover up the fact that the delinquency rate was actually startlingly high (because of Raguz's fraudulent loans). Cumis took the position that it was simply impossible for the credit union's board not to have known what was occurring when presented with absurdly rosy delinquency reports month in and month out for five years. Testimony to this effect was presented at trial—that the board was actually concerned by the fact that there had previously been a reasonable rate of delinquencies, which then suddenly stopped altogether.[12] The NCUA appealed on the grounds that the judge had denied coverage based on the conclusion that the board *should have known* of Raguz's dishonesty, whereas the termination provision requires that the insured "actually knew" of the dishonesty. The Sixth Circuit did not agree. It held that the lower court *had* held that the insured actually knew of the dishonesty. NCUA argued that this holding was against the manifest weight of the evidence. But the Sixth Circuit held this was the wrong standard—"we review such fact findings for clear error."[13] The court affirmed the judgment of the district court.

There was, however, a dissenting opinion. The dissenting judge agreed with NCUA that the termination provision barred coverage only for losses sustained after the effective date of termination. The dissenting judge would have remanded for a determination on whether the plaintiff could recover loss sustained before the discovery of the dishonesty.

Dillon v. Continental Casualty Co.[14] denied both an insurer and an insured's motion for summary judgment on issues related to when discovery of a loss had occurred, among other issues. The insured in the case was a 1031 exchange company. But the two owners of the company were embezzling funds that their clients gave them to facilitate a 1031 exchange. The company was placed into receivership, and the receiver sought to recover the loss under a crime policy. The insurance company defended on the grounds that (1) the insured could not actually prove the loss at issue due to its poor record keeping, (2) the insured could not

[12] *Id.* at 431.
[13] *Id.* at 432.
[14] 278 F. Supp. 3d 1132 (N.D. Cal. 2017).

show that the alleged loss involved funds deposited before the 2004 policy expired, and (3) no loss occurred during the 2004 policy period because the owner of the company obtained the funds as loans.

The court addressed each of these arguments in turn. As to the claim of poor record-keeping, the court agreed that it was less than perfect and that significant commingling had occurred. But the court nonetheless held that a reasonable jury could attribute certain transfers made during the policy period as thefts. It therefore allowed this issue to proceed to a jury. The court next addressed the argument that the insured could not connect the alleged thefts of exchange funds occurring during the 2004 policy period with a loss also occurring during that period. The court held that this argument "fare[d] no better than the first."[15] It again concluded that although there was no definitive evidence on when exactly the embezzlement took place, there were questionable transfers that took place during the relevant time frame that a reasonable jury could conclude were thefts that occurred during the 2004 policy period. Finally, the court addressed the argument that there was no loss during the 2004 policy period, merely a dispersal of a fraudulent loan, which was not a loss because "the loan may eventually be paid back and no loss would occur."[16] The court did not agree. It held that the facts of the case were "more like embezzlement and less like a secured loan made because of fraudulent misrepresentations."[17] The court stated that the loans were "unauthorized ab initio regardless of" whether there was the possibility to repay them.[18]

The court also addressed when discovery had occurred. The policy at issue stated: "We will pay for loss that you sustained prior to the effective date of termination or cancellation of this insurance, which is discovered by you no later than 60 days from the date of that termination."[19] The court held that this sixty-day period had to be tolled since the insured had been "adversely dominated" by the wrongdoers.

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[15] *Id.* at 1140.
[16] *Id.* at 1141.
[17] *Id.*
[18] *Id.*
[19] *Id.* at 1142.

Finally, the court rejected the insurer's argument that there was insufficient evidence of manifest intent to cause the insured to sustain a loss. The court agreed with the idea that there is a spectrum of conduct ranging from embezzlement to misguided conduct intended to benefit the insured. The court held that there was "undoubtedly" evidence that this fell on "the embezzlement side of the spectrum."[20] The court cited the fact that the two owners had pleaded guilty to criminal conspiracy, wire fraud, and money laundering. The elements of wire fraud and conspiracy to commit wire fraud were enough to persuade the court that a jury could infer from the convictions that the owners meant to cause the insured a loss.

C. The Loss of Investment Gains and the Ownership Provision

Two very similar recent cases addressed issues related to insureds attempting to recover lost investment gains. Both cases analyzed the issue through the lens of the ownership provision in a financial institution bond. In *3M Company v. National Union Fire Insurance Co.*,[21] the plaintiff was an employee welfare benefit plan. It had used an investing company to invest the assets contained in that plan. But that investment company turned out to be running a Ponzi scheme. The employee plan was miraculously able to recover the entirety of the principal that it had invested, but it was not able to recover the interest or investment returns that it should have earned. The employee plan had purchased a "Blanket Crime Policy" that covered loss resulting directly from employee dishonesty. The plan sought coverage for its lost investment returns under the policy. One of the insurance company's defenses was that 3M Company did not "own" the interest and earnings that it had lost. The insurer cited an ownership provision as requiring that the lost property be property that the insured actually owned. The ownership provision at issue provided: "The insured property may be owned by the Insured, or held by the Insured in any capacity whether or not the Insured is legally liable, or may be property as respects which the Insured is legally liable."[22] Before the district court, the insured argued that the ownership provision was "simply irrelevant" to a claim for coverage under the Employee Dishonesty insuring agreement "because

[20] *Id.*
[21] 858 F.3d 561 (8th Cir. 2017).
[22] *Id.* at 565.

the ownership provision only applies to 'insured property,' and the 'Employee Dishonesty' insuring agreement does not use the term 'insured property' or limit its coverage to such property." In other words, the insured argued that the Employee Dishonesty insuring agreement had nothing to do with the ownership provision because that provision dealt with "insured property" and the insuring agreement did not. The district court rejected the argument because it treated the ownership provision in Endorsement 8 as though it defined the term 'insured property,' even though it plainly did not. The court therefore concluded that the ownership provision limited coverage available under the Employee Dishonesty provision. The Eighth Circuit affirmed. It held that the ownership requirement of the relevant policy endorsement limited coverage under the employee dishonesty provision to property owned by the insured, and the insured's limited partnership interest in the advisors did not confer ownership over the lost earnings because until the earnings were distributed to the partners, the partnership's earnings were owned by the partnership and not by any of the limited partners. The court also noted that any obligations imposed on the insured by ERISA did not change the fact that the insured had no property interest in the earnings.

Another case with nearly identical facts is *Cooper Industries Ltd. v. National Union Fire Insurance Co.*[23] There, the insured was again seeking to recover lost investment gains. The insured's pension plan had invested money with an investment company that also turned out to be running a Ponzi scheme. There was again, as in *3M*, a chain of companies between the insured and the entity that actually had the investment gains. Again, miraculously, the insured was able to recover its lost principal. But it wanted to recover the amount it would have earned had the money been properly invested. The insurance company once again denied on the grounds that under the "ownership provision," the lost funds did not truly belong to the insured and were thus not covered. The district court agreed. The district court also, for some reason, went on to consider other defenses, and it sided with the insured on some of them. This was all dicta, however, as the ruling on the ownership provision was dispositive. The parties cross appealed—the insurer because it had lost some of the issues the court went on to

[23] 876 F.3d 119 (5th Cir. 2017).

consider in dicta. The Fifth Circuit first dismissed the cross appeal because the insurer had *prevailed* in the lower court. The court then went on to affirm the award of summary judgment to the insurer. It held that the insured relinquished ownership of the funds when it loaned them to an investment company. All the insured held was a promissory note. It no longer owned the funds themselves. The court also sided with the insurer on the argument that a loss occurred the moment the insured loaned funds to the dishonest investment company—this was a particularly difficult argument for the insured to make given that it had *recovered* all of its principal. In short, the court agreed that the insured relinquished title to the money when it loaned it to an investment company, and that the ownership provision therefore precluded coverage.

Another recent case also touched on the meaning of the "ownership provision"—surprisingly, in the context of a case arising under a Computer Fraud insuring agreement. *Posco Daewoo Am. Corp. v. Allnex USA, Inc.*[24] The plaintiff in *Posco Daewoo* was a corporation that imported and exported chemicals—often, it sold chemicals to a company called Allnex. An employee of Allnex received an e-mail that appeared to be from an employee that worked in the plaintiff's accounts payable department.[25] The e-mail requested wire transfers to be made to an account at Wells Fargo. The payments that Allnex made went to a bogus account, but they were for amounts that Allnex legitimately owed the insured. The insured argued that it was entitled to receive the remaining amounts from Allnex, but Allnex refused to provide them, arguing it had already paid the fraudster once and would not pay again. The insured sought to recover the amount Allnex refused to pay it under a Computer Fraud insuring agreement. Rather than wading into whether the Computer Fraud insuring agreement applied, the court held that the loss was not covered because the insured did not "own" the money that Allnex had refused to pay it. The court held that the insured owned the legal right to collect money from Allnex, but not the actual stolen funds themselves, which were in an account it had no right to access.[26]

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[24] No. 17-483, 2017 U.S. Dist. LEXIS 180069, at *1-3 (D.N.J. Oct. 31, 2017).

[25] *Id.* at *2.

[26] *Id.* at *15-16.

D. Insuring Agreement (D) and (E) Issues

In *Harvard Savings Bank v. Security National Insurance Co.*,[27] the court addressed whether purported loan guarantees were "negotiable instruments" covered by Insuring Agreement (E). The case involved criminals who created fake loan documents and forged the signature of the United States Department of Agriculture guaranteeing the loans. The criminals sold these "loans" to a bank as an investment. The bank of course never received any repayments and when it asked the USDA to step in as the guarantor, the bank realized that the entire loan was a sham and the guarantees were forged. It sought coverage for its loss under a financial institution bond, and in particular Insuring Agreement (D) (Forgery and Alteration) and Insuring Agreement (E) (Securities). The insurer, Security National, took the position that Insuring Agreement (D) could not provide coverage because the guarantees were not "Negotiable Instruments." The court disagreed. It held that all the documents related to the loan were treated as one single document because they had all been executed as part of one transaction. The court therefore found coverage was available under Insuring Agreement (D). It next examined Insuring Agreement (E) and held that it, too, could provide coverage. It disagreed with Security National's contention that the faked guarantees were not "counterfeit" because there were no genuine guarantees in existence. It also noted that the definition of "counterfeit" required the imitation of ***an*** original, as opposed to one specific original. This is a worrisome case that refused to follow a substantial body of case law on the meaning of "counterfeit" and "negotiable instruments."

In *Hudson Heritage Federal Credit Union v. Cumis Insurance Society, Inc.*,[28] the insured was a credit union that suffered a loss due to a scheme in which members of the credit union obtained car loans using false documents. Three separate times, "a member of credit union applied for a loan to purchase an automobile using a falsified New York State Department of Motor Vehicles title, which misrepresented the owner/seller of the automobile to be purchased with the loaned funds."[29]

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[27] No. 15 CV 11674, 2017 U.S. Dist. LEXIS 90741 (N.D. Ill. June 12, 2017).

[28] No. 17 CV 2930, 2018 U.S. Dist. LEXIS 9823 (S.D.N.Y. Jan. 22, 2018).

[29] *Id.* at *2-3.

The insured sought to recover its loss resulting from nonpayment on the loans under an insuring agreement covering forgery or alteration of an instrument, including a "document of title." The insurance company pointed out that the insured's pleading did not allege that there had been alterations to the original document of title—only to a photocopy or electronic version of the title. The plaintiff amended its pleading to state that "on information and belief," the original DMV titles were falsified. But the plaintiff had admitted that it had only received photocopies of the altered titles. The court held it was improper under these circumstances for the insured to allege "on information and belief" that the *originals* had been altered. The court refused to allow the plaintiff to take discovery to prove alteration of the originals. The court dismissed the claims for breach of contract and a declaratory judgment that coverage applied. But the court did not dismiss a claim of negligence, which was based on the argument that the insurance company should have advised the insured that it needed different coverage than it was purchasing. The court noted that the insurer and insured had a long-standing relationship and that the insured often looked to the insurer for advice on what coverage was needed. The court felt this was enough to survive a motion to dismiss the claim of negligence.

E. Computer Fraud

The problem of insureds attempting to seek coverage for social-engineering losses under a hacking policy has still not faded away. There were a few helpful cases decided on this issue recently. But unfortunately, there are two harmful cases, as well. The first case was *Medidata Solutions, Inc. v. Federal Insurance Co.*[30] The fraud in Medidata involved an unsolicited e-mail to one of the insured's (Medidata's) employees that purported to be from Medidata's president, advising that a "lawyer" would be calling about an acquisition. The "lawyer" called the employee and requested that Medidata perform a wire transfer in connection with the supposed transaction. The employee informed the fraudster that she needed an e-mail from Medidata's president. She and other employees then received an e-mail that purported to be from the president instructing them to go through with the wire transfer. The fraudster was able to abuse Medidata's e-mail system to cause the e-mail to appear to come from Medidata employees

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[30] 268 F. Supp. 3d 471 (S.D.N.Y. 2017).

and the coding of the e-mail was doctored so that the Google e-mail system presented it with the photo that accompanied e-mails from Medidata employees. The employee proceeded to arrange the wire transfer, and two account managers reviewed and approved the wire transfer without speaking to Medidata's president to confirm his authorization. Ultimately, $4.7 million was transferred to the fraudster's bank account. The following month, the "lawyer" contacted the account employee again to arrange another wire transfer. The account employee followed the same procedure, but this time one of the account managers noted that the "reply to" address in the e-mail was suspicious. The suspicion led to an investigation which uncovered the fraud, and the second wire was not made.

Medidata sought coverage under its computer fraud insuring agreement, which protected against "direct loss of Money" resulting from "Computer Fraud." "Computer Fraud" was defined as "the unlawful taking or the fraudulently induced transfer of Money . . . resulting from a Computer Violation." A "Computer Violation" was defined as "the fraudulent: (a) entry of Data into . . . a Computer System; [and] (b) change to Data elements or program logic of a Computer System, which is kept in machine readable format . . . ." "Data" included any "representation or information." "Computer System" was "a computer and all input, output, processing, storage, off-line media library and communication facilities which are connected to such computer" used by Medidata. The court held that the mere e-mail spoofing was the type of "deceitful and dishonest access" to a computer system that computer fraud insurance was intended to cover. It rejected the insurer's argument that the fraudster did not enter any computer system of Medidata because the e-mail system was run by Google and it ignored precedent requiring that the loss to the insured result directly or immediately from the use of a computer.

On appeal, the Second Circuit affirmed *Medidata*.[31] In a short opinion, the court concluded: "While Medidata concedes that no hacking occurred, the fraudsters nonetheless crafted a computer-based attack that

[31] Medidata Sols. Inc. v. Fed. Ins. Co., 729 F. App'x 117 (2d Cir. 2018).

manipulated Medidata's email system."[32] The court was also persuaded that in New York, "direct" equates to "proximate cause."[33]

The next case is *American Tooling*, which was initially decided correctly by the Eastern District of Michigan, then overturned by the Sixth Circuit. In *American Tooling Center, Inc. v. Travelers Casualty & Surety Co. of America*,[34] the court faced the by-now-familiar scenario of an insured that received an e-mail from an entity purporting to be its vendor, asking the insured to change the bank account information for the vendor for purposes of all future invoices. The insured fell for it and ended up transferring $800,000 to the new account without taking any steps to verify the request.[35] The insured sought to recover its loss under a Computer Fraud insuring agreement that covered loss resulting from the use of any computer to fraudulently cause a transfer. The court made quick work of this case, stating: "There was no infiltration or 'hacking' of [the insured's] computer system. The emails themselves did not directly cause the transfer of funds; rather, [the insured] authorized the transfer based upon the information received in the emails."[36] The court cited the recent Fifth Circuit case of *Apache Corp. v. Great American Insurance Co.*,[37] as support, as well as a handful of other recent opinions on Computer Fraud. The court noted that the case of *Owens, Schine & Nicola, P.C. v. Travelers Cas. & Sur. Co.*,[38] was not persuasive as it was a vacated opinion, and it was in any event distinguishable because the Sixth Circuit followed a narrower definition of "direct" than Connecticut did. Finally, the court noted that the *Medidata* opinion discussed above was distinguishable because it did not include the words "direct" and "directly caused by Computer Fraud" that the policy before the court included.

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[32] *Id.* at 118.

[33] *Id.* at 119.

[34] No. 16-12108, 2017 U.S. Dist. LEXIS 120473 (E.D. Mich. Aug. 1, 2017).

[35] *Id.* at *2-3.

[36] *Id.* at *7.

[37] 662 F. App'x 252 (5th Cir. 2016).

[38] 2010 Conn. Super. LEXIS 2386, 2010 WL 4226958 (Conn. Super. Sept. 20, 2010).

Unfortunately, the Sixth Circuit recently overturned the *American Tooling* decision.[39] The court was not impressed with the insurer's argument that there was no loss until the insured made the decision to pay the actual vendor. The court held instead that the insured "immediately lost its money when it transferred the approximately $834,000 to the impersonator; there was no intervening event."[40] The court next considered whether the Computer Fraud insuring agreement was meant to cover only hacking. Construing the policy in favor of the insured, the court held that the policy was not clear enough on this point, and that if Travelers had intended the coverage to be limited to hacking, it should have made it clearer. The court then analyzed several exclusions intended to limit the Computer Fraud insuring agreement to hacking, and rejected their application, as well.[41] This opinion is simply not well reasoned, and it is fortunately in the minority. But it is important for practitioners to be aware that insureds will rely on it heavily.

In *Aqua Star (USA) Corp. v. Travelers Casualty & Surety Co. of America*,[42] the insured was a seafood importer. It purchased frozen shrimp from a vendor known as Longwei. In the summer of 2013, Longwei's computer system was hacked. The hacker apparently monitored e-mail exchanges between an Aqua Star employee and a Longwei employee before intercepting those email exchanges and sending fraudulent e-mails using "spoofed" e-mail domains that appeared similar to the employees' actual e-mails. In these fraudulent e-mails, the hacker directed the Aqua Star employee to change the bank account information for Longwei for future wire transfers. Aqua Star employees made the changes as directed and were ultimately defrauded of $713,890 by the hacker.

The question before the court was whether Aqua Star's losses were covered by a crime policy issued by Travelers. The policy, in a Computer Fraud insuring agreement, covered "direct loss of, or direct loss from damage to, Money, Securities, and Other Property directly caused by Computer Fraud." Travelers denied coverage, relying on an

[39] Am. Tooling Ctr., Inc. v. Travelers Cas. & Sur. Co. of Am., 895 F.3d 455 (6th Cir. 2018).
[40] *Id.* at 460.
[41] *Id.* at 463-65.
[42] No. 16-35614, 2018 U.S. App. LEXIS 9660 (9th Cir. Apr. 17, 2018).

exclusion that excluded loss resulting directly or indirectly from the input of electronic data by a person having authority to enter data into the insured's computer system. The district court agreed with Travelers that the exclusion applied. It found that an employee of the insured voluntarily entered data into a spreadsheet on the insured's computer system. The data entered into that spreadsheet was the data used to bring about the wire transfers. The court held that the entry of data into the spreadsheet was an intervening act by someone with authority. The court granted summary judgment in favor of the insurer with respect to the breach of contract claim and a claim of bad faith. On appeal, the Ninth Circuit agreed, focusing only on the application of the exclusion. The court held that the exclusion applied "squarely." It rejected the insured's argument that the efficient proximate cause doctrine barred application of the exclusion. That rule, it reasoned, applies only when there are two competing causes or perils in play. Here, the *only* peril in play was Computer Fraud.

F. The Meaning of "Direct"

As *American Tooling* hints, the meaning of "direct" in fidelity bonds is often critical. Several recent cases shed light on this perennially relevant issue. In *Federal Deposit Insurance Corporation v. Arch Insurance Co.*,[43] the insured was Washington Mutual (WaMu), a bank that purchased mortgages and later discovered that the paperwork regarding those mortgages contained false statements of the borrowers' incomes. The loan originators created a scheme to steal from WaMu for their own financial benefit.[44] The insurance company argued "that WaMu's losses were not directly caused by the loan originators' fraud, but rather by its contractual obligations to repurchase faulty loans sold to third parties."[45] The court explained that WaMu sold the loans it purchased from the fraudulent loan originator to third parties and was obligated to repurchase them when the misrepresentations came to light. The insurer argued that it was the repurchase agreement that caused the loss, and not the underlying fraud. The court was not easily persuaded. It said that the "common sense understanding of the policy and the

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[43] No. C14-0545RSL, 2017 U.S. Dist. LEXIS 187222 (W.D. Wash. Nov. 13, 2017).

[44] *Id.* at *13.

[45] *Id.* at *12.

relationships between the entities involved shows that WaMu suffered a loss the moment it delivered funds to [the fraudulent loan originator] and received worthless paperwork in return."[46] The court did not commit to whether it was adopting the "direct means direct" approach or not, but it did conclude that, even if it did follow that approach, the loss occurred "immediately and without intervening cause from the loan originators' fraudulent acts."

In *Wilbanks Securities v. National Union Fire Ins. Co.*,[47] Stevens was an investment advisor for the insured, Wilbanks. In early 2012, Stevens advised a husband and wife to invest $1.5 million in an oil and gas company, Aztec Oil & Gas ("Aztec"). The investors were hesitant to put so much money into one company, but Stevens reassured them, going so far as to promise they would not lose their investment. The investors were finally persuaded to put their money into Aztec in early 2012. The investment performed for approximately two years. In May 2014, however, the investors expressed dissatisfaction with the investment. And shortly thereafter, it became clear that Aztec was in serious trouble and that the investors' money was lost.

Wilbanks claimed that Stevens engaged in fraudulent and dishonest acts by essentially guaranteeing performance of the investment. In fact, Stevens should not have been encouraging the investors to make this investment at all, because Stevens was not licensed to sell this type of investment. He failed his exam to obtain the necessary license shortly before the investors made this investment. The investors also alleged that there were forged signatures on a disclosure form that asked the investors to acknowledge information about the investment, including that it was a very risky investment. They claim that they never saw or signed this document. The loss the insured sought to recover was an amount it had to pay the investors in a FINRA arbitration.

The insured sought coverage under Insuring Agreements (A) and (D). The court held that coverage was available under neither provision. The court agreed that, with respect to Insuring Agreement (A), there was no evidence of the requisite manifest intent to either cause the insured a

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[46] *Id.*

[47] No. CIV-16-294-R, 2018 U.S. Dist. LEXIS 19278 (W.D. Okla. Feb. 6, 2018).

loss or obtain a financial benefit for the employee. The insurer further argued that even if the manifest intent were present, the loss to the insured resulted indirectly from Stevens' dishonest conduct. The court agreed with the argument that the "resulting directly from" language is satisfied only if there is an immediate connection between the dishonest conduct and the loss. Here, the loss was liability to a third party (the investors). As to the forgery claim, the court held that the agreement alleged to have been forged was not a document of the type listed in Insuring Agreement (D) as it did not have inherent value.

G. Issues Related to Layers of Insurance and Multiple Policies

In *Wescott Electric Co. v. Cincinnati Insurance Co.*,[48] the Pennsylvania court analyzed whether the reasonable expectations doctrine could transform a discovery policy into a loss-sustained policy. It held that it could not. The insured in that case had an employee that stole almost $3 million from it over a period of approximately ten years. The insured had four policies in place over the ten-year period, including several multi-year policies. The theft was discovered in mid-2013, which was during the policy period of the last policy the insurer had issued. The policy in place provided coverage of $100,000 for each occurrence of employee theft. The insurer paid that amount. But the insured sought to recover under a previous policy and alleged that there had been more than one "occurrence." The policy at issue provided, however, that discovery had to occur during the policy period. Here, discovery had obviously occurred only once—during the last policy period. In addition, the policy at issue defined "occurrence" as the "combined total of all separate acts whether or not related; or a series of acts whether or not related; committed by an employee." Here, because all the thefts had been committed by a single employee, it was clear there had been only one occurrence. But the insured argued that under the reasonable expectations doctrine, this language should not be enforced because earlier policies the insured had purchased from this insurer were loss-sustained policies, with a one-year discovery period. The insured asked the court to reform the later policies to match this earlier language. It asserted that no one at the insurance company had ever related that there would be a change in policy language. The court agreed with the insured that Pennsylvania generally follows the reasonable expectations doctrine,

[48] No. 17-4718, 2018 U.S. Dist. LEXIS 37938 (E.D. Pa. Mar. 8, 2018).

but refused to apply it here for three reasons. First, the language was clear and conspicuous, which barred the insured from arguing that it had not read or understood the relevant language. Second, the insured had not requested the type of coverage it was now asking the court to reform the policy to reflect. Third, the court noted that the insured had been given a copy of the policy before it took effect. The court agreed with the insurer that there had been only one "occurrence" and that the discovery nature of the policy could not be undone by the reasonable expectations doctrine.

In *Tennessee Clutch and Supply, Inc. v. Auto Owners Mutual Insurance Co.*,[49] the court also refused to allow an insured to recover more than once under back-to-back policies. There, the insured had an employee that stole approximately $48,000 during 2014, and approximately $50,000 during 2015. The policy in place provided $15,000 per occurrence of employee theft. The insurance company paid $15,000, but the insured argued that another $15,000 was owed because there had been multiple occurrences. The policies at issue included a Non-Cumulation provision stating that the policy limits did not stack from year to year. The court was also persuaded by the body of case law holding that when only one employee's theft is implicated, there is only one "occurrence." The court reversed the lower court's award of summary judgment to the insured and instructed that judgment should instead be entered in favor of the insurance company.

Another recent case involved an insured seeking coverage for multiple occurrences. *Lioness Holdings, LLC v. Sentinel Ins. Co.*,[50] The opinion in *Lioness Holdings* feels incomplete, as it merely assumes knowledge of the facts at issue and rules on the legal arguments presented by the parties without explaining them. It seems clear, however, that there was a loss caused by an employee, Mr. Reeves. The insurance company apparently argued that coverage would be limited by the per-occurrence limit, but the court held, without explanation: "the Plaintiff will be allowed to present evidence as to all of the locations in question and present the case on its theory that there were 10

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[49] No. M2016-02195-COA-R3-CV, 2017 Tenn. App. LEXIS 761 (Tenn. Ct. App. Nov. 22, 2017).

[50] No. 3:17-cv-01238-JE, 2018 U.S. Dist. LEXIS 102890 (D. Or. June 20, 2018).

occurrences."[51] The court did, however, grant the insurance company summary judgment on the grounds that breach of the covenant of good faith and fair dealing was not a "stand alone claim" under Oregon law under the facts presented. Ultimately, the case has limited precedential value given its terse holdings.

H. Statutory Bond Arguments

In *Renasant Bank v. St. Paul Mercury Insurance Co.*,[52] the insured was a bank that alleged that one of its loan officers engaged in lending transactions with her customers that resulted in losses to the bank. St. Paul denied the claim, arguing that the bank did not prove that the loan officer received an improper financial benefit, as required by the bond. The bond was a statutory bond under Mississippi law, as it was furnished to comply with the statute that required employees of state chartered banks to be bonded (Miss. Code. Ann. 81-5-15). The insured argued that the requirement of a showing of a financial benefit to the dishonest employee was inconsistent with the Mississippi statute. But the insurer argued that the "improper financial benefit" requirement was consistent with the intent of the statute. The statute requires the bond to cover losses caused by "dishonesty," and "dishonesty" "inherently incorporates an element of intent." Thus, provisions setting the parameters of intentional conduct, such as the improper financial benefit requirement, are consistent with the statute's intent, the insurer contended. The bank's sole argument that the loan officer received an improper financial benefit was that she received commissions on the allegedly fraudulent loans. The bond expressly excluded commissions from the definition of financial benefit. Further, the "majority rule" is that receipt of a commission was not receipt of an improper financial benefit. The district court sided with the insurance company, and on appeal, the Fifth Circuit affirmed. The appellate court did not actually analyze whether the bond at issue was a "statutory bond" or not because it agreed with the insurance company that even if it was, the requirement of a showing of an improper financial benefit to the dishonest employee was consistent with the statute. The court reasoned that the purpose of this requirement was to allow the insurance company to avoid covering cases of simple bad business judgment. This was consistent with the

[51] *Id.* at *6.
[52] 882 F.3d 203 (5th Cir. 2018).

Mississippi statute that required financial institutions to obtain coverage for employee *dishonesty*.

III. CONCLUSION

The cases discussed above contain a relatively even mix of cases that favor insurers and those that favor insureds. Perhaps most worryingly, *American Tooling* and *Medidata* represent a break from the recent trend of positive cases on the meaning of "Computer Fraud." These cases—*American Tooling* in particular—are traps to watch out for moving forward. As always, the real impact of all these decisions will become clearer with time.