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FIDELITY LAW UPDATE 2019

JUNE 1, 2018, THROUGH JUNE 1, 2019

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I.
INTRODUCTION

This is a survey of fidelity cases decided between June 1, 2018, and June 1, 2019. The cases discussed in this update are relatively evenly split between favoring insurers and insureds. The authors hope that these cases will inform fidelity practitioners of the most important updates during the past year.

II.
FIDELITY LAW UPDATE

A. Fidelity Discovery Disputes

Like any lawsuit, fidelity cases often involve complex discovery disputes. The case of *Sanderina, LLC v. Great American Insurance Co.*[1] involved the issue of whether the court should stay discovery pending a decision on Great American's motion for summary judgment. There, Sanderina, pursued a claim for a social engineering loss under a computer fraud insuring agreement. Sanderina claimed that it sustained a loss when an unknown third party sent emails to Sanderina's controller that appeared to come from Sanderina's owner asking the controller to transfer funds to an imposter's bank account, which the controller did.

[1] No. 2:18-cv-00772-JAD-CWH, 2019 WL 356802 (D. Nev. Jan. 29, 2019).

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Sanderina also argued that the scheme was facilitated by "hacking into Sanderina's computer system."

Following Great American's deposition of Sanderina's corporate representative, Great American moved the court to stay discovery pending the court's decision on its motion for summary judgment. Great American argued that additional discovery was unnecessary because the deposition testimony clearly established that there were no genuine issues of material fact regarding whether Sanderina's computer system was hacked or breached and that only questions of law remained regarding whether coverage was triggered. In determining whether to stay discovery, the court considered the following two factors. First, the court considered whether the pending motion was potentially dispositive of the entire case, or at least of the issue on which discovery was sought. And second, whether the potentially dispositive motion could be decided without additional discovery.[2] The analysis required the court "to take a 'preliminary peek' at the potentially dispositive motion."[3]

After taking a preliminary peek, the court concluded that a stay of discovery was warranted. The court reasoned that the motion for summary judgment, if granted, would dispose of the entire case and that the motion could be decided without additional discovery. The court also reasoned that although Sanderina sought additional discovery, it could not articulate the particular discovery it targeted on the issue of whether a third party hacked into its computer system. Importantly, the court noted that it was unclear how Sanderina's request for additional discovery of Great American's underwriting file and claims procedures, and how the requested depositions of Great American's corporate representative, adjuster, supervisor, underwriter, and sales agent impacted the issue of whether a third party hacked into Sanderina's computer system. Accordingly, the court stayed discovery pending the decision on Great American's motion for summary judgment.

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[2] *Id.* at *3 (citing Ministerio Roca Solida v. U.S. Dep't of Fish & Wildlife, 288 F.R.D. 500, 506 (D. Nev. 2013)).

[3] *Id.* (quoting Tradebay, LLC v. eBay, Inc., 278 F.R.D. 597, 603 (D. Nev. 2011)).

B. Computer Fraud and Social Engineering

Insureds continue to seek coverage for social engineering claims under policies' computer fraud insuring agreements. In *The Children's Place, Inc. v. Great American Insurance Co*.[4] a hacker infiltrated the email service of the insured's vendor to create a spoofed email with fraudulent attachments, a vendor setup form and an accompanying signed letter, to trick the insured's employee into changing the legitimate vendor's banking information to that of the hacker. Believing the funds to be going to the vendor, the employee transferred $967,714.29 to the hacker's account, resulting in a loss to the insured.

In the complaint, the insured alleged that multiple insuring agreements of a crime policy provided coverage for the loss. First, the insured alleged that the forged vendor setup form entitled it to coverage under the forgery or alteration insuring agreement. Second, it alleged that the fraudulently induced transfers insuring agreement provided coverage, and that the court should disregard the callback verifications condition precedent because it would render the coverage illusory. Finally, the insured alleged that the computer fraud insuring agreement provided coverage on the basis that the insured suffered a direct loss through the use of a computer because the hacker used a computer: (1) to falsify email domain names to appear virtually identical to those of individuals working at the insured's vendor; (2) to access and infiltrate the vendor's email service; and (3) to intercept emails sent between the vendor and the insured in order to alter the payment instructions on the insured's vendor setup form to redirect funds to the hacker's bank account.[5]

In ruling on Great American's motion to dismiss, the court held that neither the vendor setup form nor the letter forging the vendor's signature referenced a sum certain so as to trigger coverage under the forgery or alteration insuring agreement. The court also held that the complaint failed to allege that the condition precedent of the fraudulently induced transfers insuring agreement occurred, and disagreed with the insured's argument that the application of the condition precedent would result in illusory coverage. Instead, the court reasoned that the condition precedent meant that the insured must *attempt* to verify the authenticity

[4] No. 18-11963 (ES) (JAD), 2019 WL 1857118 (D.N.J. Apr. 25, 2019).
[5] *Id.* at *1.

and accuracy of the payment instruction—not that it be successful in verifying the authenticity and accuracy. Therefore, the court dismissed the claims, but allowed the insured thirty days to amend the complaint.

With respect to the computer fraud insuring agreement, the policy defined "Computer Fraud" to include "the use of any computer . . . to gain direct access to [the insured's] computer system." The insured alleged that when the hacker "redirected email messages to go to him, he effectively gained access to [the insured]'s email system because an email system that does not send the messages to the intended recipient is no longer under the control of the sender."[6] Great American argued that these allegations do not mean that the hacker *actually* accessed the insured's email system. The court, however, held that any factual issue as to whether the hacker actually accessed the email system could not be resolved against the insured on a motion to dismiss. The court further noted that it was persuaded by the reasoning in *Medidata Solutions, Inc. v. Federal Insurance Co.*[7] that the hacker did actually access the email system.

The court also disagreed with Great American's argument that the complaint did not plausibly allege causation, which is a necessary element under the computer fraud insuring agreement, and that the hacker's actions were not the cause of the actual transfers. The court held "at the motion to dismiss stage, the . . . Court [i]s obliged to accept [Plaintiff]'s factual allegations as true and to draw reasonable inferences regarding causation in her favor."[8] Reviewing only the allegations in the complaint, the court reasoned that the insured sufficiently alleged that the hacker, "through the use of a computer, . . . accessed and infiltrated [the vendor]'s web email service," "intercepted emails sent between [the vendor and the insured];" and "inserted itself into [the insured's email] conversation."[9] The insured alleged that its employee transferred the funds to the hacker as a direct result of the hacker's access to the insured's and vendor's emails, the forged letter, and altered vendor setup form. The court held that these allegations did not lack plausibility and

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[6] *Id.* at *3.

[7] 268 F. Supp. 3d 471, 478 (S.D.N.Y. 2017).

[8] *The Children's Place, Inc.*, 2019 WL 1857118, at *4 (quoting Conard v. Penn. State Policy, 902 F.3d 178, 184 (3d Cir. 2018)).

[9] *Id.* at *3.

that any further questions as to the cause of the loss should be left to the jury or for summary judgment. As such, the court concluded that Great American's contention that the hacker's activities were not the cause of the actual funds transfers was premature at the motion to dismiss stage. Accordingly, the court refused to dismiss the computer fraud claims.

The *Rainforest Chocolate, LLC v. Sentinel Insurance Co., Ltd.*[10] decision involved a social engineering claim and whether the claim was barred from coverage under the false pretense exclusion. Rainforest's employee received an email purporting to be from his manager directing the employee to transfer $19,875 to an outside bank account through an electronic-funds transfer. The email, however, was sent by an imposter who had gained control of the manager's email account and sent the email. Believing the email to be legitimate, the employee electronically transferred the money to the account. Thereafter, Rainforest learned that the manager did not send the email and contacted its bank to freeze the account. As a result, Rainforest was able to limit its loss to $10,261.36.

Rainforest sought coverage for the loss under a business owner policy issued to it by Sentinel, which contained coverage for forgery, forged instruments, loss of money and securities by theft, and computer fraud. Sentinel denied coverage partly on the basis that the false pretense exclusion barred coverage for Rainforest's loss. The false pretense exclusion excluded "physical loss or physical damage" caused by or resulting from the "[v]oluntarily parting with any property by you or anyone else to whom you have entrusted the property if induced to do so by any fraudulent scheme, trick, device or false pretense." The trial court ruled in Sentinel's favor concluding that the terms of the policy were unambiguous and that the false pretense exclusion barred coverage. Rainforest appealed the decision to the Supreme Court of Vermont.

On appeal, the court recognized that the crux of the case was whether the false pretense exclusion barred coverage for Rainforest's loss. Rainforest argued that the exclusion did not apply because it only excluded "physical loss or physical damages" and that its loss was not a physical loss. Sentinel maintained that it was undisputed that Rainforest voluntarily parted with money as contemplated by the false pretense exclusion. Rainforest, however, argued that because electronic funds are

[10] 204 A.3d 1109 (Vt. 2018).

intangible, it could not have suffered a physical loss. In response, Sentinel argued that Rainforest lost actual, physical control and possession of its money that it otherwise could have withdrawn from its bank account, and therefore Rainforest was barred from coverage under the exclusion.

The Vermont Supreme Court held the trial court erred when it determined that the false pretense exclusion was unambiguous. The court noted that the policy used two distinct phrases—"physical loss and physical damage" and "loss and damage"—within different sections throughout the policy, "sometimes switching between the two sentence to sentence, which would lead the average reader to assume there was some difference between them. But the policy itself [did] not define or explain the difference between the two phrases."[11] The court held that the false pretense exclusion was subject to at least two reasonable interpretations, and was therefore ambiguous. As a result, the court interpreted the exclusion in Rainforest's favor—the loss suffered (electronically transferred money) was not physical and thus coverage was not barred by the false pretense exclusion.

The court, however, held that the computer fraud insuring agreement did not provide coverage for Rainforest's loss. The computer fraud insuring agreement provided potential coverage for "physical loss or physical damage to 'money' . . . resulting directly from computer fraud." The court held that because it concluded that Rainforest's loss was not physical, it was therefore not covered under the computer fraud insuring agreement.

C. Causation: Direct Means Direct

The meaning of "direct" in fidelity bonds is often critical. A recent case from Nevada sheds light on this perennially relevant issue. The *CP Food & Beverage, Inc., v. United States Fire Insurance Co.*[12] decision involved the meaning of the phrase "resulting directly from." The insured ran a club where patrons could buy "funny money" to tip waitresses or pay topless dancers. The funny money could be turned in by the waitresses and the dancers in exchange for cash. The insured

[11] *Id.* at 1116.

[12] 324 F. Supp. 3d 1172 (D. Nev. 2018).

suffered a loss when certain employees began overcharging patrons' credit cards through various methods including charging the credit card multiple times for the same bill, charging for alcohol that the employees kept for themselves, and charging for funny money that the patrons never purchased and then cashing in the funny money with the insured. The scheme was eventually uncovered after multiple patrons complained to the police and disputed the charges with their credit card companies. The insured paid a total of $768,617.91 in chargebacks to the patrons' credit cards in response to its contractual requirements with the credit card companies and also as part of an agreement with law enforcement. The insured, however, did not pay a chargeback if a patron did not dispute a charge or if the patrons' dispute was not sustained.

The insured sought coverage under a commercial crime policy that provided potential coverage for loss resulting directly from theft committed by an employee. U.S. Fire argued that the policy did not cover the employees' thefts because the insured was not a direct victim of the thefts. Instead, U.S. Fire maintained that the employees stole from customers, and the loss ultimately fell on the insured only because, once the patrons or their credit card companies learned of the overcharges, the insured was held responsible for its employees' actions. The insured responded that because the employees exchanged the funny money for cash from the insured and because the insured had to reimburse the patrons for credit card charges, the employees stole from the insured and the loss was therefore covered under the policy.

Whether the policy provided coverage for the loss turned on the meaning of the phrase "resulting directly from." The court noted that other courts addressing similar policy language have fallen into two camps: proximate cause or direct means direct. Courts following the direct means direct rule have held that it means that the loss results "immediately and without intervening space, time, agency, or instrumentality" from the employee's theft."[13] As a result, under the direct means direct approach, the insured's property must be stolen, and an insured's third-party liability to a defrauded customer is not covered. The court realized that the Supreme Court of Nevada had not yet addressed the meaning of the phrase, and, as such, the court was tasked

[13] *Id*. at 1176 (quoting Tooling, Mfg. & Techs. Ass'n v. Hartford Fire Ins. Co., 693 F.3d 665, 675 (6th Cir. 2012)).

with predicting how that court would decide the issue. The court held it would predict that "Nevada would follow the 'direct means direct' rule and hold the policy language at issue does not cover third party claims or investigation costs."[14]

The court noted that the policy covered loss resulting directly from an employee's theft, and that if proximate cause was sufficient, "that would render the word 'directly' superfluous."[15] Also, the policy covered only the insured's property or property the insured held for others, and therefore the policy contemplated "a loss when the insured is deprived of property not when a third party is deprived of property and the third party later sues the insured or requires repayment under a contractual provision."[16] The court reasoned that this determination was consistent with the insured's reasonable expectations because the policy was not designed to cover the insured for liability to third parties for its vicarious liability. More specifically, the court noted that "[g]iven the policy language and keeping in mind the purposes for which [the insured] purchased this policy, [the insured] would not expect coverage for the chargebacks. . . ."[17] The employees' theft was of the patrons' funds, not the insured's and the insured was therefore not liable for a chargeback unless the patron disputed the charge. Moreover, the insured admitted that it paid the chargebacks as part of its contractual arrangement with the credit card companies and due to an agreement with law enforcement. As a result, the insured's loss "'was contingent on the occurrence of a series of events that were not inevitable, . . . were not immediate or readily ascertainable at the time of its employees' thefts, and if customers never discovered the fraudulent charges or chose not to dispute them, [the insured] 'would not have suffered the loss it now claims.'"[18] Therefore, the court held that the insured's loss did not result "directly" from the thefts and thus granted summary judgment in favor of U.S. Fire.

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[14] *Id*. at 1176-77.

[15] *Id*. at 1177.

[16] *Id*.

[17] *Id*.

[18] *Id*. (quoting Direct Mortg. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa, 625 F. Supp. 2d 1171, 1177-78 (D. Utah 2008)).

D. Discovery of the Loss

When an insured discovers its loss is crucial to whether there is coverage under a fidelity bond. The *Starr Insurance Holdings, Inc. v. U.S. Specialty Insurance Co*.[19] case involved a claim under a fidelity bond for breaches of contract and fiduciary duty "arising from dishonest and fraudulent acts that [the insured] was aware of *before* the Bond incepted."[20] The insured, Starr (also an insurance company), issued warranty contracts. Global Warranty Group LLC[21] served as Starr's warranty producer/broker, selling service contracts and theft insurance for Starr through its network of dealers, and also served as Starr's managing general agent or broker, and administered claims made on those contracts. Starr's contract with GWG required GWG to set up separate trust accounts for the claim funds furnished by Starr to GWG and the premiums collected by GWG were to be remitted to Starr within 60 days from the sale of contract.

After entering the contract, Starr learned almost immediately that GWG had cash flow problems. By May 2013, Starr learned that GWG was commingling GWG's general operating account claim funds that Starr advanced to GWG with premiums GWG owed to Starr in an attempt by GWG to manage its cash flow problems. Starr also learned in 2013 that GWG was paying all of its liabilities from that same account. Emails between Starr and GWG also established that Starr knew GWG was paying premiums to Starr with the same funds that Starr had earlier transferred to GWG to pay claims, in breach of GWG's contract with Starr. Starr concluded that this was what GWG was doing during its review of GWG on May 16, 2013. Additionally, a November 21, 2013, audit review confirmed that GWG had continued these prohibited practices. Accordingly, Starr's management, including a member of Starr's legal department, had either actual or constructive knowledge of what GWG was doing.

Starr pursued coverage under a fidelity bond, with a bond period of January 1, 2014, through January 1, 2015, for losses resulting from GWG's breaches of contract and fiduciary duty. The court initially noted

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[19] Index No. 652164/2016 (N.Y. Sup. Ct. Feb. 26, 2019) (unpub. op.).

[20] *Id*. at * 2 (emphasis in original).

[21] Hereinafter GWG.

that by seeking coverage for breaches of contract and fiduciary duty that Starr was "basically seek[ing] coverage not for a fidelity loss."[22] But in any event, the court held that even if GWG's activities were dishonest, the bond never covered post-January 1, 2014, conduct by GWG because Starr learned before the bond incepted that GWG had committed the allegedly dishonest acts. The court reasoned that Starr's knowledge of any dishonest act by GWG was sufficient to trigger the termination clause in the bond. In opposition, Starr argued that the bond did not terminate because it did not know the exact facts of the theft; that is, Starr did not know that the funds maintained in the claims account were insufficient or used by GWG for impermissible uses. The court made short use of Starr's argument, stating that Starr's contention was "flatly contradicted by indisputable evidence to the contrary."[23] First, the court noted that Starr's position that the termination provision was not triggered because Starr did not know of a theft and corresponding loss was not the law in New York.[24] Second, even if knowledge of theft was required to trigger the termination provision, the court found that the record clearly established that Starr learned in 2013 that over $747,000 was missing from Starr's account with GWG. Moreover, Starr knew that GWG diverted funds from Starr's account with GWG to a GWG general operating account and recycled claim funds from Starr to pay premiums. Therefore, because Starr discovered GWG's alleged dishonest acts that gave rise to Starr's claims before the bond incepted, the bond did not afford coverage for Starr's loss. The court concluded that "Starr continued to do business with GWG despite all it knew in 2013, and it must bear the consequences, not the insurers."[25] Therefore, the court granted summary judgment to the insurers dismissing Starr's action with prejudice.

E. Issues Related to Occurrence versus Multiple Occurrences and Multiple Policies

A recent case involved the issue of a single occurrence versus multiple occurrences. The decision in *Dan Tait, Inc. v. Farm Family*

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[22] *Starr Ins. Holdings, Inc.*, Index No. 652164/2016, at *2.

[23] *Id*. at *3.

[24] *Id*. (citing Capital Bank & Trust Co. v. Gulf Ins. Co., 91 A.D.3d 1251 (N.Y. App. Div. 2012)).

[25] *Id*. at *4.

Casualty Insurance Co.[26] involved a determination of whether an employee's series of dishonest acts over multiple policy periods, which included several types of theft and embezzlement, constituted one occurrence under the policy. Between 2012 through 2017, Dan Tait's former bookkeeper stole approximately $500,000 from Dan Tait by: (1) making unauthorized purchases with company credit cards; (2) making unauthorized withdrawals from the company's line of credit; and (3) taking company inventory for personal use. After discovering its bookkeeper's dishonesty, Dan Tait pursued coverage for the loss under an employee dishonesty provision of its business insurance policy. Farm Family determined that the bookkeeper's course of dishonest acts committed over multiple policy periods constituted only one "occurrence" and thus provided coverage in the amount of $15,000, representing the limit of the employee dishonesty coverage for one policy period. Dan Tait disagreed with Farm Family's coverage decision and filed suit.

The relevant policy provided that "[t]he most [Farm Family] will pay for loss or damage in any one occurrence is $15,000."[27] And the policy also included language aggregating multiple incidents into one occurrence: "All loss or damage . . . [c]aused by one or more persons; or . . . [i]nvolving a single act or series of acts . . . is considered one occurrence under the Policy."[28] Moreover, "[i]f a loss is covered partly by a particular Policy and also is covered partly by any prior . . . terminated insurance that [Farm Family] had issued . . . the most [Farm Family] will pay is the larger of the amount recoverable under th[e P]olicy or the prior insurance."[29] Furthermore, the policy covered only "loss or damage [that the insured] sustain[s] through acts committed or events occurring during the Policy Period and [r]egardless of the number of years [the Policy] remains in force or the number of premiums paid, no Limit of Insurance cumulates from year to year or period to period."[30] Based on the above policy language, Farm Family argued that the series of dishonest acts committed by Dan Tait's bookkeeper constituted a single occurrence. Conversely, Dan Tait argued that the court should

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[26] 79 N.Y.S.3d 514 (N.Y. Sup. Ct. 2018).
[27] *Id*. at 516-17.
[28] *Id*. at 517.
[29] *Id*.
[30] *Id*.

employ the unfortunate event test for determining the meaning of an occurrence under the policy, and that the application of this test resulted in the conclusion that the bookkeeper's separate and distinct acts of theft committed over a multi-year period constituted multiple occurrences. In the alternative, Dan Tait argued that the meaning of the term occurrence was ambiguous.

The court first rejected Dan Tait's reliance on the unfortunate event test, which the court described as a common-law test developed for "resolving whether a set of circumstances amounts to one accident or occurrence, or multiple accidents or occurrences, for purposes of resolving how much coverage is available under a third-party liability insurance policy."[31] The court reasoned that New York law was clear that the unfortunate event test applied only in the absence of "policy language that speaks to the issue of the aggregation of separate incidents into one 'occurrence' or 'accident.'"[32] Therefore, because the policy did include language demonstrating a clear intent to aggregate into a single 'occurrence' the losses caused by an employee involving a single act or series of acts, the court held that it would run counter to settled principles of New York law to apply the common law definition of occurrence.[33] As a result, the court held that all losses resulting from the bookkeeper's series of dishonest acts over a multi-year period must be considered to be one occurrence under the language of the policy.[34]

The court also disagreed with Dan Tait's argument that the term occurrence was rendered ambiguous by the phrase "a single act or a series of acts."[35] The court looked to a Nevada district court for support. That court held:

> The phrase "series of acts" clearly refers to a sequence of loss inducing acts . . . . Although "series" does impose a relatedness condition between the multiple acts upon which an "occurrence" is based, those "acts" are related

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[31] *Id*. at 518 (quoting Appalachian Ins. Co. v. Gen. Elec. Co., 863 N.E.2d 994 (N.Y. Ct. App. 2007)).

[32] *Id*.

[33] *Id*.

[34] *Id*. at 519.

[35] *Id*.

> in that they were committed by an employee (or employees) and that they caused loss, not that they caused loss in any particular way. Other courts interpreting the same definition of "occurrence" have rejected the very argument [plaintiff insured] now makes.[36]

Although the series of dishonest acts committed by the bookkeeper involved several different methods of theft, the clear and unambiguous language of the policy required that these theft incidents be aggregated into one occurrence. As such, the court concluded that the bookkeeper's series of thefts constituted one occurrence under the policy, and, consequently, it was subject to the $15,000 limit applicable to losses arising from employee dishonesty.

Lastly, Dan Tait argued that even if the series of dishonest acts committed by the bookkeeper qualified as one occurrence, Dan Tait's total loss could be allocated among the various policies that were in effect at the time of the losses. The court again declined to follow Dan Tait's argument. The court reasoned that the policy's anti-stacking provision was clear and unambiguous and prevented the insured from obtaining more than the full limit of any one policy and was consistent with the "policy's clear overall intent to preclude a stacking of coverage."[37] Accordingly, the court held that based on the policy's provision aggregating multiple incidents of employee dishonesty into one "occurrence" and the robust anti-stacking language, that the series of dishonest acts committed by the insured's employee constituted a single occurrence, and therefore Dan Tait could not recover more than the per-occurrence limit of any one policy.

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[36] *Id*. (quoting APMC Hotel Mgmt., LLC v. Fid. & Deposit Co. of Md., No. 2:09-cv-2100-LDG-VCF, 2011 WL 5525966, at *5 (D. Nev. Nov. 10, 2011)).

[37] *Id*. at 522 (quoting Shared-Interest Mgmt. v. CNA Fin. Ins. Grp., 283 A.D.2d 136, 140 (N.Y. App. Div. 2001)).

F. Issues related to Rescission

The *National Credit Union Administration Board v. CUMIS Insurance Society, Inc.*[38] opinion concerned whether the actions of the National Credit Union Administration Board[39] in cashing a check representing the return of premiums on a bond that was rescinded constituted mutual rescission. St. Francis Campus Credit Union was insured under a fidelity bond issued by Cumis. On January 23, 2014, the credit union discovered that one of its managers had embezzled over $3 million from the credit union. As a result of the theft and the credit union's ensuing financial position, the NCUAB was appointed the receiver of the credit union and subsequently submitted a proof of loss to Cumis. On June 10, 2015, Cumis called the NCUAB's in-house counsel, Robert Roach,[40] to inform the NCUAB that Cumis was rescinding the bond due to material misrepresentations in the renewal application for the bond. Cumis also sent an email to the NCUAB's coverage counsel, Ray Leake,[41] to inform him that Cumis was rescinding the bond and that a rescission letter and premium refund check were being mailed. Cumis attached a copy of the rescission letter and premium refund check to the email. Leake and Roach forwarded copies of the rescission letter and premium refund check to several individuals at the NCUAB, including additional attorneys who then communicated regarding the strengths and weaknesses of the rescission.

The NCUAB received the original rescission letter and premium refund check on June 17, 2015, but, during the mail-sorting process, a NCUAB clerk separated the check from the letter. The check was then forwarded to St. Louis and cashed pursuant to receivership procedures.[42] On October 29, 2015, one of the NCUAB's attorneys inquired whether the NCUAB cashed the premium refund check when Cumis rescinded the bond, "because *cashing* the check 'constitutes acceptance.'"[43] The

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[38] No. 16-139 (DWF/LIB), 2019 WL 1229793 (D. Minn. Mar. 15, 2019).

[39] Hereinafter NCUAB.

[40] Hereinafter Roach.

[41] Hereinafter Leake.

[42] On June 22, 2015, Cumis' computer system mistakenly generated a second rescission check, which the NCUAB ironically also cashed.

[43] *Nat'l Credit Union Admin. Bd.*, 2019 WL 1229793, at *2.

response was that the NCUAB did cash the check but that they did not know how it could have been avoided because the "standard policy is to cash all checks [received]."[44]

On January 21, 2016, the NCUAB filed its complaint against Cumis seeking a declaration that Cumis must provide coverage under the bond. Before discovery began, Cumis filed a motion for summary judgment arguing that it rightfully rescinded the bond because either (1) the dishonest employee's misrepresentation increased Cumis' risk of loss, which was grounds for rescission under Minnesota law, or (2) the NCUAB mutually rescinded the bond by cashing the premium refund check. The court denied the motion and noted that the completion of discovery could render a different outcome with respect to rescission.

Following discovery, Cumis and the NCUAB both filed cross motions for summary judgment. Cumis argued that the facts clearly showed that the NCUAB mutually rescinded the bond when it did not respond to the rescission letter and cashed and retained the premium refund check. The NCUAB argued that because it did not acquiesce or otherwise agree to rescind the bond that mutual rescission was not perfected. In the alternative, the NCUAB argued that its post-liquidation actions cannot form the basis for any argument of mutual rescission because such actions are protected by the Federal Credit Union Act.[45]

The court first turned to the issue of mutual rescission. Rescission of a contract may be accomplished by mutual agreement.[46] Whether mutual rescission has been accomplished "depends on the intent of the parties as evidenced by their acts."[47] "The parties' intent to rescind 'must be clearly expressed, and acts and conduct of the parties to be sufficient must be positive, unequivocal, and inconsistent with the existence of the contract.'"[48] And whether a party intended to rescind the contract is a question of fact. Cumis argued that the NCUAB agreed to

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[44] *Id*.

[45] Hereinafter FCUA.

[46] *Nat'l Credit Union Admin. Bd.*, 2019 WL 1229793, at *3 (citing McQuarrie v. Waseca Mut. Ins. Co., 337 N.W.2d 685, 687 (Minn. 1983)).

[47] *Id*.

[48] *Id*. (quoting Levin v. C.O.M.B. Co., 441 N.W.2d 801, 804 (Minn. 1989)).

rescind the bond when it failed to respond to its rescission letter and cashed and retained the premium refund check. It further argued that all relevant managers and attorneys of the NCUAB were aware of Cumis's rescission letter and premium refund check, and that the NCUAB received advice on the strengths and weaknesses of the rescission. Cumis further argued that the NCUAB clearly understood the consequences of failing to respond to the rescission letter and keeping the money, and that as proof, the NCUAB's previous written objection and return of an uncashed premium check to another insurance company clearly demonstrated that the NCUAB knew how to oppose rescission. In support of its argument that the bond was mutually rescinded, Cumis relied on *Mutual of Omaha Insurance Co. v. Korengold*,[49] and *Peterson v. New York Life Insurance Co*.[50] Like these cases, Cumis sent a letter to the NCUAB explaining the basis for rescinding the bond and included a check for premiums paid. The court noted that the record reflected that the rescission letter was read and discussed by several attorneys who advised senior level management of the NCUAB on the strengths and weaknesses of the rescission. As a result, Cumis contended that the NCUAB had the requisite knowledge to intend to rescind the bond when it cashed the premium refund check.

The NCUAB did not dispute that its attorneys and management discussed the rescission letter, but argued that the correspondence did not contain any advice or even discussion of whether or not to cash the check. It contended that when the rescission letter arrived, the premium refund check was separated during the mail-sorting process and subsequently cashed pursuant to standard receivership procedures, and the person cashing the premium refund check lacked the requisite knowledge to intend rescission. NCUAB further argued that its attempt to later return the premium refund check to Cumis and its filing of the complaint challenging the rescission demonstrate that it never agreed to the rescission.

The court first noted that it would be strange for any party to accept a premium refund check for approximately $19,000 in lieu of pursuing a three million dollar claim and then subsequently file a lawsuit. It also, however, agreed with Cumis that the prudent action would have

[49] 241 N.W.2d 651 (Minn. 1976).
[50] 240 N.W. 659 (Minn. 1932).

been for the NCUAB to have alerted the mailroom that a premium refund check was expected and should not be subject to normal processing procedures. But the court could not speculate why this did not occur, and could not conclude as a matter of law that the NCUAB unequivocally intended to rescind the bond when it cashed the check. Aside from the NCUAB's inaction, the court found that nothing in the record unequivocally demonstrated the NCUAB intended to rescind the bond. Unlike in *Korengold* or *Peterson*, the person at the NCUAB who actually cashed the premium refund check lacked the requisite knowledge and intent to rescind the bond because the check was deposited in accord with standard operating procedures. The court could also not speculate why the NCUAB waited so long to return or offer to return the premium refund check after the money was deposited. The court found that while *Peterson* included an undeniable assertion that the insured cashed the premium refund check because he needed the money even though he knew it would rescind the policy, there was nothing in the record for the court to conclude that the NCUAB cashed the check with the intent to rescind the bond. Therefore, the court held that fact issues remained with respect to the NCUAB's intent to rescind the bond.[51]

In the alternative, the NCUAB argued that regardless of its conduct in cashing the premium refund check, its actions are shielded from judicial action by the FCUA. The FCUA grants the NCUAB broad authority and discretion with respect to the assets of a liquidated credit union.[52] The FCUA also limits judicial action "to restrain or affect the exercise of powers or function of the [NCUAB] as a liquidating agent."[53] To determine when the limitation on judicial action applies a court must first "determine whether the challenged action is within the receiver's power or function; if so [the court] then determines whether the action requested would restrain or affect those powers."[54] The court found that the first prong of the test was met: "it is within the NCUAB's power to

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[51] *Nat'l Credit Union Admin. Bd.*, 2019 WL 1229793, at *5 (quoting *Levin*, 441 N.W.2d at 804).

[52] 12 U.S.C. §1787(b)(2)(B).

[53] *Nat'l Credit Union Admin. Bd.*, 2019 WL 1229793, at *5 (quoting 12 U.S.C. § 1787(g)).

[54] *Id.* at *6 (quoting Dittmer Props., L.P. v. FDIC, 708 F.3d 1011, 1017 (8th Cir. 2013)).

enforce coverage under the Bond."[55] The NCUAB argued that the second prong was also met because any effort to rescind the bond based on the NCUAB's post-liquidation conduct, including cashing the premium refund check, amounts to an effort to restrain or affect its collection efforts. It maintained that rescission impermissibly restrains or affects its powers as receiver or liquidating agent. The court, however, was unpersuaded by the NCUAB's argument. To that end, it specifically noted "[w]hile NCUAB makes a strong argument that 12 U.S.C. § 1787(g) deprives the Court from declaring unilateral rescission, the Court finds NCUAB's argument inapposite to mutual rescission. Mutual rescission, by its definition, 'requires an intent to rescind on the part of both parties,' and that such intent 'may be inferred from the attendant circumstances.'"[56] The court reasoned that because the FCUA grants the NCUAB the authority to agree to release assets, claims and contracts for cash under 12 C.F.R. § 709.4(e), that it was within the NCUAB's discretion to cash the premium refund check and agree to rescind the bond as opposed to pursuing coverage. It further reasoned that "[i]f the NCUAB intended to rescind the Bond, it would be a restraint on NCUAB's authority to prevent it from doing so."[57] Therefore, the court held that the NCUAB had the authority to agree to rescind the bond, and as such, a claim for mutual rescission based on the NCUAB's conduct related to cashing the premium refund check was not barred by the FCUA.[58] Accordingly, because issues of fact remained with respect to rescission and because the FCUA did not shield the NCUAB from a claim of mutual rescission, the court denied both motions for summary judgment.

G. Bad Faith

The decision in *Wyoming Valley Fraternal Order of Police v. Selective Insurance Co. of the Southeast and Stock Insurance Co.*[59]

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[55] *Id*.

[56] *Id*. (quoting Green Tree Serv'g, LLC v. DBSI Landmark Towers, LLC, 652 F.3d 910, 913 (8th Cir. 2011)).

[57] *Id*.

[58] *Id*. at *7 ("Permitting a claim of mutual rescission does not 'restrain or affect' the NCUAB's collection efforts; instead, it allows the NCUAB to operate within the full breadth of its authority.").

[59] No. 3:18-CV-2270, 2019 WL 626460 (M.D. Pa. Feb. 14, 2019).

involved an insurer's motion to dismiss a bad faith claim asserted against it. The insured pursued coverage for theft under an insurance policy, which contained crime coverage. Selective denied the theft claim and the insured filed suit against Selective for breach of contract and for bad faith. After removing the lawsuit to federal court, Selective moved to dismiss the bad faith claim.

Under Pennsylvania law, an insured may receive damages and other relief if the insurer acts in bad faith.[60] Bad faith claims are "fact specific and depend on the conduct of the insurer vis a vis the insured."[61] And, "[i]n order to recover in a bad faith action, the plaintiff must present clear and convincing evidence (1) that the insurer did not have a reasonable basis for denying benefits under the policy and (2) that the insurer knew of or recklessly disregarded its lack of a reasonable basis."[62] In deciding whether an insurer had a reasonable basis for denying a claim, a court must examine what factors the insurer considered in evaluating a claim.[63]

After reviewing the complaint, the court reasoned that the insured's bad faith claim was premised on "bare-bones conclusory allegations" (rather than factual allegations), which were insufficient to state a bad faith claim.[64] The claim contained only conclusory allegations, such as the allegations that Selective failed to properly investigate the claim and that Selective knew and disregarded the fact that it had no reasonable basis for its conduct in denying the claim. The complaint failed to provide any factual support as to why Selective's conduct and actions were unreasonable. When the court stripped away the conclusory allegations, the remaining factual allegations in the complaint did not state the necessary elements of a claim for bath faith. The court reasoned that while the conclusory allegations suggest that a bad faith claim is *possible*, they do not allow for any non-speculative

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[60] *See* 42 PA. C.S.A. § 8371.

[61] *Wy. Valley Fraternal Order of Police*, 2019 WL 626460, at *2 (quoting Terletsky v. Prudential Prop. & Cas. Ins. Co., 649 A.2d 680 (Pa. Super. Ct. 1994)).

[62] *Id*. (quoting Rancosky v. Wash. Nat'l Ins. Co., 170 A.3d 364, 365 (Pa. 2017)).

[63] *Id*.

[64] *Id*. at *3.

inference that a finding of bad faith is *plausible*. Therefore, the court dismissed the bad faith claims because the insured failed to plead any facts for which it could possibly be inferred that Selective acted in bad faith in denying the claim. The court did, however, allow the insured leave to amend its bad faith claim.

In *CP Food & Beverage, Inc., v. United States Fire Insurance Co*.,[65] discussed above, U.S. Fire argued that it had a reasonable basis for denying the insured's claim, and thus it did not act in bad faith as a matter of law. The insured argued that it would be able to prove bad faith because U.S. Fire did not investigate the claim and never asserted the insured was not a direct victim of the theft. The court quickly disproved the insured's contention noting that U.S. Fire sent a letter denying coverage on October 26, 2016, in which it stated that the thefts were not covered because the employees took money from customers, not from the insured, and that the insured did not suffer a loss directly from a theft. But in any event, under Nevada law, to establish a claim for bad faith on denial of payment on all or part of a claim, a plaintiff must establish that (1) the insurer denied the claim, (2) the denial was unreasonable, and (3) the insurer knew it lacked a reasonable basis to deny the claim or acted with reckless disregard as to the unreasonableness of the denial.[66] The court noted that "if the insurer had a reasonable basis for its decision, there can be no finding of bad faith as a matter of law."[67] The court held that because U.S. Fire properly denied coverage, it did not act in bad faith in denying the claim. The court noted that even if its prediction that the Supreme Court of Nevada would not adopt the "direct means direct" rule, U.S. Fire still at least had a reasonable basis for its decision to deny coverage. Therefore, the court granted summary judgment in U.S. Fire's favor on the insured's bad faith claims.

H. Issues related to Subrogation

Many issues arise when an insurer becomes subrogated to its insured's rights and causes of action against a dishonest employee. The *Cumis Insurance Society, Inc. v. Clark, et al*.[68] case involved an insurer's

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[65] 324 F. Supp. 3d 1172 (D. Nev. 2018).
[66] *Id*. at 1178.
[67] *Id*.
[68] 318 F. Supp. 3d 199 (D.D.C. 2018).

subrogation claim against a dishonest employee. The dishonest employee, Reginald Clark, was employed as an accountant for Hoya Federal Credit Union. During Clark's employment at the credit union, he engaged in fraudulent conduct that caused the credit union to suffer a loss in the amount of $540,196.14, which Cumis paid to the credit union under a fidelity bond. As a result, Cumis sued Clark asserting claims for fraud, breach of fiduciary duty, and unjust enrichment to recover the funds it paid to the credit union pursuant to its subrogation rights under the fidelity bond.

Cumis alleged that Clark engaged in at least three fraudulent schemes. First, Cumis alleged that Clark "volunteered" to bring the daily deposits to the Credit Union's bank, but then took the deposit bag to his home instead, removed the cash from the deposits and created new deposit slips without reference to a cash deposit, and then deposited the checks the following business day. Second, Cumis alleged that Clark participated in "stop payment" schemes with checks written from his own account and the accounts of other credit union members. Third, Cumis alleged that Clark arranged fraudulent wire transfers on at least three occasions.

After filing his answer, Clark, acting pro se, moved to stay the case, invoking his Fifth Amendment privilege against self-incrimination in light of a parallel criminal investigation and grand jury proceedings, which the court granted. Clark was subsequently indicted and then convicted of three counts of bank fraud, two counts of wire fraud, and two counts of creating a false entry in federal credit institution records. Thereafter, the court lifted the stay and Cumis filed a motion for summary judgment and Clark filed a motion to dismiss.

In the motion to dismiss, Clark argued that Cumis failed to state a claim upon which relief could be granted and failed to plead fraud with the particularity required. With respect to fraud, the complaint must meet the heightened pleading requirements of Rule 9(b) of the Federal Rules of Civil Procedure, which require that the circumstances constituting the alleged fraud be pleaded with particularity.[69] As noted by the court, "[s]pecifically, the complaint must set forth the time, place, and content

[69] *Id*. at 209.

of the fraud and . . . identify the individuals allegedly involved."[70] But Rule 9(b) does not require, as the court noted, a plaintiff to set forth pleadings in the utmost detail: "[W]hen a plaintiff describes the nature of the alleged misrepresentations, the general time frame in which they were made, and the parties involved, . . . his failure to specify the exact time and particular place of each misrepresentation or omission will not mandate dismissal of his claim."[71]

Clark argued that Cumis failed to plead fraud with particularity as required under Rule 9(b) because Cumis did not provide any specific allegations beyond the three wire transfers in which the actual dates and amounts of loss were described. The court, although noting that Clark raised a colorable argument, ultimately disagreed with Clark. The court noted that Cumis' amended complaint, although not setting forth each individual instance of alleged fraudulent conduct, set forth with particularity the place and content of each category of the alleged fraud—the case deposit scheme, the stop-payment scheme, and the wire-transfer scheme. And the amended complaint also set forth the specific individuals involved in each fraudulent scheme. Accordingly, the court held that Cumis satisfied the Rule 9(b) pleading requirements that afforded Clark a meaningful opportunity to respond.

With respect to Cumis's motion for summary judgment, Cumis first requested that Clark be sanctioned for his failure to appropriately participate in the case, including deeming admitted requests for admissions that Clark never responded to. Because such admissions would be dispositive of the entire case, Cumis asked the court to grant it summary judgment. The court took into account Clark's pro se status and the fact that he was imprisoned as a result of his criminal convictions for a significant period of time during the pendency of the case and found that his conduct was not so flagrant or egregious as to warrant summary or default judgment.[72] Instead, the court determined that there was good cause to re-open discovery for a limited period of time to accommodate Cumis, rather than impose a severe litigation-ending sanction.

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[70] *Id*.

[71] *Id*. (quoting Daisley v. Riggs Bank, N.A., 372 F. Supp. 2d 61, 79 (D.D.C. 2005)).

[72] *Id*. at 214.

Cumis also sought summary judgment on the basis that Clark's criminal convictions collaterally estopped Clark from disputing his liability in the civil proceeding. "Under the doctrine of collateral estoppel, 'once a court has decided an issue of fact or law necessary to its judgment, that decision may preclude relitigation of the issue in a suit on a different cause of action involving a party to the first case.'"[73] For collateral estoppel to apply, three elements must be met: (1) the issue must have been actually litigated, (2) the issue must have been actually and necessarily determined by a court of competent jurisdiction, and (3) preclusion in a subsequent proceeding must not work an unfairness.[74] But "[w]here a civil litigant seeks to estop an opposing party based on a prior criminal proceeding, estoppel only applies to those matters that must have been decided in favor of the government in the prior case or, in other words, to those issues necessary to the criminal judgment."[75] And where a civil complaint alleges conduct beyond that for which the defendant was convicted in an earlier criminal case, "a plaintiff is not entitled to summary judgment on grounds of collateral estoppel alone."[76] The court found that Cumis failed to provide it with a sufficient record of the criminal conviction in order for it to determine what matters were directly at issue and necessarily decided by the jury in the criminal case. Therefore, without knowing exactly what the convictions against Clark were and the exact facts considered, the court held that Cumis was not entitled to summary judgment on grounds of collateral estoppel. The court continued that even if Clark was collaterally estopped from denying the specific conduct underlying his criminal convictions, this would still not entitle Cumis to summary judgment. The court reasoned that each of Clark's criminal convictions stemmed from discrete factual occurrences that were much narrower than Cumis' broad allegations of fraud. Therefore, the court stated that even if it found that there were grounds for collateral estoppel on the basis of Clark's convictions, "Cumis could not use such collateral estoppel to 'boot strap' summary

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[73] *Id*. at 215 (quoting United States v. All Assets Held at Bank Julius, 229 F. Supp. 3d 62, 73 (D.D.C. 2017)).

[74] *Id*.

[75] *Id*. at 216 (citing SEC v. Bilzerian, 29 F.3d 689, 693-95, n.10 (D.C.C. 1994)).

[76] *Id*.

judgment in this case."[77] Accordingly, the court denied Cumis' motion for summary judgment.

III.
CONCLUSION

The cases discussed above contain a relatively even mix of cases that favor insurers and those that favor insureds. As always, the real impact of all these decisions will become clearer with time.

[77] *Id*. at 217-18.