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NORTH CAROLINA INSURANCE LAW

By John M. Kirby

- I. FUNDAMENTALS OF COVERAGE
 - A. Choice of Law
 - B. Interpretation is Based on Policy Terms
 - C. Rules of Construction
 - D. Effect of Statutes
 - E. Recovery Based on Theories Other Than Policy Terms
 - 1. Estoppel/Waiver
 - 2. Modification of Contract
 - 3. Negligent Misrepresentation (by insurer)
 - 4. Negligence in Handling Claim
 - 5. Reformation
 - 6. Fiduciary Duty

- II. TYPICAL COVERAGE PROVISIONS
 - A. Specific Coverage Provisions
 - 1. Occurrence
 - a. “Occurrence” in construction cases
 - 2. Property Damage or Bodily Injury
 - 3. Damages
 - a. Property Damage in Construction Cases
 - 4. Legally Obligated to Pay
 - 5. Whether the Damages Occurred Within the Policy Period
 - 6. Personal and Advertising Injury
 - 7. “Insured” and related terms
 - 8. Limits
 - B. Exclusions
 - 1. Intentional Act Exclusion
 - a. Personal Injury Coverage
 - 2. Care, Custody and Control
 - 3. Real Property (ongoing operations)
 - 4. “business risk” exclusions

- a. Repairs due to incorrect work
 - b. Damage to Insured's Product
 - c. Damage to Insured's Work
 - d. Impaired property
- 5. employee exclusion
- 6. Contractual Liability
 - a. Claim for Insured's Breach of Contract
 - b. Liability Assumed in a Contract
- 7. Pollution Exclusion
- 8. business pursuits
- C. Other Insurance clauses
 - 1. Umbrella and True Excess Policies
- D. Standing/Privity issues
- E. Other defenses
 - 1. Misrepresentation on policy application.
 - 2. Violating policy provision.
 - 3. Late notice.
 - 4. Non-payment of premium / Cancellation

III. DUTY TO DEFEND

- A. Basic Test
 - 1. Significance of Conflict
 - 2. Policy Defenses Affecting Duty to Defend
- B. Defending under Reservation of Rights
- C. Wrongful Refusal to Defend
 - 1. waiver of consent-to-settle clause
 - 2. waiver of other coverage issues
 - 3. Attorneys Fees in pursuing insurer
- D. Selection of Counsel
- E. Claims for Reimbursement of Defense and Settlement Costs
 - 1. Cases by Insured
 - 2. Cases by Another Insurer
 - a. By Insurer with No Duty to Defend
 - b. By Insurer with Duty to Defend
- F. Whether Excess Insurer has Duty to Defend
- G. Insurer's Right to Withdraw Defense

IV. EXTRA-CONTRACTUAL LIABILITY

- A. Unfair and Deceptive Acts
 - 1. Evidence Sufficient
 - a. Sufficient to survive Directed Verdict
 - b. Sufficient to survive Summary Judgment
 - c. Sufficient to survive Motion to Dismiss
 - 2. Evidence Insufficient
 - a. Insufficiently to survive DV
 - b. Insufficiently to survive SJ

- c. Insufficiently pled
 - 3. Treble damages; computation of same
 - 4. Attorneys Fees
 - 5. Reliance
 - 6. Standing
 - 7. Statute of Limitations
- B. Bad Faith
 - 1. Evidence Sufficient
 - a. Sufficient to survive DV
 - b. Sufficient to survive SJ
 - c. Sufficient to survive Motion to Dismiss
 - 2. Evidence Insufficient
 - a. Insufficient to survive DV
 - b. Insufficient to survive SJ
 - c. Insufficient to survive Motion to Dismiss
 - 3. Damages
 - 4. Attorneys fees and expenses
 - 5. Bad Faith failure to settle (third party)
 - 6. Bad Faith Breach of Duty to Defend
 - 7. Failure to Preserve Limits
 - 8. Settling Insured's Deductible
 - 9. Not Assignable
 - 10. Standing
 - 11. Discovery Issues

I. FUNDAMENTALS OF COVERAGE

The initial inquiry in any coverage dispute is whether the claim asserted is “covered” by the terms of the insurance policy. This requires a good understanding of the facts and of the applicable policy provisions. There are several principles or rules of construction that the courts employ to interpret policy provisions, and there are several cases addressing specific provisions.

In addition to the terms of the policy, the case law, which is founded primarily on contract law, recognizes arguments by both the insurer and the insured to create, or negate, coverage, or liability on other theories, based on other doctrines, such as negligence and waiver.

Coverage issues arise under all types of policies. The most common policies are automobile policies (including personal auto policies, business auto policies, commercial auto policies, garage policies), homeowner's policies, general liability policies, professional policies (claims made or errors and omissions policies), medical expenses

coverage (personal health coverage or “medical payments”). Regardless of the policy, the same rules of construction apply.

This article addresses doctrines and cases occurring in many types of insurance policies. The focus, however, is on liability policies, and further on the comprehensive general liability (CGL) policy.

A. Choice of Law

If the claim or the insurance policy originated in any significant manner outside North Carolina, then attention must be given to the applicable choice of law. G.S. § 58-3-1 states, “All contracts of insurance on property, lives, or interests in this State shall be deemed to be made therein, and all contracts of insurance the applications for which are taken within the State shall be deemed to have been made within this State and are subject to the laws thereof.” In situations where this statute is inapplicable (i.e. where the policy is not “on property, lives, or interests” in North Carolina), then the common law rule of *lex loci contractus* applies.

Most of the cases addressing this issue arise in the context of an automobile accident. With respect to an automobile case, “the general rule is that an automobile insurance contract should be interpreted and the rights and liabilities of the parties thereto determined in accordance with the laws of the state where the contract was entered even if the liability of the insured arose out of an accident in North Carolina.” Fortune Ins. Co. v. Owens, 351 N.C. 424, 428 (2000) (“The mere presence of the insured interests in this State at the time of an accident does not constitute a sufficient connection to warrant application of North Carolina law.”; where “the only contact between the Fortune policy and North Carolina is that ‘the automobile accident on January 29, 1990, occurred in North Carolina and following the accident Gary Edgar Owens provided the officer with a temporary North Carolina address.’,” Florida law applies). This case is typical of many cases addressing choice of law issues; they often focus on traditional notions of *lex loci contractus*, rather than initially determining whether G.S. § 55-3-1 applies.

Our Supreme Court has held that where there are more substantial connections with North Carolina, North Carolina law applies. Collins & Aikman Corp. v. Hartford Accident & Indem. Co., 335 N.C. 91 (1993) (even though policy was originally delivered to broker in California, and was later sent to the insured’s office in Charlotte, where insured owned numerous trucks which were predominately titled in North Carolina, and insured’s transportation division is located in Albemarle, and auto accident occurred in North Carolina, “The policy in this case protects the interest of plaintiff against having to pay damages for the wrongful acts of its agents. The insurance contract is deemed to have been made in North Carolina.”). See also Cont'l Cas. Co. v. Physicians Weight Loss Ctrs. of Am., 61 Fed. Appx. 841 (4th Cir. 2003) (duty to defend under professional liability policy determined by North Carolina law where underlying suit was brought in North Carolina, and insured had fifty businesses (at issue in the suit) in North Carolina, and 50,000 North Carolina citizens were customers of the insured; North Carolina had much more than a casual connection with the substance of the insurance policy).

A case decided a century ago held that a choice-of-law provision is invalid. Blackwell v. Life Ass'n, 141 N.C. 117, 53 S.E. 833 (1906) (provision in policy stating "This contract shall be governed by, subject to, and construed only according to the laws of the State of New York, the home office of said association" is void). This case has never been expressly overturned, but modern cases are more prone to enforcing such provisions. Perkins v. CCH Computax, Inc., 333 N.C. 140, 146 (1992) ("the North Carolina rule . . . recognizes the validity and enforceability of choice of law and consent to jurisdiction provisions").

Even where North Carolina law applies, it should be noted that when there is no North Carolina authority directly on point, our courts often look to the law of other jurisdictions. Reference to these sources is especially appropriate in insurance disputes because of the fairly standardized policy language. This article focuses on cases from North Carolina and cases applying North Carolina law, but it cites to cases from other jurisdictions for general principles of insurance law, especially where there is scant North Carolina authority on the issue.

B. Interpretation is Based on Policy Terms

The policy is essentially a contract, and as a general matter a coverage dispute should be decided based on the actual language of the policy at issue. "Language in a policy of insurance is the determining factor in resolving coverage questions unless that language is in conflict with applicable statutory provisions governing such coverage." Lanning v. Allstate Ins. Co., 332 N.C. 309, 312 (1992) (where policy expressly provided that med-pay could not be stacked, prior cases with ambiguous policy provisions was not controlling).

Thus, in determining coverage, it is important to have the actual policy, as the terms of different policies may be different.

There are, however some instances where the court will seemingly analyze coverage by considering issues beyond the mere terms of the policy.

Some cases address the insured's "reasonable expectations." W & J Rives, Inc. v. Kemper Ins. Group, 92 N.C. App. 313, 317 (1988) ("Rives had not agreed with Polo, at the time of the theft, to provide insurance for the Polo materials and goods. Thus it would seem that a reasonable person in the position of Rives would have understood that the Polo goods were covered by Aetna's policy. The exclusion clause, therefore, does not apply to the Polo claim."). North Carolina has not, however, widely embraced the doctrine of the insured's "reasonable expectations" in construing a policy. The court may sometimes employ equitable or policy considerations in construing an insurance policy.

The cases sometimes recognize that a provision contrary to public policy will not be enforced. For example, a choice-of-law provision has been held to be against public policy and void. Blackwell v. Life Ass'n, 141 N.C. 117, 53 S.E. 833 (1906). It is

difficult for the Insurer to overcome coverage by relying on public policy. For example, an argument that coverage would result in a double recovery, or a windfall, to the insured has been rejected. An argument that coverage for punitive damages is contrary to public policy has been rejected. An insured's argument that an appraisal provision is contrary to public policy has been rejected.

Some decisions refuse to construe a policy so as to render it worthless. One case, however, allows the policy to be construed to as to provide "illusory coverage." Davidson v. Knauff Ins. Agency, Inc., 93 N.C. App. 20, 23 (1989) ("As plaintiff's uninsured motorist coverage already insured against motorists with less than the statutorily required minimum liability coverage of \$25,000, we noted plaintiff's contention that 'there are no circumstances under which he can collect on his underinsured coverage [of \$ 25,000] and he has paid his premium for this coverage in exchange for nothing.' It appears that the plaintiff is correct in this argument but it does not justify our rewriting the policy.").

That coverage is narrow will not prevent its enforcement as written.

C. Rules of Construction

Our courts have developed several rules of construction to determine whether an insurance policy covers a claim. As shown in Section I.B., the policy is the primary focus in any coverage analysis.

Many of the governing principles are summarized as follows:

As with all contracts, the goal of construction is to arrive at the intent of the parties when the policy was issued. Where a policy defines a term, that definition is to be used. If no definition is given, non-technical words are to be given their meaning in ordinary speech, unless the context clearly indicates another meaning was intended. The various terms of the policy are to be harmoniously construed, and if possible, every word and every provision is to be given effect. If, however, the meaning of words or the effect of provisions is uncertain or capable of several reasonable interpretations, the doubts will be resolved against the insurance company and in favor of the policyholder. Whereas, if the meaning of the policy is clear and only one reasonable interpretation exists, the courts must enforce the contract as written; they may not, under the guise of construing an ambiguous term, rewrite the contract or impose liabilities on the parties not bargained for and found therein.

Woods v. Nationwide Mut. Ins. Co., 295 N.C. 500, 505-506 (1978).

"If a policy defines a term, then that meaning is to be applied 'regardless of whether a broader or narrower meaning is customarily given to the term, the parties being free, apart from statutory limitations, to make their contract for themselves and to give

words therein the meaning they see fit.” Nationwide Mut. Ins. Co. v. Mabe, 342 N.C. 482 (1996). “[A]ll parts of an insurance policy are to be construed harmoniously so as to give effect to each of the policy's provisions. Id. The policy should be construed to give meaning to each provision.

“Where the insurance contract does not limit the definition of the word, this Court certainly should not step in to do so. Any ambiguity in the contract must, in fact, be construed against Nationwide, the drafter of the contract.” Baxley v. Nationwide Mut. Ins. Co., 334 N.C. 1, 7 (1993).

In determining whether there is coverage, “A party seeking benefits under an insurance contract has the burden of showing coverage. Until a prima facie case of coverage is shown, the insurer has no burden to prove a policy exclusion.” Fortune Ins. Co. v. Owens, 351 N.C. 424, 430 (2000).

A provision from one portion of the policy will not necessarily apply to a different portion of the policy. The insurer generally cannot rely on manuals or other documents to limit coverage.

There are a couple of statutes pertaining to the form and language of insurance policies. One statute provides that the policy should be “readable.” G.S. § 58-38-5.

The failure of an insurer to comply with a statutory requirement for the policy may result in the court construing that portion of the policy against the insurer. For example, a form which purported to reject coverage, but which did not conform to the statutory requirements was invalid, and the policy was held to afford coverage.

Further, policies must be approved by the Commissioner of Insurance. G.S. § 58-38-30. The effect of using a form without approval from the Commissioner is somewhat unclear.

“[T]here exists in North Carolina a duty for the insured to read the terms of the insurance policy.” Kirk v. R. Stanford Webb Agency, Inc., 75 N.C. App. 148, 151, 330 S.E.2d 262, 264, disc. review denied, 314 N.C. 541, 335 S.E.2d 18 (1985). The insurance agent does not have a duty to explain the policy to the insured.

As shown in section II.B., exclusions are construed against the insurer.

D. Effect of Statutes

Where a statute addresses a particular coverage issue, that provision will prevail over any contradictory provision in the policy.

There are, for example, extensive statutory requirements for automobile and fire insurance policies. See N.C.G.S. Sec. 58-44-15.

As discussed in Section II.A.7., where the statutory insurance is for the benefit of third person (i.e. other than the insured), then liability imposed on the insurer solely by virtue of statute, and not by the policy terms, may create a right of indemnity by the insurer against its insured.

E. Recovery Based on Theories Other Than Policy Terms

An insured can attempt to obtain recovery against the insurer on alternative theories or claims, where the policy language does not otherwise provide for recovery against the insurer, or where an exclusion would otherwise apply to defeat coverage. The courts recognize several alternative means of recover to an insured (or putative insured).

1. Estoppel/Waiver

The courts sometimes find that the insurer is estopped from denying coverage, or from raising an exclusion or other policy provision as a defense to coverage, or that the insurer has waived some coverage issues or defenses, by its conduct.

For example, “By denying liability or refusing to settle claims against insured, which are covered by the automobile indemnity policy, the insurance company commits a breach of the policy contract and thereby waives the provisions defining the duties and obligations of the insured.” Blue Bird Cab Co. v. American Fidelity & Casualty Co., 219 N.C. 788, 796-797 (1941).

Most cases, however, impose significant limitations on these doctrines.

It is well settled that conditions going to the coverage or scope of the policy, as distinguished from those furnishing a ground for forfeiture, may not be waived by implication from conduct or action, without an express agreement to that effect supported by a new consideration. This rule may be, as it often is, otherwise stated that the doctrine of waiver may not be applied to bring within the coverage of the policy risks not covered by its terms, or risks expressly excluded therefrom.

Hunter v. Jefferson Standard Life Ins. Co., 241 N.C. 593, 595 (1955); Pearce v. American Defender Life Ins. Co., 74 N.C. App. 620, 626-627 (1985) (where policy “expressly exempts from coverage death resulting from an accident involving an aircraft on which the insured serves as a crew member,” and insured was erroneously informed that it would be covered during such activities, “We think it clear that application of the doctrines of waiver or estoppel on these facts would essentially rewrite the policy, extending coverage to a risk expressly excluded therefrom, and obligating defendant to pay a loss for which it charged no premium. This we cannot do.”). Stated otherwise:

[W]aiver and estoppel cannot be used to create coverage which is nonexistent or expressly excluded from a policy. The essential question which must be answered when an issue of waiver or estoppel is raised is

whether the contested provision is a matter of forfeiture, to which the principles [of waiver and estoppel] apply, or a matter of coverage, where any change in terms must be by express agreement supported by new consideration.

Brendle v. Shenandoah Life Ins. Co., 76 N.C. App. 271, 276 (1985).

Thus, the general rule is that a policy condition or requirement can be waived by the insurer, but the essential coverage and exclusionary terms cannot be waived. One case, however, held that estoppel and waiver applied to prevent the insurer from relying on an exclusion. United States Fidelity & Guar. Co. v. Country Club, 119 N.C. App. 365, 374 (1995) (even though policy did not cover insured's liability arising from automobile accident, due to liquor exclusion, insured may be covered by doctrines of waiver and estoppel, where insurer knew that insured provided alcohol to guests); Country Club of Johnston County, Inc. v. United States Fid. & Guar. Co., 150 N.C. App. 231 (2002) (in determining whether insurer is estopped from denying coverage, court looks closely at notes and testimony of underwriter). This case, however, appears aberrational in view of Hunter, Brendle, et al.

A claim estoppel based on a statement by the insurer does not apply unless the insured relies on the misinformation.

2. Modification of Contract

The insured may also argue that the insurer, directly or through its agent, modified or changed the terms of the policy.

With regard to statements by the insurer prior to the issuance of the policy, the general rule is that such statements are inadmissible and do not bind the insurer. Such statements cannot "contradict or vary" the terms of the policy.

Statements made by the insurer, or its agent, made after the policy is issued may be deemed to modify the policy where the requisite elements are met. Pursuant to standard contract principles, the agent's statements can bind the insurer only if he had actual or apparent authority to bind the principle. Where the insured relies on apparent authority, "It must be shown that a party was reasonable in believing that another had conferred authority to that party to act on its behalf." Capitol Funds, Inc. v. Royal Indem. Co., 119 N.C. App. 351, 357 (1995).

In Royal Indemnity, the defendant-insurer issued a fire insurance policy to the plaintiff-insured through the defendant's agent. The agent stated that a particular location was covered by the policy, when in fact that location was not listed in the policy, and thus not insured by the terms of the policy. The jury found that the agent had actual and apparent authority to act for the insurer, and the court of appeals affirmed because the "[e]vidence presented shows that defendant Royal had knowledge that Cummings LeGrand [agent] was the retail agent; that defendant Royal used Cummings LeGrand to

do its bidding; and that it never informed Capitol Funds [insured] that Cumming LeGrand's authority was limited." Id. at 357.

Where the agent does not have authority, then it cannot bind the principal. Sasser v. Pilot Fire Ins. Co., 203 N.C. 232, 238 (1932).

Pursuant to ordinary contract law, a statement which is too vague is not binding.

Under the terms of many policies, a modification must be in writing, and the insured's modification argument fails in the absence of the appropriate writing. Where, however, the policy does not specifically state that the modification must be in writing, then the agent may modify the policy.

3. Negligent Misrepresentation (by insurer)

Where the insurer or its agent makes a misrepresentation to the insured (or a third person) regarding the coverage under a policy, then the insured may have a claim for negligent misrepresentation if he can establish the elements for this offense. This is not a claim for coverage, but is instead a separate tort claim.

There is some authority that the agent may have a duty to speak, and his failure to do so constitutes a misrepresentation.

Where the insurer is held liable because of the negligence of the agent, there is authority that the insurer and the agent are joint-tortfeasors, entitled to contribution from each other. It is not clear that this result is correct. The general rule in most other jurisdictions is that the insurer is entitled to indemnification from the agent where the insurer's liability is predicated upon the agent's negligence or representation.

In order to have a claim for negligent misrepresentation, the insured must show that it reasonably relied on the insurer's statements. Where reliance on the insurer's statements is unreasonable, the claim fails. The Supreme Court has held that where the policy expressly precludes the agent from binding the insurer, that the insured may not rely on the agent's statements.

Contributory negligence should be a defense to a claim for negligent representation.

4. Negligence in Handling Claim

There are some areas where the insured may be able to sue the insurer for negligence in adjusting and defending the claim. The nature of this claim is not entirely clear. It may be viewed purely as a tort claim, arising from a contractual relationship. It may also be viewed as a claim for a breach of an implied contractual duty (e.g. a duty to adjust and defend the claim reasonably, or in good faith). The exact scope of this liability under this theory is not clear.

The insurer has these duties when it defends its insured. “When State Farm undertook the defense of Connor's action for damages, it owed its insured the duty to act diligently and in good faith.” Connor v. State Farm Mut. Auto. Ins. Co., 265 N.C. 188, 191 (1965). The breach of this duty gives the insured a claim against the insurer.

Many of the cases addressing breach of these duties are discussed in Section IV.B.5., pertaining to claims against the insurer for “bad faith” in claims handling. It is not clear, however, whether an insured must show mere negligence to prevail in a claim for compensatory damages arising from claims handling, or whether the insured must show “bad faith” in order to pursue these theories. Most of the cases, however, indicate that the insurer is held to a standard of reasonableness. When deciding whether an insurer handled a claim “reasonably,” the most persuasive evidence should be evidence of industry standards.

In one extraordinary case, the insurer was subject to liability for personal injuries resulting from negligence in adjusting the claim. Prince v. Wright, 141 N.C. App. 262 (2000) (where insurer adjuster fire loss at house arising from claim of insured-landlord, and insurer inspected house, insurer created duty toward plaintiff-tenant, and insurer could be liable to tenants for fire following inspection).

5. Reformation

The insured may be able to reform the policy where there is “clear, cogent, and convincing evidence” that the policy as written did not accurately reflect the true intent of the parties regarding the coverage to be afforded.

Some cases appear to use the notion of reformation, without expressly using the doctrine. See, e.g. Stockton v. North Carolina Farm Bureau Mut. Ins. Co., 139 N.C. App. 196, 197 (2000) (where policy was issued to "Oak Farm," but this was non-existent entity, UIM coverage was extended to son of purchaser of policy; accepting Plaintiff's argument that “the language in the UIM endorsement defining ‘insured’ to include family of the named insured mandates a finding that the Stocktons are also named insureds under the policy.”; affirming summary judgment for insured, because Oak Farm no legal existence complete in itself; court not expressly using doctrine of reformation); Ratliff v. Virginia Surety Co., 232 N.C. 166, 170 (1950) (allowing insured's claim to proceed where there was an apparent error in VIN number on policy).

6. Fiduciary Duty

“While we have recognized that an insurance agent has a fiduciary duty to keep the insured correctly informed as to his insurance coverage, we have not held that an insurance company or an adjuster has a fiduciary duty to an insured with respect to settlement of claims.” Cash v. State Farm Mut. Auto. Ins. Co., 137 N.C. App. 192, 206 (2000). Thus, where the insurer negligent assured the insured that its telephone system was covered, the agent had a fiduciary duty to keep the insured correctly informed, and a

judgment against the insurer will be upheld. R-Anell Homes, Inc. v. Alexander & Alexander, Inc., 62 N.C. App. 653 (1983).

II. TYPICAL COVERAGE PROVISIONS

Coverage will typically depend on applying the policy provisions to the facts underlying the claim. In each policy, there are crucial coverage terms, or criteria, and typically there are exclusions. Determining whether the claim is covered by the policy depends on an analysis of these coverage provisions and exclusions. The focus of this Section is on an analysis of coverage under liability policies, and especially CGL policies. Many of these coverage terms and concepts, however, apply to several types of policies.

A. Specific Coverage Provisions

A typical homeowner's (HO) liability policy states, "If a claim is made or a suit is brought against an insured for damages because of bodily injury or property damage caused by an occurrence to which this coverage applies, we will . . . pay up to our limit of liability for the damages for which the insured is legally liable." See, e.g., North Carolina Farm Bureau Mut. Ins. Co. v. Stox, 330 N.C. 697, 700 (1992) (addressing case with this language in homeowner's policy). A typical CGL policy states, "We will pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which this insurance applies. . . . This insurance applies to "bodily injury" and "property damage" only if: The 'bodily injury' or 'property damage' is caused by an 'occurrence' that takes place in the 'coverage territory.'" E.g. Gaston County Dyeing Machine Co. v. Northfield Ins. Co., 351 N.C. 293, 300 (2000).

Thus, essential requirements are that there be an "occurrence" resulting in "property damage or bodily injury" during the policy, resulting in "damages" which the insured is "legally obligated to pay" (or is "legally liable"). See, e.g., Hobson Constr. Co. v. Great American Ins. Co., 71 N.C. App. 586, 590 (1984) ("If 'property damage' occurred while the policy was in effect, the insurer must pay the legal damages due to such 'property damage' absent some exclusion contained in the policy.").

Other policies use some of these terms also. For example, a life insurance policy may condition benefits on an "accident."

The court and the parties should carefully and literally apply these terms, and their relationship to each other. For example, in determining whether there is coverage in a CGL policy, the issue is not whether the damages awarded against insured represent "property damage" or "bodily injury," but rather whether the insured's liability is for damages which arise from bodily injury or property damage. Thus, a claim for punitive damages which arises from bodily injury is covered, even if the punitive damages are "awarded for the bad conduct of the plaintiff's agent and not for damages for bodily injury." Collins & Aikman Corp. v. Hartford Accident & Indem. Co., 335 N.C. 91

(1993) (“Punitive damages were recovered because of the recovery for bodily injuries to the deceased persons. This recovery is covered by the policy.”).

The most common and crucial coverage provisions are addressed below.

1. Occurrence

Most liability policies require an “occurrence” in order to have coverage. (See also Section II.A.7., addressing “personal and advertising injury,” which generally do not require an “occurrence.”) In the context of a CGL policy, the “occurrence” must result in property damage or bodily injury. It bears noting that the policy requires only that an occurrence lead to this damage or injury, and not that all causes of the damage or injury be an “occurrence.”

An “occurrence” is typically defined as an “accident,” or as an “accident, including continuous or repeated exposure to substantially the same general harmful conditions.” The term “accident” was described by the North Carolina Supreme Court in Tayloe v. Hartford Accident & Indem. Co., 257 N.C. 626, 127 S.E.2d 238 (1962) as follows:

“Accident” is defined [by dictionary] as “an unforeseen event, occurring without the will or design of the person whose mere act causes it; an unexpected, unusual, or undesigned occurrence; the effect of an unknown cause, or, the cause being known, an unprecedented consequence of it; a casualty.”

The leading case from our Supreme Court on this term in a CGL policy is Stox. Stox held: “We conclude that where the term ‘accident’ is not specifically defined in an insurance policy, that term does include injury resulting from an intentional act, if the injury is not intentional or substantially certain to be the result of the intentional act.” North Carolina Farm Bureau Mut. Ins. Co. v. Stox, 330 N.C. 697, 709 (1992) (where trial court found that insured did not intend to injure co-worker when he pushed her, there was an occurrence).

Many cases address whether there is an “occurrence.” In the following cases, the court found there was no “occurrence”:

- Claim by police officer against his employer alleging improper training and that employer “knew or should have known that its action in instructing its officers how to use the radios [which resulted in shooting of plaintiff] was substantially certain to cause the death or serious injury of an officer.”
- Torts of alienation of affection and criminal conversation are not “accidents.”

- Where insured-vendor falsely represented that there were no prior water damages to property, there was no occurrence.
- “A refusal to lease equipment to a newly-formed company after already allegedly agreeing to do so, even from the viewpoint of Holz-Her, was substantially certain to cause South Bay delays and other consequential business injuries.”
- Where insured-city’s chief building inspector destroyed defendant’s greenhouses, possibly under erroneous interpretation of city building code, there was no accident or occurrence, as the decision did not happen by chance and was not unexpected, unusual or unforeseen.
- Where insured sold lots in subdivision, with restrictive covenant limiting use to residential, and then insured built mini-warehouse facility, and insured was sued by other landowners for breach of covenant, injury was substantially certain to occur.
- Intentional assault by the driver of an automobile was not covered by an automobile insurance policy covering accidental injury.

The following cases found an “occurrence”:

- Where insured accumulated debris, resulting in damage to a stream, there was an “occurrence,” as insured intended accumulation but did not intend damage to stream.
- “While plaintiff’s actions taken in an attempt to manage and maintain the property with plumbing, pest control and grounds keeping were intentional, the resulting damage to the property occasioned thereby was not.”
- Where insured hired surveyor, who made mistake in determining property line, and cut down adjoining landowner’s trees under belief that they were his, the damage was “caused by an unexpected event or happening”; Court emphasized that insured obtained endorsement modifying coverage terms, providing coverage for damage “caused by an unexpected event or happening . . . which results . . . in injury to or destruction of property . . . provided the insured did not intend that injury . . . or destruction would result.”
- Where insured intended to shoot stop sign but instead shot into bedroom window and injured occupant, his conduct did not rise to level requiring inferred intent to injure.

- In a claim for negligent hiring, an assault by employee is an occurrence.

Many of the cases addressing whether there is an occurrence are coterminous with cases addressing the “intentional acts exclusion,” addressed later.

a. “Occurrence” in construction cases

In the construction context, there is a developing body of case law addressing whether various construction claims involve an “occurrence.” North Carolina state courts have scant authority on whether there is an “occurrence” when a contractor’s work has defects or fails. Federal courts applying North Carolina law, however, have addressed some of these issues.

Most of these cases involve the construction of a building which is accepted by the owner, and the owner later discovers construction defects, which may cause damage to other parts of the building or the contents. The typical insurance issue is whether the owner’s claim against the contractor is covered. Some cases address the coverage of a subcontractor.

In the leading case, it was held that “defective workmanship does not constitute an ‘occurrence.’” Wm. C. Vick Constr. Co. v. Pennsylvania Nat’l Mut. Cas. Ins. Co., 52 F. Supp. 2d 569, 584, 585 (E.D.N.C. 1999). In Vick, the insured-builder was sued by the property owner for the cost of repairing a roof that leaked and a stucco wall that cracked. The court held that because the damage was the result of faulty or defective workmanship, the damage was not the result of an “occurrence” or “accident.” In determining that the faulty construction was not an “occurrence,” the court emphasized the foreseeability of the resulting conditions is critical to determining whether there is an occurrence. “The natural and ordinary consequences of improperly applying a waterproofing membrane and failing to apply fiberglass matting in stucco construction could very well be a leaky membrane and cracked walls.” The court thus blurred the line between determining whether the original cause (defective construction) is an “occurrence,” and determining whether the ultimate damage (or loss or consequence, such as leaks or cracks) is foreseeable (or the natural consequence of the faulty construction).

Most courts which have addressed this issue have held that defective construction is not an “occurrence,” even when it damages other parts of the construction. Further, the fact that the defective work was done by a subcontractor does not render defective work to be an occurrence.

Where the damage that results from defective workmanship causes bodily injury (e.g., if a defectively built ceiling fell on a person) or caused damage other property (e.g., if the same ceiling fell and caused damage of office furniture), that subsequent damage would be deemed to have resulted from an event deemed an “accident” because the damage to the person or office furniture was an unforeseen and unexpected event.

Cases decided in the wake of Vick have provided some clarification of these issues. The cases generally hold that when the loss or damage resulting from defective construction is to the construction itself, there is no occurrence. For example, defects in cabinets were the natural consequence of the poor workmanship, not the result of an “accident.”

Further, even where there is damage to other property, there is no “occurrence” where that subsequent damage is “customarily associated” with repairing the defective work. Where a sub-contractor was hired to replace stucco siding with a different siding, and the sub-contractor was sued alleging that “in installing the conventional hard-coat stucco, damaged [owner’s] property including damage to driveways, patios, chimneys, painted walls, stone walkways, slate roofs, air conditioners and landscaping,” but the plaintiff made no allegations concerning how the damage occurred, and its counsel acknowledged at oral argument that part of sub-contractor’s work included the effort customarily associated with cleaning up a worksite following application of hard-coat stucco, and claimant did not show that such damage was not the expected consequence of defective or poor workmanship. Similarly, when defective cabinets must be replaced, the costs incurred in the replacement process (repair to drywall, repaint walls, reinstall sinks) is not an “accident.”

Where, however, the insured’s work damages other property (i.e. property not constructed by the insured), then there is an occurrence. Even if the damage to other property was foreseeable, it cannot be said that this resulting damage to other property was intended so as to disqualify the incident as an accident. Thus, where defectively installed windows cause water damage to the owner’s carpets, there is an “occurrence.” Similarly, another jurisdiction has held that where a pipe bursts and damages furniture, there is an occurrence.

One case applying North Carolina law has held that there may be an occurrence where the damage to the insured-subcontractor’s work or product may be due the errors of other sub-contractors, because the damage is not necessarily “foreseeable,” “expected,” or “intended” from the standpoint of the insured. It is difficult to reconcile this case with the other cases. This case appears to blur the distinction between the insured’s liability and coverage.

2. Property Damage or Bodily Injury

In order for there to be coverage, the “occurrence” must result in bodily injury or property damage. Many policies define “property damage” as:

- (1) Physical injury to or destruction of tangible property which occurs during the policy period, including the loss of use thereof at any time resulting therefrom, or
- (2) Loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an

occurrence during the policy period.

Hobson Constr. Co. v. Great American Ins. Co., 71 N.C. App. 586, 590 (1984). See also Prod. Sys. v. Amerisure Ins. Co., 167 N.C. App. 601, 606 (2004) (policy defining term as “Physical injury to tangible property, including all resulting loss of use of that property.”).

The key element of “property damage” is a change in the condition of the property. The property must have been “previously undamaged.” Prod. Sys. v. Amerisure Ins. Co., 167 N.C. App. 601, 606 (2004).

Where the insured contaminates the soil and groundwater, this is “property damage.”

North Carolina state courts have not addressed whether certain “economic losses,” such as lost profits, are “property damage.” A federal case applying North Carolina has construed “property damage” to not include economic losses, and this is the majority approach.

In North Carolina it is not clear the extent to which a claim for “loss of use” constitutes “property damage,” even if the policy defines “property damage” to include loss of use. In Prod. Sys. v. Amerisure Ins. Co., 167 N.C. App. 601 (2004), the court held that a complaint which included claims for “loss of use” were not covered because they did not constitute “property damage.” In Amerisure, the insured was sued for improperly constructing conveyor belts, which damaged other parts of the system and necessitated repairs to the line and resulted in loss of use. As noted above, the case seems to hold that all losses arising from the insured’s improper work are not “property damage.” But see Wayne Bros., Inc. v. N. River Ins. Co., 2003 U.S. Dist. LEXIS 16838 (M.D.N.C. 2003) (where insured allegedly incorrectly installed concrete slab, resulting in delamination of slab, but claimant is seeking not only the costs of repair of the delamination, but also damages arising from its loss of use, business disruption and damage to its equipment, there is “property damage”).

The term “bodily injury” is typically defined as “bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom.” See Fieldcrest Cannon v. Fireman's Fund Ins. Co., 127 N.C. App. 729, 732 (1997). See also Holt v. Atlantic Cas. Ins. Co., 141 N.C. App. 139, 141 (2000) (policy stated, “Bodily injury’ means bodily harm, sickness or disease, including death that results.”).

One issue which arises as to “bodily injury” is whether claims for emotional distress are claims for “bodily injury.” Cases have reached conflicting results on this issue.

a. Property Damage in Construction Cases

Cases against a contractor arising from its construction present distinct issues in determining whether there is “property damage.” There are a couple of North Carolina cases addressing this issue, as well as several federal cases.

The leading case held that costs to repair and complete a dam are not “property damage.” Hobson Constr. v. Great American Ins. Co., 71 N.C. App. 586 (1984), disc. review denied, 313 N.C. 329 (1985). The opinion does not clarify the nature of these “repairs.”

A subsequent case construed Hobson to mean that “property damage” does not include “the expense of repairing property or completing a project that was not done correctly or according to contract in the first instance.” Prod. Sys. v. Amerisure Ins. Co., 167 N.C. App. 601, 606 (2004).

The leading federal case held that, “A mere defect in construction is not “property damage.” Wm. C. Vick Constr. Co. v. Pennsylvania Nat'l Mut. Cas. Ins. Co., 52 F. Supp. 2d 569 (E.D.N.C. 1999) (relying heavily on Hobson).

Pursuant to Vick, where the claim against the insured-contractor is simply for deficient work, there is no “property damage.” This is true even where the original deficient work causes damage (or a change) to other parts of the work. For example, where the builder applied a roofing membrane upside-down, resulting in a pitted area, wrinkling, separation of the membrane from the slab, and water leaks, and where a stucco wall developed cracks (not necessarily the result of the leaks), the claims against the builder did not arise from “property damage.” Where the allegations are that “the subject property was never constructed properly in the first place,” there is no property damage. Other jurisdictions have generally taken this view.

Thus, the issue of whether there is “property damage” is determined not simply by whether the property has changed, but by whether those changes are to the insured’s work and are the result of the original defective construction. A change in the property caused solely by defective construction is not “property damage.”

Damage to property other than the insured’s work, however, is “property damage.” For example, where the contractor’s defective building causes damage to carpets furnished by the owner, there is property damage. The cost to correct the faulty workmanship, however, is not property damage and is not covered.

The state and federal cases applying North Carolina law have not addressed whether the damage of one subcontractor’s work caused by another subcontractor’s work is “property damage,” in a claim against the contractor. One case, applying Virginia law, distinguished Vick on this basis, and held that such damage is “property damage.”

One case has held that where the insured’s work may have failed not due to defective workmanship, but rather due to the actions of others, then there may be “property damage.” As noted in the previous section regarding “occurrences,” this case

appears to have confused issues of liability and issues of coverage. It is therefore difficult to reconcile this case with other cases, which hold that damage to the insured's work is not property damage.

As noted in the preceding section, it is not clear the extent to which a claim for "loss of use" constitutes "property damage," even if the property so defines "property damage." In Prod. Sys. v. Amerisure Ins. Co., 167 N.C. App. 601 (2004), the court held that a complaint which included claims for "loss of use" were not covered because they did not constitute "property damage." In this case, the insured was sued for improperly constructing conveyor belts, which damaged other parts of the system and necessitated repairs to the line and resulted in loss of use. As noted above, the case seems to hold that all losses arising from the insured's improper work are not "property damage."

Federal authority prior to Amerisure held that where the claimant sought loss of use arising from the insured's defect work, there was property damage and the claim was covered. Other jurisdictions to address the issue of whether loss of use is "property damage" are split as to whether there must also be other damage which constitutes "property damage"; i.e., some courts hold that loss of use alone is not sufficient to establish "property damage" and thus coverage.

3. Damages

In a CGL policy, the insurer is required to pay only for the insured's liability to pay for "damages" arising from property damage or bodily injury.

"Damages" is not defined in most policies, but is generally understood to mean "money paid or ordered to be paid as compensation for injury or loss" and "the estimated money equivalent 'for detriment or injury sustained.'" C.D. Spangler Constr. Co. v. Industrial Crankshaft and Eng'g, Inc., 326 N.C. 133 (1990).

"Damages" does not include purely injunctive relief. Where, however, the insured must expend sums to comply with an injunctive order, those expenses are damages and are covered.

4. Legally Obligated to Pay

The policy does not require payment (i.e. "indemnity") unless and until the insured is "legally obligated to pay" damages.

Where the claimant has settled with the insured, but has agreed to not seek recovery from the insured, there is no coverage because the insured is not legally obligated to pay damages. A further limitation is that a consent judgment does not obligate the insurer to pay, where the insurer was not a party to the action.

It should also be noted that even once there is a judgment, the insurer can raise coverage issues, and can raise fraud or collusion.

5. Whether the Damages Occurred Within the Policy Period

Most insurance policies provide a time period during which some event (e.g. an accident, property damage, or a claim) must occur in order to create coverage. Under most CGL policies, which are “occurrence-based,” the policy provides coverage only if the property damage or bodily injury occurs during the policy period (even if, e.g., suit is not filed until much later). A typical policy states, “This insurance applies to ‘bodily injury’ and ‘property damage’ only if: . . . The ‘bodily injury’ or ‘property damage’ occurs during the policy period.” See Gaston County Dyeing Machine Co. v. Northfield Ins. Co., 351 N.C. 293, 300 (2000).

The typical policy language is thus clear that the date of the existence of property damage is the critical issue in determining whether a particular policy covers a loss. By way of distinction, the policy does not state or suggest that the existence of the underlying cause or defect leading to the damage, or that the discovery of the damage, is the event which “triggers” coverage. Nevertheless, cases from North Carolina and elsewhere have struggled with determining the appropriate “trigger” rule.

North Carolina generally follows the rule that the policy in effect when the property damage occurs provides coverage; this is known as the “injury-in-fact” rule. Gaston County Dyeing Machine Co. v. Northfield Ins. Co., 351 N.C. 293, 303 (2000). Accord Imperial Casualty & Indem. Co. v. Radiator Specialty Co., 862 F. Supp. 1437 (E.D.N.C. 1994) (“the court has concluded that the courts of this state would not adopt the manifestation rule in asbestos-related injury cases”; policy in effect on first exposure to injury-causing conditions provides coverage). This is clearly the rule when the date of loss can be determined with certainty.

One case has held that where the construction defects that caused the water damage were built outside the policy period, then the claim is not covered. This case can be read to suggest that the triggering event is not the actual property damage, but rather the underlying construction defect which ultimately leads to the property damage. The case, however, suggests, and may be read to infer a presumption that, the property damage, consisting of leaking water, began on the date of the faulty construction. It is not clear whether the result in this case would have been different if the insured had presented evidence that the damage, consisting of leaking water, had not occurred until a later date.

In a claim for alienation of affections, there is authority that the damage does not occur at the time of the affair, but when the claimant learns of the affair. It is not clear whether the court was applying a manifestation rule, or whether it was holding that the damage did not occur until the affair was discovered.

Where the date of injury is not known, it is not clear whether North Carolina has a manifestation date of discovery, or another rule (e.g. continuous trigger). A previous case from the Court of Appeals held that “The ‘general’ rule is that, for insurance

purposes, property damage ‘occurs’ when it is manifested or discovered.” West American Ins. Co. v. Tufco Flooring East, Inc., 104 N.C. App. 312, 317 (1991). Gaston Dye overruled Tufco for cases where the date of damage can be ascertained, but it did not clearly overrule the Tufco rule for cases where the date of loss cannot be ascertained.

Nevertheless, the Tufco reasoning (that property damage “occurs” upon manifestation or discovery and not upon actual injury) has been applied in other cases, leaving the validity of those holdings uncertain. Bruce-Terminix Co. v. Zurich Ins. Co., 130 N.C. App. 729, 733-734 (1998) (applying Tufco discovery rule in case against termite company; “While there may have been indications of termites in Gibson's home prior to March 1993, termite damage did not manifest itself to her, as stated in her deposition, until March 1993, and therefore, as supported by Tufco, that date is the date of discovery.”).

North Carolina has apparently rejected any notion of a “continuous trigger.” I.e., even where the property damage occurs over multiple policy periods, only the first policy’s coverage is invoked. This is true even though the insured does not discover the damage until later. Further, coverage under the first policy is provided for the entire loss. These issues were decided in Gaston Dye. The facts and holding of Gaston Dye are instructive.

In Gaston Dye, a “pressure vessel” leaked, causing damage to products being made by Sterling Pharmaceuticals on Date A (June 21, 1992). The damage continued until it was discovered on Date B (August 31, 1992). One insurer provided coverage on the date of the first injury (Date A); another insurer provided coverage on the date of subsequent injuries and on date of discovery (Date B). The Court held that only the first insurer provided coverage, as follows:

Under the insurance policies at issue in this case, coverage is triggered by "property damage" when the property damage is caused by an "occurrence" and when the property damage occurs during the policy period. The property damage alleged in this case was the contamination of sixty tons of Iohexol, a contrast media dye used for diagnostic medical imaging, valued in excess of \$20 million. . . .

. . . Stated differently, the "injury-in-fact" in this case can be determined with certainty because the cause of the property damage occurred and property damage resulted on 21 June 1992. Therefore, the 1 July 1991 to 1 July 1992 policy period is triggered, even though the contamination continued until discovery of the leak on 31 August 1992. . . .

. . . [W]here the date of the injury-in-fact can be known with certainty, the insurance policy or policies on the risk on that date are triggered.

Gaston County Dyeing Machine Co. v. Northfield Ins. Co., 351 N.C. 293, 303 (2000). A prior case, applying the discovery rule, rejected a “continuous trigger” doctrine, invoking

several policies for a loss. Bruce-Terminix Co. v. Zurich Ins. Co., 130 N.C. App. 729, 733-734 (1998) (“there can only be one date” of discovery).

In addition to the occurrence-based policies, some policies are “claims made” policies. They cover claims made (not accidents occurring) during the policy period.

6. Personal and Advertising Injury

Many CGL and other policies also provide coverage for “Advertising and Personal Injury.” A policy may cover “personal injury” claims defined as:

- (1) false arrest, false imprisonment, wrongful eviction, wrongful detention, malicious prosecution or humiliation;
- (2) libel, slander, defamation of character, invasion of rights of privacy, discrimination or violation of Civil Rights, or assault and battery;
- (3) erroneous service of civil process or papers;
- (4) bodily injury as hereinabove defined.

Graham v. James F. Jackson Associates, Inc., 84 N.C. App. 427, 429-430 (1987) (citing policy with these provisions). Other policies may describe the covered offenses as follows:

- (a) False arrest, detention or imprisonment;
- (b) Malicious prosecution;
- (c) The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies by or on behalf of its owner, landlord or lessor;
- (d) Oral or written publication of material that slanders or libels a person or organization. . . .
- (e) Oral or written publication of material that violates a person's right of privacy.

Whiteville Oil Co. v. Federated Mut. Ins. Co., 889 F. Supp. 241, 245 (E.D.N.C. 1995) (citing policy with these provisions).

Under these provisions, coverage is afforded only for the enumerated claims. The courts find coverage only if the allegations match a covered offense. The covered offenses will generally be construed in accordance with recognized tort claims.

Generally there is no need for an “occurrence” in these policies. But see Henderson v. United States Fid. & Guar. Co., 346 N.C. 741 (1997) (“The Court of Appeals also held that plaintiffs' damages did not arise out of an ‘occurrence’ as required for coverage under both policies and that there is no coverage under USF&G's policy for ‘personal injury.’ We agree with the Court of Appeals' decision and affirm on these issues as well.”).

7. “Insured” and related terms

Most policies describe their coverage with respect to particular “insured.” The policy usually has a “named insured,” as indicated on the declarations page. In addition, there may be other insureds, or “additional insureds.” First party policies may refer to other parties with distinct rights, such as “loss payees.” Sometimes the application of this terminology, and determining the identity of the “insured,” is critical to determining the insurer’s obligation.

When addressing issues of the identity of the “named insured,” our courts have predictably ruled in favor of finding coverage. For example, where there are two insureds, one of whom owns a vehicle, the court may conclude that the vehicle was “not owned by the Named Insured,” where it results in coverage.

Similarly, where a policy covered “family members” of Oak Farm, which generally referred to a farm but was technically a non-existent entity, the court held that a member of the family living on the farm was insured. Stockton v. North Carolina Farm Bureau Mut. Ins. Co., 139 N.C. App. 196, disc. review denied, 352 N.C. 683 (2000).

On the other hand, where there is no ambiguity in the identity of the named insured, that term will be construed literally. For example, where the policy insures family members of the named insured, who is a corporation, there are no persons meeting this definition of insured, because a corporation does not have family members.

Many policies insure other persons as “additional insureds” or “omnibus insureds.” This can potentially raise an ambiguity when a provision refers to “the insured,” when there are multiple insureds. In one case, the Court addressed the issue of whether a wife’s claim under a HO policy for fire damage to the house was barred because her husband, also an insured, burned the house intentionally. The Court adopted the “innocent spouse” rule and held that the wife’s claim was not barred, but that she could only recover one-half of the amount remaining after payment of the mortgage.

In another case, the insurer insured a municipality its employee, who assaulted the claimant. The policy covered only claims for damages not intended by the “insured.” The insurer argued that the municipality was not entitled to coverage because its employee, also an “insured,” intended the injury. The court ruled in favor of the municipality, stating:

The language of the policy clearly provides that the expectations or intent

are to be viewed from the standpoint of the insured, as opposed to that of the injured party. The City argues that because Akion was covered as an additional insured under the endorsement, the event should be viewed from his standpoint, and that because plaintiff contends Akion intentionally assaulted her, his actions were outside the coverage of the policy. We do not agree. The City is the named insured. It certainly did not expect or intend that its employees would assault a third party. As to the City, the acts of Akion were an "occurrence" under the terms of the insurance policy.

The use of the term "insured" in this context is ambiguous.

Edwards v. Akion, 52 N.C. App. 688, 692 (1981), aff'd, 304 N.C. 585 (1981). See also Newell v. Nationwide Mut. Ins. Co., 334 N.C. 391 1993 (rejecting argument that term "any person" does not include named insured).

An "additional insured" may have rights less than those of the named insured.

Conversely, in the context of first party coverage, some persons may have rights greater than the named insured. For example, a loss payee with a "mortgage" clause has benefits which are not negated by the insured's misrepresentations to the insurer in applying for the insurance.

An ordinary loss payee clause, however, has no rights greater than the insured.

There may also be different categories of insured, with different liabilities to the insurer. For example, where a person is an "insured" only because the insurer is required to cover that person by a statute aimed at the protection of third persons, the insurer may obtain reimbursement from that insured. The insurer could not otherwise, however, seek indemnity from its insured.

8. Limits

Many policies, such as a liability policy, homeowner's policy, or health insurance policy, have a maximum "limit" of insurance provided. Other policies, such as a life insurance policy, have a relatively fixed payment in the event of loss.

As a general rule, the insurer cannot be liable to the insured (or the claimant) for more than its policy limit. The limits are not applicable, however, to "extra-contractual" exposure, addressed in Section IV.

Some policies have a "per person," "per occurrence," or "aggregate" limit, and have different limits for different coverages. These are ideally clearly stated in the policy, but may sometimes be noted in industry terminology.

Policies may also have a "deductible," which may be denominated a "self insured

retention.”

In some cases the court must determine the number of occurrences, either for determining the amount to be paid per occurrence, or to determine the number of applicable deductibles. For example, where an employee embezzles funds by writing multiple checks, this may constitute only one “occurrence,” significantly limiting the amount recoverable by the insured. Where the insured is an automobile accident involving several impacts occurring in rapid succession, he is subject to only one deductible.

B. Exclusions

If there are one or more claims which meet the basic criteria for coverage (e.g. an “occurrence” resulting in “property damage” resulting in the damages which the insured is legally obligated to pay), then the insurer may nevertheless not have to pay the claim if there is an applicable exclusion.

Most policies have a series of exclusions for various conditions or causes of the loss. In general, the courts will uphold exclusions.

Exclusions are generally construed very narrowly, as opposed to coverage terms which are construed broadly. As stated by one court:

Those provisions in an insurance policy which extend coverage to the insured must be construed liberally so as to afford coverage whenever possible by reasonable construction. However, the converse is true when interpreting the exclusionary provisions of a policy; exclusionary provisions are not favored and, if ambiguous, will be construed against the insurer and in favor of the insured.

North Carolina Farm Bureau Mut. Ins. Co. v. Stox, 330 N.C. 697, 700 (1992).

In State Capital Ins. Co. v. Nationwide Mut. Ins. Co., 318 N.C. 534, 536 (1986), the injured party (tort victim) began to exit the truck, and insured’s hand came in contact with the rifle in the vehicle and it discharged, causing a bullet to strike the victim in the leg. The HO policy excluded injury “arising out of the ownership, maintenance, use, loading or unloading of” a vehicle owned by the insured. The automobile policy provided coverage only to liability arising out of the use of an automobile. The Court held that both policies provided coverage, stating:

[E]ven when language in two insurance policies is similar, the rules of construction applied to an exclusionary clause are substantially different from the rules of construction applied to a coverage clause. Exclusionary clauses are interpreted narrowly while coverage clauses are interpreted broadly to provide the greatest possible protection to the insured. Since the terms of the policy must be construed against the insurance company, the

same language in two different policies can have different meanings.

State Capital Ins. Co. v. Nationwide Mut. Ins. Co., 318 N.C. 534, 543 (1986) (under HO policy, claim did not arise out of use of automobile; under auto policy, claim arose from use of vehicle).

Numerous cases construe exclusionary provisions narrowly.

In order for an exclusion to bar coverage, it must be a proximate cause of the injuries. Further, an exclusion which negates coverage for damage “arising out of” a given event applies only if there is no other proximate cause of the damage. One case addressed a provision excluding injuries arising out of the use of an automobile, and held that “the ambiguous ‘arising out of’ language in a homeowner’s policy exclusion is one of proximate cause.” State Capital, 318 N.C. at 547, 350 S.E.2d at 74. The Court further held that the exclusionary language “should be interpreted as excluding accidents for which the sole proximate cause involves the use of an automobile. If there is any non-automobile proximate cause, then the automobile use exclusion does not apply.” In State Capital, the claimant was injured by a gun which accidentally discharged from a vehicle, and the court held that the exclusion did not apply.

Where several proximate causes of an injury all arise out of an excluded activity, the exclusion applies. A claim for negligent hiring arising from an automobile accident is excluded. Even though the focus of the claim is negligent hiring, the damage arises out of the use of an automobile.

1. Intentional Act Exclusion

Most policies have some sort of “intentional acts” exclusion. This exclusion is rooted in the idea that insurance is designed to cover “risks,” or contingencies, as opposed to liability directly within the control of the insured. This exclusion typically states that the policy does not cover “bodily injury or property damage . . . which is expected or intended by the insured.”

Examples of conduct triggering this exclusion are:

- Homeowner's intentional act of concealing a video camera in his bathroom and filming the claimant.
- Termination from employment.
- Firing multiple shots from a rifle at night in the direction of a prowler who is approximately fifty feet away.
- Sexual harassment against an employee.
- Assault done in self defense.

The claimant cannot create coverage by denominating intentional conduct as “negligence.”

Where the insured intends the injury, the exclusion applies. A more difficult situation is presented if a person other than the insured seeking coverage intended the injury. Even if the policy states that the exclusion is to be determined from the standpoint of the “insured,” there may be multiple insureds for a particular event. In such a case, the court should determine coverage based on the perspective of the person seeking coverage. Thus, an assailant is not covered for his assault, but his employer may be covered for the same assault.

In some policies, coverage is limited to an “accident resulting in bodily injury or property damage neither intended nor expected from the standpoint of the insured.” This coverage language embodies language similar to the “intentional acts exclusion.” For all practical purposes, this definition of “occurrence” has the same effect as the intentional acts exclusion with respect to precluding coverage for damages caused intentionally by the insured.

a. Personal Injury Coverage

Within the personal and advertising injury coverages, the intentional acts exclusions are sometimes held ambiguous and unenforceable.

Other policies have a similar exclusion for person injury “Caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict ‘personal and advertising injury.’” These are probably likewise not enforceable in a personal injury policy.

2. Care, Custody and Control

Many CGL policies have exclusions for “‘Property damage’ to Personal property in your care, custody or control.”

These provisions are narrowly construed. Two cases have held that this language is unenforceable, and that it applies only if the insured is in sole possession of the property. One of these cases further holds that the provision applies only if the insured is in sole possession of the property. There are, however, cases which uphold these provisions, and which do not require that the property be in the sole possession of the insured.

3. Real Property (ongoing operations)

The CGL policy typically excludes property damage to “That particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the ‘property damage’ arises out of

those operations.”

The critical issues for this exclusion are that it applies only to “real property” and that it applies only to damage which occurs during work (“operations”) of the insured or its subcontractor. The word “performing” connotes ongoing activity. Further, the exclusion is limited to “that particular part” of the real property where these operations are ongoing. North Carolina has no cases addressing these provisions.

Where the damage occurs contemporaneously with construction, the exclusion applies. Where the damage occurs after the work is complete, then the exclusion does not apply.

Cases from other jurisdictions have struggled with determining whether the damage to the real property occurred to “that particular part” of the property where the operations were occurring.

Many cases from other jurisdictions have used this exclusion to exclude claims for defective construction.

There is some law from another jurisdiction to the effect that where the work is done by a subcontractor hired by the owner, over which sub the insured has no control, the exclusion is inapplicable.

4. “business risk” exclusions

Some policies, including the CGL policy, have several exclusions which are often referred to as “business risk” exclusions. There are several ideas behind these related exclusions. Some are premised on the notion that some risks should remain with the insured, especially those that are inherent to the insured’s business or are due to factors within the insured’s control. Some are premised on the availability of other insurance better designed to cover the risk (e.g. an inland marine policy, or a builder’s risk policy).

In Western World Ins. Co. v. Carrington, 90 N.C. App. 520 (1988), the court faced an exclusion for “to property damage to work performed by or on behalf of the named insured arising out of the work or any portion thereof, or out of materials, parts or equipment furnished in connection therewith.” The insured had been sued for costs incurred in replacing an allegedly defective waterproofing system installed by the insured. Regarding this provision, the court said:

Exclusion (o) is one of several "work product" exclusions found in standardized liability insurance policies. Since the quality of the insured's work is a "business risk" which is solely within his own control, liability insurance generally does not provide coverage for claims arising out of the failure of the insured's product or work to meet the quality or specifications for which the insured may be liable as a matter of contract. The cases interpreting this kind of exclusion recognize, as we do, that liability insurance policies are not intended to be performance bonds.

Consequently, courts have uniformly held that the language of exclusion (o) excludes damages sought for the cost of repairing or replacing the insured's own work or product. Here, the record shows that the damages sought against Carrington are those costs incurred in replacing his allegedly defective waterproofing system with an effective waterproofing system. Therefore, the claim is excluded from the policy's coverage.

Defendants contend that exclusion (o) does not apply and cite several cases, All of the cases cited by defendants, however, are readily distinguishable since they involve claims for damages other than costs for repairing or replacing the insured's defective work or product. . . . The exclusion has also been held inapplicable where the damages sought are for diminution in value of the property or product of which the insured's work or product is merely a part.

In all of those cases, the damages claimed were for damage to property other than that of the insured, which was caused either by the defective work or product, or the need to repair or replace that work or product. In this case, from the record before us it is clear that Clancy & Theys is not seeking damages for diminution in the structure's value, or costs for repairing the creaking in the concrete, or costs for any damage to its own property caused by the allegedly defective waterproofing. Clancy & Theys' only claim is for costs incurred in substituting or replacing the protective functions which Carrington's original waterproofing work should have provided. The damages sought are solely for bringing the quality of the insured's work up to the standard bargained for. Consequently, the policy provides no coverage for the claim.

Western World, 90 N.C. App. at 523-525.

The courts tend to recognize that the CGL and other liability policies are not intended to cover merely defective work as that is a "business risk"; they do, however, tend to cover resulting damages.

Our Supreme Court faced an exclusion for "faulty work you performed" in a garage policy in Barbee v. Hartford Mut. Ins. Co., 330 N.C. 100 (1991), in which the insured was sued for damage to a car engine caused by insured's mechanic's error in dropping a spark plug in a cylinder. The court held that the claim was excluded by the exclusion.

The general thrust of cases from other jurisdictions is, in accordance with Western World, that *resulting* damage is covered, but the defects in the insured's work are not covered. The Barbee case is obviously to the contrary, but may be limited to an exclusion for "faulty work," which typically does not appear in a CGL policy.

At least one case, in a different context, has seemingly rejected the distinction between the insured's work and resulting damage.

The following sections address specific “business risk” exclusions which appear in many modern CGL policies.

a. Repairs due to incorrect work

Most CGL policies also exclude property damage to “That particular part of any property that must be restored, repaired or replaced because ‘your work’ was incorrectly performed on it.” Pursuant to the policy, this exclusion generally “does not apply to ‘property damage’ included in the ‘products-completed operations hazard.’”

Understanding this exclusion requires an analysis of several terms. The phrase “your work” is typically defined as “any goods or products, other than real property, manufactured, sold, handled, distributed or disposed of by (1) you; (2) others trading under your name; or (3) a person or organization whose business or assets you have acquired.” The term “products-completed operations hazard” (or “PCOH”) is typically defined as: “includes all ‘bodily injury’ and ‘property damage’ occurring away from premises you own or rent and arising out of ‘your product’ or ‘your work’ except (1) products that are still in your physical possession ; or (2) work that has not yet been completed or abandoned. . . .”

Thus, the thrust of this exclusion is that where the insured’s incorrect work, during operations, causes damage to the property on which the insured worked, the damage is excluded. If the damage occurs after the operations are completed, then this exclusion does not apply, but other exclusions may apply.

A similar exclusion was addressed in Western World Ins. Co. v. Carrington, 90 N.C. App. 520 (1988), for “property damage to work performed by or on behalf of the named insured arising out of the work or any portion thereof, or out of materials, parts or equipment furnished in connection therewith.” The Western World court held that pursuant to this provision, a claim to repair defective construction by the insured is excluded.

Where the language of the exclusion expressly excludes repairs due to faulty workmanship “by or on behalf of” the insured, the exclusion applies to work done by a sub-contractor. Where the policy does not have this language, then it is not clear in North Carolina whether the work of a subcontractor is “your work,” and thus whether this exclusion applies. A federal case holds that the “insured’s product” includes the product of a subcontractor, and hence this lends support to the argument that the work of a contractor-insured is “your work.”

If this exclusion is inapplicable because the damages are included in the PCOH, then this provision does not create coverage. If the damages are included in the PCOH, then it simply means that this exclusion is inapplicable; the court must look for the other coverage terms, and look at the other exclusions.

Cases from other jurisdictions have held that this exclusion does not apply where

the insured's building causes damage to other portions of the building after completion.

b. Damage to Insured's Product

Many CGL policies have exclusions for "'Property damage' to 'your product' arising out of it or any part of it."

North Carolina does not have any cases applying this exclusion. The exclusion from Western World was similar, but pertained to "work" and not a "product." Nevertheless, Western World Ins. Co. v. Carrington, 90 N.C. App. 520 (1988) should generally indicate that damages arising solely from damages to the insured's product are excluded.

For the purpose of this exclusion, a federal court has held that a building is a "product."

For this exclusion, the product of a sub-contractor is deemed to be the work of the contractor. Other jurisdictions have held that the entire building is the insured's product, even if he used subcontractors. Thus, damage to one part of the structure caused by a defect in another part of the structure is not covered, even if the work is done by subcontractors.

Other jurisdictions have generally construed this exclusion to exclude a claim for the cost of repairing the defective work itself. The exclusion does not, however, apply to claims for resulting damage.

c. Damage to Insured's Work

The CLG policy typically has an exclusion for "'Property damage' to 'your work' arising out of it or any part of it and included in the 'Products-Completed Operations hazard.' This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor."

This exclusion is similar to the exclusion addressed in Western World Ins. Co. v. Carrington, 90 N.C. App. 520 (1988), for "property damage to work performed by or on behalf of the named insured arising out of the work or any portion thereof, or out of materials, parts or equipment furnished in connection therewith." The Western World court held that pursuant to this provision, a claim to repair defective construction by the insured is excluded. The Western World exclusion, however, did not have the exception for the work of a subcontractor.

The thrust of this exclusion is thus that damage to the insured's work (and not a sub-contractor's work) arising out of the insured's work (and not a sub-contractor's work), occurring after operations are completed, is excluded. Thus, for example, if the insured is a roofer who fails to properly flash the roof, and the roof leaks after construction resulting in water damage to the roof (e.g. sheathing), then the damage to

the roof is excluded.

This exclusion excludes claims are based solely on repairing faulty workmanship. Where the insured erects a building with a defective roof (resulting in leaks) and with a stucco wall that cracks, the claims against the builder for repairing the roof and cracks is excluded by this provision.

This exclusion has been held to not apply if the true cause of the property damage is in doubt (i.e. if another sub-contractor's errors may have caused the damage). As discussed in other sections, the precedential value of this case is not clear.

Cases from other jurisdictions are in conflict as to whether this exclusion essentially creates coverage for damage caused by the defective work of a sub-contractor.

Many cases hold that exclusion l. does not create coverage, where it does not otherwise exist. Some cases, however, seem to construe exclusion l as creating coverage for a sub-contractor's defective work, as long as there is an occurrence and "property damage." Several cases have followed these cases, seemingly allowing broad coverage for a sub-contractor's defective work.

Cases from other jurisdictions generally hold that this exclusion applies to claims against the contractor for defective construction, at least for the cost of repairing the defective work.

d. Impaired property

Many CGL policies have an exclusion for "impaired property," excluding:

"Property damage" to "impaired property" or property that has not been physically injured, arising out of:

- (1) A defect, deficiency, inadequacy or dangerous condition in "your product" or "your work", or
- (2) A delay or failure by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms.
(Exclusion m).

The term "impaired property" is defined as follows:

"Impaired property" means tangible property, other than "your product" or "your work", that cannot be used or is less useful because:

- a. It incorporates "your product" or "your work" that is known or thought to be defective, deficient, inadequate or dangerous; or

b. You have failed to fulfill the terms of a contract or agreement;

if such property can be restored to use by:

a. The repair, replacement, adjustment or removal of "your product" or "your work"; or

b. Your fulfilling the terms of the contract or agreement.

This exclusion may have an exception for “the loss of use of other property arising out of sudden and accidental physical injury to ‘your product’ or ‘your work’ after it has been put to its intended use.”

This exclusion does not apply where the mere repairing, replacing of the insured’s work will not restore the owner’s “impaired property.”

There are only a few cases addressing this provision.

5. employee exclusion

Many liability policies exclude claims for bodily injury to an employee. In general, these provisions are enforced.

Often tort claims by employees will be barred by workers compensation law, and the claim for injuries to an employee will be covered by a workers compensation policy.

6. Contractual Liability

There are different types of “contractual” liability which may arise against the insured that raise coverage issues under a CGL policy.

a. Claim for Insured’s Breach of Contract

The first set of contract-based claims that raise coverage issues are claims against the insured for breach of contract. Many persons in the insurance industry often draw a dichotomy between “negligence” claims and “contract” claims, asserting that negligence claims are covered and contract claims are not. Most policies, however, do not draw this distinction.

A claim for breach of contract, and claims arising from breach of contract, can be covered. Stanback v. Westchester Fire Ins. Co., 68 N.C. App. 107 (1984) (insurer was required to defend action against insured by spouse alleging that insured breached their separation agreement).

It should be noted, however, that many such contract actions will not contain the

essential coverage requirements. For example, there may be no “property damage,” or no “occurrence.”

The second inquiry (assuming that the claim meets the basic coverage requirements) is whether the contract claim is excluded. There are several exclusions which are implicated in these claims. These are often referred to as the “business risk” exclusions. In most instances, a claim for breach of contract will not be covered for one of these other reasons.

Some policies, especially the “personal injury” coverage, may have a specific exclusion for contractual liability, such as an exclusion for liability “Arising out of a breach of contract, except an implied contract to use another's advertising idea in your ‘advertisement’.”

b. Liability Assumed in a Contract

The policy specifically excludes coverage for “liability assumed in a contract.” This generally refers to an assumption of liability by the insured. The provision may state that it excludes “‘Bodily injury’ or ‘property damage’ for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages . . . assumed in a contract or agreement that is an ‘insured contract’.” “Insured contract” may be defined as “that part of any other contract . . . under which you assume the tort liability of another party to pay for ‘bodily injury’ . . . to a third person or organization.”

Where the insured is legally required to make a payment, such an exclusion will not preclude recovery by the insured for payments so made.

The provision generally does not exclude the insured’s liability arising from failure to properly perform under a contract. In Bruce-Terminix, the insured was sued for damages arising from his failure to properly detect or remove termites from the claimant’s house, resulting in damage. The Court of Appeals explained that the insured’s liability was not excluded simply because it arose from a contract, stating:

With regard to the claim for breach of contract/warranty, Zurich cites a policy clause which excludes liability coverage for property damage “which the insured is obligated to pay . . . by reason of the assumption of liability in a contract or agreement.” This exclusion is followed by a limitation which states that the exclusion does not apply to liability “the insured would have in the absence of the contract or agreement.” . . . In addition, if the exclusion is interpreted to apply to any liability resulting from contracts between Terminix and its clients, it is contrary to the primary objective of a commercial general liability policy.

Bruce-Terminix Co. v. Zurich Ins. Co., 130 N.C. App. 729, 736 (1998) (emphasis added).

This law, however, was complicated in Pa. Nat'l Mut. Cas. Ins. Co. v. Associated Scaffolders & Equip. Co., 157 N.C. App. 555 (2003). In that case, the insured-engineering company entered an agreement with an equipment-lessor and agreed to maintain the scaffolding in accordance with regulations and agreed to indemnify the lessor. A claimant injured by the scaffolding sued the lessor, and the lessor sued the insured under an indemnity clause and for breach of contract in failing to maintain the scaffolding pursuant to contract. The policy excluded claims for bodily injury by reason of assumption of liability in a contract. The court held that there was no coverage or duty to defend either claim.

Regarding the contractual indemnification claim, the court it held that there was no coverage for the claim based on the insured's indemnity agreement because the agreement violated G.S. § 22B-1 (generally invalidating indemnity provisions in construction contracts).

Regarding the claim based on the insured's failure to comply the regulations, as required by the contract, the court held that the exception for an "insured contract" (defined as "that part of any other contract . . . under which you assume the tort liability ['Tort liability means a liability that would be imposed by law in the absence of any contract or agreement'] of another party to pay for 'bodily injury' . . . to a third person or organization") did not apply. "The policy clearly states that the exception which grants coverage applies to tort claims only which 'would be imposed by law in the absence of any contract or agreement.' This claim lies outside the policy coverage." Associated Scaffolders, 579 S.E.2d at 407.

The applicability of the exclusion for "liability assumed in a contract" is therefore uncertain in view of these cases.

7. Pollution Exclusion

Many policies contain a "pollution exclusion." These provisions are generally designed to prevent coverage for liability arising from the release of a contaminant. For example, one case held that where fumes escaped from a gas station, causing losses and emotional distress to a nearby restaurant, the exclusion applied.

Some policies have an exclusion for pollution, with an exception for "sudden and accidental" pollution. These policies are enforced as written, and provide coverage only where the pollution is sudden and accidental. Where the pollution was gradual, the exclusion applies. In most of these cases, the court seems readily willing to infer that the contamination was gradual, where there is no evidence of a sudden and accidental spill, even if the complete facts regarding the contamination are not clear.

North Carolina has adopted a rule, in West American Ins. Co. v. Tufco Flooring East, Inc., 104 N.C. App. 312, 409 S.E.2d 692 (1991), that the exclusion applies only to "environmental" discharges of pollutants, even where the policy does not have this requirement. In Tufco, the court held that the exclusion did not apply where the insured

released a chemical in a building, because the release was not into the “environment,” even though the exclusion does not require an “environmental” release. This reasoning has been criticized by other courts. The reasoning of Tufco may or may not apply to other types of pollution exclusions. Tufco should be regarded as fairly weak authority for this proposition, for several reasons. Nevertheless, the pollution exclusion may be limited to an “environmental” release in North Carolina. Thus, the release of a contaminant within a building may not be excluded.

Some policies have a “total pollution exclusion,” which does negate the exclusion for a sudden and accidental release. These are generally enforced, and typically exclude coverage for the release of a contaminant.

9. business pursuits

Many policies, such as a HO policy, exclude liability arising from the insured’s “business pursuits.” The applicability of the business pursuits exclusion is somewhat unclear. Our Supreme Court has held that such an exclusion in a HO policy is ambiguous. In North Carolina Farm Bureau Mut. Ins. Co. v. Stox, 330 N.C. 697, 700 (1992), the policy excluded “bodily injury or property damage . . . arising out of business pursuits of an insured,” and further stated, “This exclusion does not apply to . . . activities which are usual to non-business pursuits.” The Court held that the “‘business pursuits’ exclusion and the exception to that exclusion are ambiguous.” The Court held that as long as the activity at issue is “usual to non-business pursuits,” then the provision is not implicated. The Stox Court held that an insured who pushed a co-worker at work did not lose coverage because his act was “usual to non-business pursuits.”

Where the exclusion simply excludes “business pursuits,” without the additional language in Stox, the provision is valid. Further, any liability arising from one’s employment is arguably excluded. Nationwide Mut. Fire Ins. Co. v. Grady, 130 N.C. App. 292, 297 (1998) (where insured allegedly committed an “intentional assault and battery” when claimant and struck him while walking down a hallway where they worked, and policy excluded bodily injury “arising out of business pursuits of an insured,” and “Business” was defined to include “trade, profession, or occupation,” claim was excluded).

C. “Other Insurance” clauses

Most policies have a provision indicating the effect of other insurance covering the loss. These provisions are generally enforced as written. “The liability of each company must be determined by the terms of its own policy, subject to such modification as may be imposed by statute or by authorized administrative regulation or order.’ To determine who is the primary carrier and who is the excess carrier, if any, we must examine the ‘Other Insurance’ clauses in the competing policies.” Isenhour v. Universal Underwriters Ins. Co., 341 N.C. 597, 608 (1995) (citation omitted).

If one policy purports to be “primary” and another policy “excess,” then the

“excess” policy is required to indemnify only after the primary policy is exhausted. (As discussed in section III.F., it is less clear whether such an excess insurer may have other duties, such as duty to defend.)

More complicated situations are presented when the policies have competing “other insurance” provisions. Some policies have an excess insurance clause, purporting to render its coverage “excess” over other policies. A provision which states that it has no duty to make payments if the insured is covered by another policy is an “escape or no-liability clause.” A provision which purports to state that the insurer has no duty if there is other insurance, primary or excess, is a “super escape” provision. The interplay of these provisions has been described as follows:

When a standard escape clause in one policy competes with an excess clause in another policy, the policy with the standard escape clause is considered primary, and the policy with the excess clause is considered secondary, or excess. However, when a super escape clause in one policy competes with an excess clause in another policy, the super escape clause is given effect and the insurer whose policy contains the super escape clause is absolved from liability. When two policies both contain identical excess clauses, or excess clauses which are worded in such a way that it is impossible to distinguish between them or to determine which policy is primary, "the clauses are deemed mutually repugnant and neither excess clause will be given effect."

Aetna Casualty & Sur. Co. v. Continental Ins. Co., 110 N.C. App. 278, 282 (1993).

Where two policies purport to be “excess,” even if the language is not identical, the provisions are repugnant, and the policies share coverage.

Some cases state that, “Where . . . the excess insurance clauses are identical in language, we do not see how we can hold the coverage of either company is primary or excess.” Alliance Mut. Ins. Co. v. New York Cent. Mut. Fire Ins. Co., 70 N.C. App. 140, 142 (1984). A proper analysis, however, requires the court to also examine whether the policy language is repugnant when applied to the facts at issue.

Some policies state that the obtaining of additional insurance on the same property voids coverage under the policy. In such a situation, the original policies are void, and only the last policy provides coverage.

1. Umbrella and True Excess Policies

Some policies provide a special type of excess coverage what is “pure excess” or “umbrella” coverage. North Carolina does not have a lot of authority addressing this type of policy. Cases from other jurisdictions have generally understood these policies as follows:

In resolving conflicting “other insurance” clauses it is important to distinguish between policies that are true excess policies and those that are actually primary policies with “excess” other insurance clauses. A true excess policy is one that provides that the insurer is liable only for the excess above and beyond that which may be collected from the primary insurer. It is customary in such policies to include a requirement for underlying primary insurance for a certain amount and to list such other primary insurance within the excess policy. On the other hand an "excess" other insurance clause within a primary policy is considered a self-serving provision that attempts to make the insurer only secondarily liable if another unexhausted policy is available to cover claims.

Penton v. Hotho, 601 So. 2d 762, 765 (La. App. 1992).

Thus, an “umbrella” or “pure excess” policy is distinct from a policy which is merely “excess” based on the “other insurance” language. Umbrella policies are generally excess over all other policies which apply to the loss. For example, in Harleysville Mut. Ins. Co. v. Zurich-American Ins. Co., 157 N.C. App. 317, 324 (2003), St. Paul issued an umbrella policy which stated, “If there is any other insurance for injury or damage covered by this agreement, we won't make any payments until the other insurance has been used up with the payment of damages.” Harleysville had a \$1,000,000 garage policy and a \$1,000,000 excess policy. The court rejected an argument by Harleysville that its excess policy and the St. Paul umbrella policy shared liability in excess of the \$1,000,000 garage policy on a pro rata basis. The court did not even address the “other insurance” language in the Harleysville excess policy.

The result reached in Harleysville v. Zurich-American is in accord with the majority of jurisdictions to address this issue. There are only a small number of cases which hold that the umbrella policy shares coverage with an excess insurer, or that the umbrella policy is primary.

Other jurisdictions have extended the status afforded to the “umbrella” policy to a “pure” or “true” excess policy.

There is, however, a case in North Carolina which reached the opposite result. In Gaston County Dyeing Machine Co. v. Northfield Ins. Co., 351 N.C. 293, 296 (2000), United Capital Insurance Company (United) issued a CGL policy to Rosenmund (a vendor of a pressure vessel use in Dyeing) providing limits of two million dollars. Rosenmund was also an additional insured on a primary policy issued to Gaston (manufacturer of vessel) by Liberty, and an additional insured under Gaston’s excess policies (with Northfield and International). The insurers funded a settlement and then litigated which carriers were liable.

The Court first held that the Liberty (the primary CGL policy insuring Rosenmund as an additional insured) was not a “co-primary insurer” with United because the United policy purported to be “excess over any of the other insurance, whether

primary, excess, contingent or on any other basis” (and none of the enumerated exceptions applied). Regarding the Gaston excess policies, the Court then stated:

International also contends that United provided primary coverage to Rosenmund and asserts that because its policy is a "pure" excess policy, it can never be made primary to United's "primary" policy. International is correct that its 1 July 1991 to 1 July 1992 occurrence policy is an "excess" insurance policy. Its insuring agreement provides that International will "indemnify the insured for that amount of loss which exceeds the amount of loss payable by underlying policies described in the Declarations." Clearly, the International policy was intended to cover losses only in excess of those covered by underlying insurance. However, the United policy is not listed in the International policy's declarations as an "underlying policy," and therefore, International did not issue its excess policy contingent upon the existence of the United policy. We disagree with International's assertion that its policy is in some way inherently excess to the United policy.

Further, for the same reasons articulated earlier, the International 1991-92 policy is "other insurance" by the terms of the United policy. The International policy is an occurrence-based policy, effective before 4 October 1991, and it continues after 4 December 1986. The United policy specifically provides that it is excess over any other insurance "whether primary, excess, contingent or on any other basis."

The International policy also contains an "other insurance" clause, which provides as follows:

K. Other Insurance. If other valid and collectible insurance is available to the insured which covers a loss also covered by this policy, other than insurance that is specifically purchased as being in excess of this policy, this policy shall operate in excess of, and not contribute with, such other insurance.

However, in this case, because the United policy is excess, it is not "available" within the meaning of the International policy's "other insurance" clause.

Gaston County Dyeing Machine Co. v. Northfield Ins. Co., 351 N.C. 293, 308-309 (2000).

Thus, the North Carolina Supreme Court held that a true excess policy provided primary coverage for an additional insured, over an ordinary policy issued to the additional insured. The court held that the policy issued directly to the AI did not constitute "available" insurance where that other policy purported to be excess.

D. Standing/Privity issues

As a general matter, the claimant who has a tort (or other) claim against the insured, but is not a party to the insurance contract, has no direct claims against the insurer. The claimant acquires rights under the policy only upon obtaining a judgment.

When an injured person is not a party to an insurance liability indemnity contract, and the contract contains no agreement that the insurance shall inure to the benefit of the person injured, the insurance is a matter wholly between the insurer and the insured, and the injured person has no legal or equitable interest. No claim against an insurer can be made by the injured "unless and until 'execution against the [insured] is returned unsatisfied' in an action brought against him. This, in terms, is made a condition precedent to the right of the injured party to maintain an action against the indemnity company."

Selective Ins. Co. v. Mid-Carolina Insulation Co., 126 N.C. App. 217, 220 (1997) (in declaratory judgment action by insurer against insured and tort-victim, tort-victim had no standing to appeal ruling where insured did not appeal).

As a general rule, the claimant cannot assert claims against the tort-feasor's liability insurer, and there are no duties owed to the claimant. Once the claimant obtains a judgment against the insurer, however, he has rights against the insurer. Some authority even goes so far as to state that a claimant with a judgment against the insured is in "privity" with the insurer.

This rule may not apply where the judgment against the insured is a consent judgment.

Even when the claimant obtains a judgment, it should have no greater rights than the insured. The tort-victim would generally be limited to the insured's rights under the policy.

It would require a strained construction of the language of the policy and of the statute to hold that the plaintiff in this action who is not a party to the contract between defendant and the U-Drive-It Company acquired rights, either under the policy or under the statute, which are superior to those of the assured and that the defendant is liable to him although it is not liable to the party with whom the contract was made. One who seeks to take advantage of a contract made for his benefit--if indeed the contract of insurance can be so construed--must take it subject to all its terms and conditions.

Sears v. Maryland Casualty Co., 220 N.C. 9, 13 (1941) (where policy required indemnification only for liability of insured-owner of leased vehicle, and insured-owner prevailed at trial, insurer was not liable for judgment against driver). But see Hales v.

North Carolina Ins. Guar. Ass'n, 337 N.C. 329 (1994) (even though insured had lost in coverage action against insurer for liability coverage, tort-victim who was not a party to that action can pursue claim for coverage; claim is not barred by *res judicata*).

E. Other defenses

There are several “defenses” which the insurer may raise to defeat a duty to pay, other than these enumerated coverage provisions and exclusions.

1. Misrepresentation on policy application.

Where the insured makes a material misrepresentation in applying for his policy, he loses coverage. Where the misinformation affects the premium, the misrepresentation is material. Information provided by the agent may also bar the insured’s claim.

2. Violating policy provision.

Where the insured violates a provision requiring his cooperation, he may lose coverage. “The acceptance by the insured of a policy which includes conditions imposes upon him the duty of complying therewith, and failure so to do releases the insurer from liability in the absence of a contrary contract provision, or a waiver or estoppel.” Star Varifoam Corp. v. Buffalo Reinsurance Co., 64 N.C. App. 306, 308 (1983) (where insured violated provision in fire policy requiring insured to maintain sprinkler system, insured lost coverage; summary judgment affirmed).

The insured has several specific duties under the policy, and usually has a duty to cooperate with the insurer.

By express policy language, the insured is required to cooperate, attend hearings and trials and give evidence. He has a duty equal to that of the insurer to act diligently and in good faith. Hence when an insured fails, without justification, to attend the trial of his case in accordance with his promise, the insurer has the right to assert noncompliance with the cooperation provision of the policy.

Connor v. State Farm Mut. Auto. Ins. Co., 265 N.C. 188, 191 (1965) (insured had burden to show reasonable justification for his absence, and there were issues of whether insurer acted reasonably in proceeding with trial absence of insured).

The insured may, however, lose coverage as a matter of law for not cooperating with the insurer. The insured also must comply with any requirements in the policy regarding submitting claims. There are numerous other potential policy defenses arising from the insured’s breach of a policy condition or provision.

The cases are not clear as to whether the existence of prejudice from the insured’s breach affects coverage. For example, one case held that the insured lost coverage by

failing to appear for a medical exam (which was required by the policy), but does not discuss any prejudice flowing from this breach. Most cases require prejudice in order to void coverage. The cases in the next section (regarding late notice) clearly require proof of prejudice.

3. Late notice.

Most policies require the insured to notify the insurer of a loss. The failure to timely notify the insurer of the claim can void coverage where the insurer is prejudiced, or where the delay is in bad faith. Our courts have established that:

When faced with a claim that notice was not timely given, the trier of fact must first decide whether the notice was given as soon as practicable. If not, the trier of fact must decide whether the insured has shown that he acted in good faith, e.g., that he had no actual knowledge that a claim might be filed against him. If the good faith test is met the burden then shifts to the insurer to show that its ability to investigate and defend was materially prejudiced by the delay.

Liberty Mut. Ins. Co. v. Pennington, 356 N.C. 571, 580 (2002).

An insurer without notice will generally not be liable for a default judgment (absent a contrary statutory provision).

4. Non-payment of premium / Cancellation

Most policies will state that there is no coverage if the insured does not pay its premium. Such provisions will generally be enforced, but the insurer must follow any applicable cancellation procedures.

III. DUTY TO DEFEND

Most liability policies provide that the insurer will defend the insured in a claim seeking covered damages. The duty to defend arises under “third party” claims. I.e. where a third-person (other than the insurer and the insured) seeks damages from the insured, and the insurer agrees not only to pay for the covered loss, but to defend the claim. The most common policies involving a duty to defend are CGL policies, automobile liability policies, and homeowner’s policies.

As with other policy provisions, the provisions regarding the duty to defend will be construed in favor of the insured. An attempt to limit or terminate the duty to defend will be construed narrowly, and ambiguities will be construed against the insurer.

A typical policy will state, “If a claim is made or a suit is brought against an insured for damages because of bodily injury or property damage caused by an

occurrence to which this coverage applies, we will . . . provide a defense at our expense by counsel of our choice, even if the suit is groundless, false or fraudulent.” See North Carolina Farm Bureau Mut. Ins. Co. v. Stox, 330 N.C. 697, 700 (1992).

Where the insurer retains counsel for the insured, and the policy allows the insurer to control the defense, then the defense counsel will generally follow the directives of the insurer. RPC 91 (“Where the insured has contractually surrendered control of the defense and authority to settle the claim to the insurer, counsel will generally be obliged to accept his or her instructions in these matters from the insurer.”). “In order to fully protect the insured from exposure in excess of the policy limits, especially with regard to settlement, defense counsel obtained by the insurer should also advise the insured that he or she cannot fully represent those interests and that it would be appropriate for the insured to consider employing independent counsel to provide such representation.” Id.

A. Basic Test

The leading case on the duty to defend is Waste Management of Carolinas, Inc. v. Peerless Ins. Co., 315 N.C. 688, 692 (1986). In that case, the North Carolina Supreme Court described the “comparison test,” and provided significant guidance for these issues, stating:

Generally speaking, the insurer's duty to defend the insured is broader than its obligation to pay damages incurred by events covered by a particular policy. An insurer's duty to defend is ordinarily measured by the facts as alleged in the pleadings; its duty to pay is measured by the facts ultimately determined at trial. When the pleadings state facts demonstrating that the alleged injury is covered by the policy, then the insurer has a duty to defend, whether or not the insured is ultimately liable. Conversely, when the pleadings allege facts indicating that the event in question is not covered, and the insurer has no knowledge that the facts are otherwise, then it is not bound to defend.

Where the insurer knows or could reasonably ascertain facts that, if proven, would be covered by its policy, the duty to defend is not dismissed because the facts alleged in a third-party complaint appear to be outside coverage, or within a policy exception to coverage. In this event, the insurer's refusal to defend is at his own peril: if the evidence subsequently presented at trial reveals that the events are covered, the insurer will be responsible for the cost of the defense. "This is not to free the carrier from its covenant to defend, but rather to translate its obligation into one to reimburse the insured if it is later adjudged that the claim was one within the policy covenant to pay." In addition, many jurisdictions have recognized that the modern acceptance of notice pleading and of the plasticity of pleadings in general imposes upon the insurer a duty to investigate and evaluate facts expressed or implied in the third-party

complaint as well as facts learned from the insured and from other sources. Even though the insurer is bound by the policy to defend "groundless, false or fraudulent" lawsuits filed against the insured, if the facts are not even arguably covered by the policy, then the insurer has no duty to defend.

...

In order to determine whether such circumstances are covered by the provisions of TRS's liability insurance with Penn and Peerless, the policy provisions must be analyzed, then compared with the events as alleged. This is widely known as the "comparison test": the pleadings are read side-by-side with the policy to determine whether the events as alleged are covered or excluded. Any doubt as to coverage is to be resolved in favor of the insured.

Waste Management of Carolinas, Inc. v. Peerless Ins. Co., 315 N.C. 688, 692 (1986).

Several points are worth noting regarding the duty to defend.

The duty is invoked if there is even the "possibility" of coverage, based on the allegations of the complaint.

The duty is generally based on the allegations of the complaint. If the complaint suggests coverage, then the insurer must defend..

In Waste Management, the Court faced a pollution exclusion, and the issue was whether the pollution was "sudden and accidental." The Court recited some of the allegations of the complaint ("intentional disposal by TRS of solid wastes during the six-year period of the landfill's operation which contributed to the contamination of groundwater beneath the landfill."; the "contributions and negligent acts and omissions" by TRS and other named trash haulers constituted the "sole and proximate cause of any contamination of the aquifer and water supply in the Flemington area") and held that "The complaints do not allege that the dumping or the contamination occurred either suddenly or accidentally; indeed, the facts alleged suggest a gradual seepage of contaminants into the aquifer." The Court thus held that the insurer was entitled to summary judgment and had no duty to defend.

Where the complaint does not indicate when the injuries occurred, all insurers with possible coverage, based on the allegations of the complaint, have a duty to defend; this duty exists regardless of the actual date of the loss. Ames v. Continental Cas. Co., 79 N.C. App. 530, 538, disc. review denied, 316 N.C. 730 (1986). But see Am. Mfrs. Mut. Ins. Co. v. Morgan, 147 N.C. App. 438, 445 (2001) (affirming no duty to defend where trial court "found that the complaint provided no basis to determine when the alleged injuries occurred").

The duty to defend is generally not affected by the validity of the claims.

An exception to this may exist where the insured's potential liability is contrary to public policy. One case held that where the insured's liability, which otherwise may have been covered, arose out of a contract requiring the insured to indemnify another party, which was later held to violate public policy codified in G.S. § 22B-1, that the insurer did not have a duty to defend. It is not clear how far this doctrine can be applied.

“[A]llegations of facts that describe a hybrid of covered and excluded events or pleadings that disclose a mere possibility that the insured is liable (and that the potential liability is covered) suffice to impose a duty to defend upon the insurer.” Waste Management, 315 N.C. at 691 n.2.

The insured must establish only one potentially covered claim to invoke the duty to defend. Further, if any of the claims are possibly covered, then the insurer has a duty to defend the entire suit.

Many of the cases determine the duty to defend without a clear analysis of the allegations of the complaint. Some cases even make assumptions, or inferences, beyond the complaint in denying a duty to defend.

The insured, however, may go beyond the pleadings to establish a duty to defend.

Further, the insurer is required to defend if an investigation would have shown the facts indicating coverage.

Although the insurer may have a duty to defend based on facts outside the complaint, North Carolina has not clearly addressed whether there are any circumstances in which the insurer may rely on facts outside the pleadings to defeat a duty to defend. Other jurisdictions are somewhat mixed on this point.

The duty to defend extends to a “suit.” The term “suit” has been construed broadly, to include an administrative proceeding.

1. Significance of Conflict

As a general matter, the presence of a conflict of interest between the insurer and the insured does not negate the insurer's duty to provide a defense. (Whether such a conflict affects the insurer's right to select defense counsel is discussed in section III.D.)

In National Mortg. Corp. v. American Title Ins. Co., 41 N.C. App. 613, 623 (1979), discussed in a subsequent section, the Court of Appeals held that where there is a conflict of interest between the insurer and the insured, and the insurer reserves rights to deny coverage, the insured may reject the insurer's defense counsel, and may obtain reimbursement for its own counsel. Thus, regardless of which party selects defense counsel, the duty to defend is not negated by a conflict.

An older federal case applying North Carolina came to the opposite conclusion. This holding, however, does not appear to represent current North Carolina law.

2. Policy Defenses Affecting Duty to Defend

Some issues and facts outside the pleadings can be considered in determining the duty to defend, especially where they pertain to a defense to coverage.

For example, where the insured does not provide timely notice of the incident, there may be no duty to defend. Also, the existence of other insurance may negate a duty to defend. And the insured's failure to forward suit papers may negate the duty to defend.

B. Defending under Reservation of Rights

An insurer which defends but does not deny coverage, or reserve rights, may be held to have waived, or be estopped from asserting, various policy defenses.

When an insurer defends a claim for which coverage is questionable, our courts have stated:

The opposite rule as we gather it from the decisions of various jurisdictions is that an objection that the liability is not one within the terms of the policy may be waived, and where the insurer undertakes the defense of the action by the injured person against the insured, with full information as to the character of the injury, it will be deemed to have waived such objection. The effect of this rule would seem to be that by having elected to defend the action of the plaintiff against its insured the insurer deprived its insured of his right to control his own lawsuit, and thereby assured the insured that the insurer would recognize the liability as falling within the terms of the policy.

Early v. Farm Bureau Mut. Auto. Ins. Co., 224 N.C. 172, 174 (1944).

North Carolina cases have not addressed whether the insured must show prejudice to invoke the waiver doctrine, or whether there is a presumption of prejudice. These issues have been addressed extensively in other jurisdictions.

Where the insurer issues a reservation of rights letter, it may later contest coverage.

North Carolina does not have any cases the specificity which is required of the notice. The notice must, however, be sufficient to apprise the insured of the risks of non-covered claims. North Carolina does not have any cases on a belated reservation of rights. The majority of cases from other jurisdictions have held that an insurer may

reserve rights several months after retaining counsel for the insured, if the delay was not unreasonable and the insured was not prejudiced.

Where the insurer obtains the insured's written acknowledgement that the insurer is not waiving its rights, it preserves its defenses.

An unjustified reservation of rights letter may lead to a Chapter 75 claim for unfair and deceptive trade practices.

Finally, although North Carolina does not have any cases on the issue, the insurer can generally reserve rights at a later time as long as the delay does not prejudice the insured.

C. Wrongful Refusal to Defend

Where an insurer wrongfully refuses to defend, it will be liable for the resulting losses. For example, as shown below, it is liable for the insured's defense costs.

In addition, the failure to defend may constitute or may be evidence of bad faith or of an unfair trade practice, as addressed in Section V.

Further, the insurer is deemed to have waived some coverage issues if it wrongfully refuses to defend.

1. waiver of consent-to-settle clause

Where the insurer wrongfully refuses to defend, and the insured enters a settlement, the insurer is liable for the settlement (if the claim is covered), and cannot assert a policy provision prohibiting the insured from settling a claim without the insurer's consent.

The first and most obvious of the positive obligations created by an insurer's unjustified refusal to defend is its obligation to pay the amount of the judgment rendered against the insured or of any reasonable compromise or settlement made in good faith by the insured of the action brought against him by the injured party.

Nixon v. Liberty Mut. Ins. Co., 255 N.C. 106, 111 (1961).

By denying liability or refusing to settle claims against insured, which are covered by the automobile indemnity policy, the insurance company commits a breach of the policy contract and thereby waives the provisions defining the duties and obligations of the insured. Thereafter, the insured may properly assume responsibility for the conduct of his own defense of the case, and may either continue the litigation and go to trial with the case, or, if his judgment so dictates, he may make a reasonable settlement

of the claim. Under such circumstances, he may recover from the company the amount which is reasonably required to effect the settlement as damages ordinarily and naturally resulting from the insurer's failure to defend the action, even though the contract provided for recovery only when the payment is in satisfaction of a judgment.

...

If, under such circumstances its insured entered into a reasonable consent judgment in good faith, then there is a positive obligation on defendant, created by its unjustified refusal to defend the suit instituted by plaintiff against its insured to recover damages for bodily injuries, to pay the amount and costs of such reasonable consent judgment entered into in good faith by its insured in the action brought against him by plaintiff, and, therefore, the only questions still litigable, according to the pleadings before us, are: One, whether the policy was in force at the time of plaintiff's injuries. And two, if the policy was in force, whether the consent judgment entered into was reasonable and made in good faith, and if not, the amount of plaintiff's damages

Nixon v. Liberty Mut. Ins. Co., 255 N.C. 106, 111-112 (1961).

2. waiver of other coverage issues

Under North Carolina law, an insurer which refuses to defend is deemed to be estopped from contesting coverage for the insured's settlement. This doctrine originated in Ames, which held that an insurer which wrongfully refuses to defend the insured "is estopped from denying coverage and is obligated to pay the amount of any reasonable settlement made in good faith by the insured." Ames v. Continental Cas. Co., 79 N.C. App. 530, 538, disc. review denied, 316 N.C. 730 (1986). In Ames, one insurer contended that the acts or omissions did not occur during its policy period. The court held that since there was a possibility of coverage (based on the complaint), there was a duty to defend. It further held that the non-defending insurer was precluded from showing that the occurrences did not occur during its policy period, and it was liable for its *pro rata* share of the settlement, and for half the defense costs. "In view of Continental's wrongful breach of the policy contract we find it unnecessary to discuss whether Lloyd's has failed to show that any amount of the settlement represents payment for wrongful acts occurring in 1971."

The Ames reasoning has also been extended to prevent a non-defending insurer from contesting whether the automobile is covered and whether the driver was an insured. Naddeo v. Allstate Ins. Co., 139 N.C. App. 311, 319-20, 533 S.E.2d 501, 506-07 (2000).

The result in Ames, however, was not necessarily required by the existing case law (primarily Nixon). The Ames rationale allows the doctrine of estoppel to create

coverage where it does not otherwise exist (i.e. coverage for acts outside the policy period); this is different from preventing the insurer from relying on a defense to coverage, as was the case in Nixon.

The insurer, however, is not liable for damages for the settlement in excess of its policy limits.

3. Attorneys Fees in pursuing insurer

As a general matter, the insured may not recover its attorneys fees incurred in suing the insurer for failure to defend or indemnify. If the refusal to defend was in violation of Chapter 75, then the insured may be able to recover those fees, as discussed in section IV.A.4.

D. Selection of Counsel

Many other states have dealt with the issue of whether the insured may select his own counsel, especially if there is a reservation of rights or a conflict of interest. The only case on this issue in North Carolina is National Mortg. Corp. v. American Title Ins. Co., 41 N.C. App. 613, 623 (1979), rev'd other grounds, 299 N.C. 369 (1980) which said:

The insurer who refuses to defend an action against its insured where coverage is in dispute does so at its own risk. The insurer's conditional tender of defense does not absolve it of its contractual duty to defend an action for loss within the coverage of the policy. Just as an insured is not required to accept a defense conditioned upon entering into a "non-waiver agreement", he is not required to accept a defense rendered under a "reservation of rights". Plaintiff was entitled to reject the conditional offer by the defendant to defend the Abernethy case and still seek indemnity for the costs of defending that action.

National Mortg. Corp. v. American Title Ins. Co., 41 N.C. App. 613, 623 (1979), rev'd other grounds, 299 N.C. 369 (1980). See also Stout v. Grain Dealers Mut. Ins. Co., 307 F.2d 521 (4th Cir. 1962) (insurer with conflict of interest is not required to provide defense).

Most jurisdictions to have thoroughly addressed this issue hold that where insurer reserves rights and where there is a conflict, that the insured may select its counsel. A mere reservation of rights is insufficient to provide the insured with this right. The conflict which enables the insured to retain its counsel exists when there is a factual issue which has bearing upon liability and upon coverage.

A minority of courts, however, hold that the insured has no right to independent counsel. These hold rely on defense counsel to resolve conflicts in favor of the insured.

In North Carolina, the ethical rules imposed on defense counsel require that she

try to avoid a conflict, but that when a conflict arises that she put the rights of the insured above the rights of the insurer. See, e.g., RPC 56 (“While Attorney A owes some duty of loyalty to Insurance Company in cases in which Attorney A defends insureds of Insurance Company, the insureds, rather than the Insurance Company, are considered to be Attorney A's primary clients.”).

Thus, North Carolina has a sufficient scheme to address the potential conflict, and the better-reasoned rule in North Carolina is that a conflict between the insurer and the insured on a particular issue does not entitle the insured to select his own counsel.

Sometimes an insurer may have to defend two insureds with conflicting interests. North Carolina has no cases on point, but most cases hold that in such a situation, the insurer must defend its insureds in good faith, and may not give favor to either.

The insurer may not use its in-house counsel to defend the insured. Gardner v. North Carolina State Bar, 316 N.C. 285 (1986) (corporation cannot perform legal services for others, based on G.S. § 84-5).

E. Claims for Reimbursement of Defense and Settlement Costs

Where the insurer wrongfully refuses to defend, it may have to reimburse the insured or another insurer for the defense costs and settlement. The cases have to be categorized by which party is seeking reimbursement, and which insurer had a duty to defend.

1. Cases by Insured

Where the insured pays for its counsel, it is entitled to reimbursement for those expenses if the insurer wrongfully refused to defend.

Also, as shown in Section III.C.1., the insured may recover the amount of a reasonable settlement made in good faith. It is not entirely clear who bears the burden of proof on these issues. The language from Nixon suggests that the insured bears these burdens. Nixon v. Liberty Mut. Ins. Co., 255 N.C. 106, 111-112 (1961).

In such cases, the insurer will generally have significant leeway in discovery to explore the basis of the settlement. Communications otherwise protected by the attorney-client immunity may be discoverable, because the good faith of the settlement is at issue.

2. Cases by Another Insurer

An insurer which settles may thereafter sue another insurer seeking contribution for the settlement.

The cases regarding claims between insurers for recovery of defense costs are somewhat complicated.

a. By Insurer with No Duty to Defend

An insurer with no duty to defend, who defends the insured in good faith, is entitled to reimbursement from an insurer with a duty to defend.

b. By Insurer with Duty to Defend

As a general matter, an insurer with a duty to defend has a right of contribution from another insurer with a duty to defend.

The only exception to this doctrine is where an excess insurer defends and (a) the excess insurer has a genuine excess exposure to protect and (b) the primary carrier eventually defends and settles the claim; in such a case, there is no right to indemnity for defense costs. Fireman's Fund Ins. Co. v. North Carolina Farm Bureau Mut. Ins. Co., 269 N.C. 358 (1967). Fireman's Fund focused on the doctrine of subrogation, and it is not clear that it precludes an action for contribution.

F. Whether Excess Insurer has Duty to Defend

Where one policy is excess, the law is conflicting as to whether it has a duty to defend. It is first necessary to understand the priority among the policies.

The general test for determining the priority of to insurers with duties to indemnify has been stated as follows: "Here, we have two policies providing UIM coverage issued by different companies to different policyholders. "The liability of each company must be determined by the terms of its own policy, subject to such modification as may be imposed by statute or by authorized administrative regulation or order." To determine who is the primary carrier and who is the excess carrier, if any, we must examine the "Other Insurance" clauses in the competing policies."

Isenhour v. Universal Underwriters Ins. Co., 341 N.C. 597 (1995) (citations omitted).

It should also be noted that a policy can declare that another insurer must defend.

There is some authority in North Carolina that an excess insurer has a duty to defend. Fireman's Fund Ins. Co. v. North Carolina Farm Bureau Mut. Ins. Co., 269 N.C. 358 (1967) ("Irrespective of the existence of other insurance available to Jerry Denning, each of the plaintiffs, by its own policy, came under a duty to him to defend on his behalf a suit against him by a third party claimant, . . ."). There is also authority that the excess carrier has no such duty. United States Fire Ins. Co. v. Nationwide Mut. Ins. Co., 735 F. Supp. 1320, 1325 (E.D.N.C. 1990) ("the excess carrier not only has no duty but also has no right to insist on defending the suit").

The insurer providing a defense can be liable to an excess carrier who is obligated for damages within the excess coverage.

G. Insurer's Right to Withdraw Defense

North Carolina does not have any law regarding whether an insurer may withdraw its defense. Where there is no duty to defend in the first place (i.e. based on the comparison test), the insurer should be allowed to withdraw its defense, where that does not prejudice the insured.

Where the insurer withdraws its defense, it should do so in a manner so as to not prejudice the insured (beyond requiring him to defend himself). It should give adequate notice to the insured, with ample opportunity for the insured to retain new counsel. If the case is on the verge of trial, the insurer may not be able to safely withdraw its defense.

It is less clear whether the insurer may rely on facts outside the pleadings or newly discovered matter to withdraw its defense. Based on the "comparison test," it is difficult to see how an insurer with a duty to defend initially can later withdraw its defense, absent perhaps a breach of the duty to cooperate. Other states have struggled with this issue.

In an automobile policy, a liability carrier which tenders its limits, without obtaining a release of the insured, may be relieved of its duty to defend. G.S. § 20-279.21(b)(4).

If the defense is withdrawn due to the insurer's payment of limits, there may be some exposure for bad faith:

[A]ny payment of the policy limits which does not release the insured from a pending claim (e.g., unilateral tender of policy limits to the court, the claimant or the insured), even if sufficient to terminate the duty to defend under the wording of the policy involved, raises serious questions as to whether the insurer has discharged its policy obligations in good faith.

Brown v. Lumbermens Mut. Casualty Co., 326 N.C. 387, 403 (1990) (Whichard, J., dissenting).

IV. EXTRA-CONTRACTUAL LIABILITY

As indicated above in the sections above, where the insurer fails (or refuses) to pay pursuant to its policy provisions (whether a first- or third-party claim), the insurer may be sued for actual damages for breach of contract, usually being the amount owed under the policy. In the case of a failure to defend, it includes the cost of defense.

There are, however, situations where the insurer may be liable for amounts beyond mere compensatory damages. These are sometimes referred to as extra-contractual damages. The two claims recognized by North Carolina law upon which an insurer may be held liable for these damages are for violations of Chapter 75 (i.e. unfair and deceptive acts) and for “bad faith.”

A. Unfair and Deceptive Acts

One form of extra-contractual liability arises from acts in violation of Chapter 75. G.S. § 75-1.1(a) provides, “Unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are declared unlawful.”

This statute is significant for two reasons. First, it may provide a remedy where one does not exist under other theories (e.g. negligence or contract). Second, a person violating this statute must pay treble damages. G.S. § 75-16 provides:

If any person shall be injured or the business of any person, firm or corporation shall be broken up, destroyed or injured by reason of any act or thing done by any other person, firm or corporation in violation of the provisions of this Chapter, such person, firm or corporation so injured shall have a right of action on account of such injury done, and if damages are assessed in such case judgment shall be rendered in favor of the plaintiff and against the defendant for treble the amount fixed by the verdict.

The first issue is therefore whether the insurer’s conduct constitutes an “unfair or deceptive” act or practice. The most recent pronouncement on Chapter 75 claims against insurance companies is Gray. Regarding the conduct which constitutes a violation of the act, the Court wrote:

In enacting N.C.G.S. §§ 75-1.1 and 75-16, the legislature intended to effect a private cause of action for consumers. In order to establish a violation of N.C.G.S. § 75-1.1, a plaintiff must show: (1) an unfair or deceptive act or practice, (2) in or affecting commerce, and (3) which proximately caused injury to plaintiffs.

[A] practice is deceptive if it has the tendency to deceive. This Court has also observed that “[a] practice is unfair when it offends established public policy as well as when the practice is immoral, unethical, oppressive, unscrupulous, or substantially injurious to consumers.” Good faith is not a defense to an alleged violation of N.C.G.S. § 75-1.1. Moreover, where a party engages in conduct manifesting an inequitable assertion of power or position, such conduct constitutes an unfair act or practice.

Gray v. North Carolina Ins. Underwriting Ass’n, 352 N.C. 61, 68 (2000).

Gray also addressed the interplay of Chapter 58 (regulation of insurance) and Chapter 75 (unfair practices), as follows:

We agree with the practice of looking to N.C.G.S. § 58-63-15(11) for examples of conduct to support a finding of unfair or deceptive acts or practices. Although N.C.G.S. § 58-63-15(11) does regulate settlement claims in the insurance industry, insurance companies are not immune to the general principles and provisions of N.C.G.S. § 75-1.1.

An insurance company that engages in the act or practice of "not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear," N.C.G.S. § 58-63-15(11)(f), also engages in conduct that embodies the broader standards of N.C.G.S. § 75-1.1 because such conduct is inherently unfair, unscrupulous, immoral, and injurious to consumers. Thus, such conduct that violates subsection (f) of N.C.G.S. § 58-63-15(11) constitutes a violation of N.C.G.S. § 75-1.1, as a matter of law, without the necessity of an additional showing of frequency indicating a "general business practice," N.C.G.S. § 58-63-15(11).

Gray, 352 N.C. at 71.

Prior to this case, it was less clear whether a Chapter 75 claim needed to be predicated upon a is now clear that a violation of Chapter 58 is not required to support a Chapter 75 claim.

Thus, an insured may establish a violation of Chapter 75 by conduct which is unfair or deceptive without regard to whether it violates Chapter 58, and may also establish unfair or deceptive conduct by showing a violation of Chapter 58.

Chapter 58 enumerates several practices which are unfair. It states, in relevant part, "The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:"

(1) Misrepresentations and False Advertising of Policy Contracts. -- Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or . . . or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(2) False Information and Advertising Generally. – [regarding other insurers]

- (3) Defamation. [toward another insurer]
- (4) Boycott, Coercion and Intimidation. – [in restraint of trade]
- (5) False Financial Statements. --
- (6) Stock Operations and Insurance Company Advisory Board Contracts. --
- (7) Unfair Discrimination.
- (8) Rebates.
- (9) Advertising of Health, Accident or Hospitalization Insurance. --
- (10) Soliciting, etc., Unauthorized Insurance Contracts in Other States. --
- (11) Unfair Claim Settlement Practices. -- Committing or performing with such frequency as to indicate a general business practice of any of the following: Provided, however, that no violation of this subsection shall of itself create any cause of action in favor of any person other than the Commissioner:
 - a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
 - b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
 - c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
 - d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;
 - e. Failing to affirm or deny coverage of claims within a reasonable time after proof-of-loss statements have been completed;
 - f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
 - g. Compelling [the] insured to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insured;
 - h. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled;

- i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;
 - j. Making claims payments to insureds or beneficiaries not accompanied by [a] statement setting forth the coverage under which the payments are being made;
 - k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
 - l. Delaying the investigation or payment of claims by requiring an insured claimant, or the physician, of [or] either, to submit a preliminary claim report and then requiring the subsequent submission of formal proof-of-loss forms, both of which submissions contain substantially the same information;
 - m. Failing to promptly settle claims where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; and
 - n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.
- (12) Misuse of borrowers' confidential information.
- (13) Overinsurance in Credit or Loan Transactions. --

G.S. § 58-63-15.

The cases addressing whether the facts are sufficient to support a Chapter 75 claim are highly fact specific. The following sections address whether a given set of facts of pleadings are sufficient to establish a violation of Chapter 75.

1. Evidence Sufficient

a. Sufficient to survive Directed Verdict

In the following cases, the court held that the evidence was sufficient to support a judgment against the insurer for violating Chapter 75.

- o Where insured sustained wind damage, which was covered by policy, and insurer rejected opinion of first adjuster to pay claim, and fired that adjuster and retained another adjuster, then offered a settlement figure

(lower than that suggested by first adjuster) which was rejected, and issued advance payment to insured and another person claiming interest in property, and jury found that insurer violated one or more provisions of Chapter 58 (duty to settle, communicate with insured, make reasonable offers), evidence was sufficient.

- Where insured inquired as to whether rider would cover his death while flying a plane, and insurer's agent incorrectly said that it would, there was evidence that insurer violated Chapter 58 prohibition against "[m]aking, issuing, circulating, or causing to be made, issued, or circulated, any . . . statement misrepresenting the terms of any policy issued . . . or the benefits or advantages promised thereby"
- Where jury determined that insurer "prematurely and improperly" determined it would deny the insured's claim (arising from sale of alcohol) prior to conducting a "meaningful investigation," insurer "misrepresented" to the insured that it would investigate the claim, insurer "unfairly" and "improperly" sent a reservation of rights letter based on exclusion without having "an adequate or documented basis," and insurer solicited an opinion letter from counsel only after having made its decision regarding coverage, insurer's "conduct arguably violates" various provisions of Chapter 58.
- Where jury found defendant liable for wrongful death and awarded \$104,003.00, insurer then stipulated that claimant was entitled to payment under UIM policy, and jury then concluded that the defendant had refused to settle the plaintiff's claim in bad faith, that insurer failed to adjust the plaintiff's loss fairly, follow its own standards, act reasonably in communications, conduct a reasonable investigation and to effect a fair settlement in good faith, evidence was sufficient.

b. Sufficient to survive Summary Judgment

In the following case, the court held that the forecast evidence on the Chapter 75 claim was sufficient to survive summary judgment:

- In action by excess insurer against primary insurer for failure to settle claim, alleging insurer's failure to make an adequate evaluation of potential exposure, failure to ever make an offer, exclusion of excess carriers from meeting after first week of trial, failure to inform excess insurer that cases were calendared for trial, failure to provide information upon request, and refusal to pay interest, forecast of evidence was sufficient.
- Where plaintiff, victim of auto accident, obtained judgment against tortfeasor, in excess of two liability policies and implicating his UIM

coverage, and dispute arose among insurers as to duties to pay pre-judgment and post-judgment interest, and UIM carrier refused to pay full amount of judgment in excess of liability payments (based on alleged offset for MedPay, which had been decided contrary to UIM carrier), plaintiff established violations of Chapter 58 pertaining to communicating promptly with insured, attempting in good faith to effectuate prompt, fair and equitable settlements, unreasonable offers, failing to explain the basis for denial.

- Offering underinsurance coverage which has no value, because of other underinsurance available is an "unfair trade practice which would at the least tend to deceive."

c. Sufficient to survive Motion to Dismiss

In the following case, the court held that the pleadings were sufficient to allege a claim for violation of chapter 75:

- Where plaintiff relied on G.S. § 58-63-15(11) (f, h, m and n), and alleged \$98,000 in medical expenses arising out of the injuries sustained in the auto accident, with documentation proving permanent and disabling injuries, and underlying carrier paid \$50,000, and plaintiff had \$150,00 additional in UIM coverage, and additional \$100,000 in coverage was disputed, and plaintiff alleged that insurer had an across-the-board policy of denying such claims (stacking), and plaintiff alleged that insurer acted without reason and attempted to coerce plaintiff, allegations were sufficient.

2. Evidence Insufficient

a. Insufficiently to survive DV

In the following case, the court held that the evidence was insufficient to create a jury issue in the insured's Chapter 75 claim.

- Where policy writer's employee told insured that the lower floor, a "walkout," was classified separately from a basement and eligible for contents coverage, insured's building flooded, and the flood policy denied claim because the lower floor was a basement, and defendants stood to gain very little from their misleading conduct which was limited to this plaintiff, their actions cannot be characterized as immoral, and the effect of defendants' actions in the marketplace would be negligible, and there was no unfair advantage to be gained from defendants' actions since the flood insurance sought by plaintiffs was not available among competing insurers, evidence was insufficient.

- Where insurer merely re-evaluated workers compensation claim and determined that it was not responsible for the claimant's underlying arthritic condition, insurer attempted to settle claim, and insurer left open \$2000 offer, evidence was insufficient.

b. Insufficiently to survive SJ

In the following cases, the courts held that forecast of evidence was insufficient to establish a Chapter 75 claim:

- Where insured's home was struck by lightning, insured settled claim for \$643.65 as full payment, then more than three years later insured noticed cracks along mortar joints and through some bricks, and re-submitted claim, and adjuster inspected plaintiffs' premises and retained engineer, and adjuster requested that insured dig trench to concrete footing to expose the alleged lightning damage, insured protested but complied, resulting in insured having to drain trench following rain, and adjuster then notified insured that claim was denied on basis of expert's conclusion that damage was due to water intrusion, and insured retained engineer who opined that the lightning had cracked concrete footing, and adjuster then denied claim based on cause of damage and also on expiration of time period for filing claims, "the record does not reveal the existence of any facts which would create any genuine issue that the manner in which defendant conducted its investigation, or its subsequent denial of plaintiffs' claim, was unethical, oppressive or deceptive in any way."
- Where disability insurer required proof of disability each month benefits were applied for, as the policy permitted, insurer was not "unfair in requiring an insured whose injury is of uncertain duration and subject to improvement to show that he is still disabled before paying him further disability benefits," and even though insured claimed that his home was foreclosed upon and that he lost all equity therein because the insurer failed to pay timely benefits under his disability policy, insured failed to support Chapter 75 claim.
- In claim for fire loss, where policy provided for payment of only 75% in event that dwelling did not have phone, and insured was never informed of this by agent, who "told him he would have full coverage," and insureds never read policy, "Because the endorsement made no misrepresentation and because neither defendant-agent nor defendant-insurer violated any duty owed plaintiffs, neither defendant could possibly be guilty of any unfair trade practice pursuant to G.S. 75-1.1."

c. Insufficiently pled

The courts in the following cases held that a claim for Chapter 75 was not

sufficiently pled:

- Claim by insured against insurer for paying tort claim where insured alleged that claim was fraudulent; “[Insurer’s] alleged statement does not indicate that it will not pay fraudulent claims, only that it wishes not to do so. Plaintiff does not allege in his pleadings that [insurer] does, in fact, wish to pay fraudulent claims. Therefore, the complaint does not state facts sufficient to give rise to a cause of action under this section.”
- Where insurer answered claimant’s complaint by alleging claimant’s intoxication at time of accident, claimant dismissed claim and refiled action and added insurer as party, claiming violation of Chapter 75 by alleging he had been intoxicated, claimant’s allegations that the insurer’s attorney relied on hearsay statements gathered by an accident investigator and did not sufficiently investigate the defense before raising it in the answer were insufficient.

3. Treble damages; computation of same

The manner of trebling damages is somewhat unclear. The leading authority on this is Gray. Gray seems to hold that the only amount which is trebled is the damages resulting from the breach of contract, and that the contract damages are not to be trebled. In Gray, the jury found that the insured was entitled to \$256,000 under the policy. It also found \$117,000 in damages flowing from this breach. “The trial court then trebled the jury award of \$117,000 to \$351,000 pursuant to N.C.G.S. § 75-16. Accordingly, the trial court correctly trebled only the damages found by the jury in Issue Six -- those proximately caused by the violation of N.C.G.S. § 75-1.1.” Gray, 352 N.C. at 75. The trial court awarded the insured \$256,000 plus \$351,000, for a total of \$607,000. Although the opinions from the Supreme Court and Court of Appeals are not entirely clear, it appears that this computation was affirmed.

Another case would suggest that the insured cannot recover the contract damages and treble damages for the other damage. Vazquez v. Allstate Ins. Co., 137 N.C. App. 741, 745 (2000) (jury awarded \$104,000 for wrongful death, then \$29,160 for the acts constituting unfair and deceptive trade practices and for the defendant's bad faith refusal to settle, trial court required insured to choose between (1) \$50,000 (limits), (2) \$29,000 (bad faith), (3) treble damages (\$29,160.00 x 3 = \$87,480.00)).

It would seem that where the insurer’s wrongful conduct is non-payment of the benefit, that the benefit should be trebled. High Country Arts & Craft Guild v. Hartford Fire Ins. Co., 126 F.3d 629, 631 (1997) (affirming judgment where jury awarded \$246,809 to insured in compensatory damages and \$148,085.42 in punitive damages, and insured elected an award of treble damages and attorneys fees under Chapter 75).

4. Attorneys Fees

The insured may recover his attorneys fees in pursuing the Chapter 75 claim, where the insurer willfully engaged in the practice and there was an unwarranted refusal by the party to resolve the issue fully. Vazquez v. Allstate Ins. Co., 137 N.C. App. 741, 743 (2000) (Additionally, the trial court awarded the plaintiff \$87,480.00 in attorney fees.).

5. Reliance

Where the insured alleges a deceptive act, he must establish that he relied on the deceptive act to his detriment in order to maintain a Chapter 75 claim. Pearce v. American Defender Life Ins. Co., 316 N.C. 461, 472 (1986) (“The evidence is sufficient to support a finding that Lt. Pearce relied to his detriment upon the statements in defendant's letter.”).

6. Standing

A person not a party to the insurance contract does not have a Chapter 75 claim against the insurer. Wilson v. Wilson, 121 N.C. App. 662, 665 (1996) (“a private right of action under N.C.G.S. § 58-63.15 and N.C.G.S. § 75-1.1 may not be asserted by a third-party claimant against the insurer of an adverse party.”).

After the claimant obtains a judgment against the insured, however, the claimant may have a Chapter 75 claim against the insurer. Murray v. Nationwide Mut. Ins. Co., 123 N.C. App. 1, 16 (1996).

7. Statute of Limitations

A claim under chapter 75 is subject to a four year statute of limitations. Applying that rule to an insurance claim is not always clear. There is not much conclusive law on when a Chapter 75 claim “accrues.” The statute generally runs from the date of the violation, at which time the plaintiff can file the claim. One case against an insurer based on a misrepresentation held that the claim did not accrue until the date on which the information harmed the claimant, and not on the date of the misrepresentation.

B. Bad Faith

The second avenue for extra-contractual damage is for “tortious,” or “bad faith,” breach of contract, giving rise to punitive damages. The seminal case on this issue in North Carolina is Newton, which stated:

The general rule in most jurisdictions is that punitive damages are not allowed even though the breach be wilful, malicious or oppressive. Nevertheless, where there is an identifiable tort even though the tort also constitutes, or accompanies, a breach of contract, the tort itself may give rise to a claim for punitive damages.

...

While the distinction between malicious or oppressive breach of contract, for which punitive damages are generally not allowed, and tortious conduct which also constitutes, or accompanies, a breach of contract is one occasionally difficult of observance in practice, it is nevertheless fundamental to any consideration of the question of punitive damages in contract cases

...

The aggravated conduct which supports an award for punitive damages when an identifiable tort is alleged may be established by allegations of behavior extrinsic to the tort itself, as in slander cases. Or it may be established by allegations sufficient to allege a tort where that tort, by its very nature, encompasses any of the elements of aggravation. Such a tort is fraud, since fraud is, itself, one of the elements of aggravation which will permit punitive damages to be awarded.

Newton v. Standard Fire Ins. Co., 291 N.C. 105, 111 (1976).

The Court held that the evidence was insufficient in that case, but further stated:

Insurer's knowledge that plaintiff was in a precarious financial position in view of his loss does not in itself show bad faith on the part of the insurer in refusing to pay the claim, or for that matter, that the refusal was unjustified. Had plaintiff claimed that after due investigation by defendant it was determined that the claim was valid and defendant nevertheless refused to pay or that defendant refused to make any investigation at all, and that defendant's refusals were in bad faith with an intent to cause further damage to plaintiff, a different question would be presented.

We are slow to impose upon an insurer liabilities beyond those called for in the insurance contract. To create exposure to such risks except for the most extreme circumstances would, we are certain, be detrimental to the consuming public whose insurance premiums would surely be increased to cover them.

On the other hand, because of the great disparity of financial resources which generally exists between insurer and insured and the fact that insurance companies, like common carriers and utilities, are regulated and clearly affected with a public interest, we recognize the wisdom of a rule which would deter refusals on the part of insurers to pay valid claims when the refusals are both unjustified and in bad faith.

Newton, 291 N.C. at 116.

"An insurance company is expected to deal fairly and in good faith with its policyholders." Robinson v. N.C. Farm Bureau Ins. Co., 86 N.C. App. 44, 50, 356 S.E.2d 392, 395 (1987), disc. review improv. allowed, 321 N.C. 592, 364 S.E.2d 140 (1988). Regarding the denial of a claim, our courts have stated:

The claim was clearly the basis of an honest disagreement between the parties and that plaintiffs' claim of tortious breach and punitive damages were required to be dismissed. . . . Necessarily, there can be no claim for punitive damages if there has been no tort committed. It appears that defendant here promptly and consistently denied plaintiffs' insurance claim based on an interpretation that is neither strained nor fanciful, regardless of whether it is correct. Further, while defendant's agents may have provided plaintiffs with inaccurate advice, they did so apparently in good faith, with the desire to be helpful and perform their duties, not with the intent to injure plaintiffs or with a disregard for plaintiffs' unfortunate predicament.

Olive v. Great American Ins. Co., 76 N.C. App. 180, 189 (1985).

Regarding the denial of a claim for health benefits, it has been said:

In order for the Plaintiff to recover on her claim for punitive damages under North Carolina law, she would have to produce evidence that the Defendant had determined that the claim was valid and that the Defendant nevertheless refused to pay and that such refusal was in bad faith with intent to cause further damage to Plaintiff. There is nothing in this evidence to warrant a finding by this Court that the Defendant's denial of Plaintiff's claim was in bad faith with intent to cause further damage to this Plaintiff.

Michael v. Metropolitan Life Ins. Co., 631 F. Supp. 451, 453 (D.N.C. 1986) (judgment for insurer upon findings of fact, where insurer denied coverage for new fertility treatment, with 20% success rate).

A claim for punitive damages must comply with Chapter 1D. Such a claim requires fraud, malice, or willful or wanton conduct. G.S. § 1D-15(a). Willful or wanton means "conscious and intentional disregard of and indifference to the rights and safety of others, which the defendant knows or should know is reasonably likely to result in injury, damage, or other harm. 'Willful or wanton conduct' means more than gross negligence." G.S. § 1D-5(7). Punitives may not be awarded based on vicarious liability. G.S. § 1D-15(c).

The insurer is probably more exposed to an extra-contractual claim if it has not obtained the opinion of legal counsel. See, e.g., Country Club of Johnston County, Inc. v. United States Fid. & Guar. Co., 150 N.C. App. 231, 246-247 (2002) (affirming treble

damages under Chapter 75 where, inter alia, “USF&G solicited an opinion letter from counsel only after having made its decision regarding coverage”).

When the insured raises the insurer’s “bad faith,” some insurers have argued that the insured’s own “bad faith” precludes of limits his recovery. North Carolina has not addressed the significance of an insured’s “bad faith.” Most courts reject this doctrine.

Our courts do recognize the insured’s duty of good faith, as follows:

By express policy language, the insured is required to cooperate, attend hearings and trials and give evidence. He has a duty equal to that of the insurer to act diligently and in good faith. Hence when an insured fails, without justification, to attend the trial of his case in accordance with his promise, the insurer has the right to assert noncompliance with the cooperation provision of the policy.

Connor v. State Farm Mut. Auto. Ins. Co., 265 N.C. 188, 191 (1965). Our courts, however, have not addressed whether the insured’s bad faith is relevant in a bad faith claim against the insurer.

The cases addressing whether the pleadings, evidence, or forecast of evidence is sufficient to establish a bad faith claim are highly fact-specific. The following sections address whether the facts are sufficient for a bad faith claim:

1. Evidence Sufficient

a. Sufficient to survive DV

In the following cases, the courts held that the evidence was sufficient to support a judgment against the insurer for bad faith:

- A punitive damages verdict of \$225,000 was affirmed against insurer where passenger was killed in auto accident, insurer issued \$250,000 liability policy covering driver (driving passenger), and \$2,000 in medpay, and insurer used adjuster who aggressively attempted to resolve all claims with passenger’s family, and insurer did not pay for funeral expenses for ten months, negotiations ensued, adjuster said he "just plumb forgot" about medpay claim for funeral expenses, evidence “tends to establish that defendant intended to ‘wear down’ the [insureds] to influence settlement of the liability claim,” agent contacted plaintiff husband five times before the funeral to urge them to meet as soon as possible, and even insinuated that the policy could be voided if they did not immediately comply, and adjuster told them their daughter wasn’t worth very much, that his daughter was not asleep at the time of the accident and that she had "burned up," insurer denied that Rusty Lewis was the driver of the car, although decedent’s body was found seat-belted on the passenger side, and Lovells had to hire reconstruction expert on this issue before defendant admitted liability, and in response to insured’s inquiry

concerning nonpayment of the medpay claim, defendant's agent responded "[y]ou're the one who got a lawyer," evincing an intent to delay prompt settlement of the suit and hostility to the fact that plaintiff had retained a lawyer.

- Where plaintiff was insured under fire insurance policy, and sued defendant-insurer for benefits and punitive damages for denying claim and other bad faith conduct, and jury awarded \$105,000, the policy limits, for fire damage done to the house, \$37,000 for fire damage done to the contents, and \$15,000 for living expenses, \$20,000 for wrongful conduct of adjuster in maliciously and untruthfully notifying various neighbors and acquaintances of plaintiff that insurer had determined that plaintiff burned his house or caused it to be burned for insurance purposes, and awarded \$100,000 for defendant's wrongful failure to settle the claim in good faith, judgment is affirmed. Fire marshall determined fire was deliberately set, but investigation eliminated plaintiff as a suspect; insurer had returned multiple proof of loss forms with the notation "rejected" across the top, and delayed in responding, and two estimators testified that repairs would exceed the policy limits of \$105,000, and insurer's estimate from a carpenter, not a general contractor, was for \$48,286.63 without tearing any portion of it down, and insurer contended "among other things, that shoes over a year old had no value at all," and insurer offered to settle entire claim for \$69,607.85, and insurer hired adjuster who told witness that he "determined this was a contract burning of the house and that it was done for insurance purposes" and that he "knew that the house had been burned . . . for insurance purposes," and offered witness \$10,000 fee and immunity from prosecution if he would sign a statement and testify that he was hired by insured to set fire to the house. "The evidence produced at trial is clearly sufficient, we think, to support the jury's finding that with accompanying aggravation of a very high degree, indeed, defendant tortiously refused in bad faith to settle plaintiff's claim. Defendant's argument that plaintiff failed to prove the existence of a "separate identifiable tort" is based on a misreading of the law." "[A]fter arbitrarily rejecting plaintiff's well documented claim defendant took no steps at all to check plaintiff's estimated construction costs for several months and then selected an unqualified builder to do the checking, and then waited another month before making a settlement offer for the real property loss that had no reasonable basis and an offer to settle the contents loss that disregarded the actual utility and value of the destroyed items." Insurer "requir[ed] him to go to the inconvenience and expense of obtaining qualified, expert estimates defendant had no intention of considering; inordinately delaying both the settlement and plaintiff's return to his usual comforts and amenities of life; and then offering about half the amount owed in anticipation that plaintiff would have neither the will nor the resources to refuse it."

b. Sufficient to survive SJ

In the following cases, the courts held that the evidence was sufficient to survive the insurer's motion for summary judgment:

- Where plaintiff, victim of auto accident, obtained judgment against tort-feasor, in excess of two liability policies and implicating his UIM coverage, and dispute arose among insurers as to duties to pay pre-judgment and post-judgment interest, and UIM carrier refused to pay full amount of judgment in excess of liability payments (based on alleged offset for MedPay, which had been decided contrary to UIM carrier), Bad Faith against insurer (UIM) carrier survives SJ because insurer refused to pay interest allegedly without cause and allegedly failed to attempt in good faith to settle; "the judgment based on plaintiff's first cause of action . . . attests to the aggravating conduct of [insurer]."
- In fire loss, where insurer denied that the building was damaged in excess of \$100,000.00, offering instead to pay plaintiff \$88,451.00, and umpire set loss at \$170,000, and insurer then paid the \$100,000.00 building loss, which was seven months after the fire, five months after the plaintiff's initial submission of its proof of loss claims, and insured had obtained estimates for \$170,000 and \$111,000, forecast of evidence was sufficient.
- In action by excess insurer against primary insurer for failure to settle claim, alleging insurer's failure to make an adequate evaluation of potential exposure, failure to ever make an offer, exclusion of excess carriers from meeting after first week of trial, failure to inform excess insurer that cases were calendared for trial, failure to provide information upon request, and refusal to pay interest, forecast is sufficient.

c. Sufficient to survive Motion to Dismiss

In the following cases, the courts held that the pleadings stated a claim for bad faith:

- Where plaintiff alleged \$98,000 in medical expenses arising out of the injuries sustained in the auto accident, with documentation proving permanent and disabling injuries, and underlying carrier paid \$50,000, and plaintiff had \$150 additional in UIM coverage, and additional \$100K in coverage was disputed, and plaintiff alleged that insurer had an across-the-board policy of denying such claims (stacking), "plaintiff has sufficiently alleged a tortious act accompanied by some element of aggravation."
- Where plaintiff sustained theft loss, adjuster said that insurer discouraged the payment of any such claims for benefits pursuant to such theft coverage and alleged numerous excuses as to why insurer refused to compensate insured, with insurer raising new requirements and objections, allegations were sufficient.

- Where the insured alleges “bad faith” and 5-month passage of time between when the adjuster first observed the damages to plaintiff’s mobile home and when a claim check was issued, extended period of negotiations with little progress toward reaching a resolution, and a substantial disparity between both of plaintiff’s estimates and the estimate relied upon by defendant, allegations were sufficient.
- Where the insured alleged that insurer breached its duty to act in good faith in refusing without reason to pay for private duty nurses and all doctor bills, refusing to adequately investigate plaintiff’s claim and refusing to negotiate and settle plaintiff’s claim, and plaintiff specifically alleged that despite the opinions of two of decedent’s treating physicians regarding the necessity of nursing care, defendant refused to investigate the claim or consult a qualified physician for evaluation before denying the claim and that such refusal was in bad faith, and Plaintiff further alleged that defendant refused to pay for private duty nursing care after it had previously approved that expense and communicated that approval to plaintiff, allegations were sufficient.

2. Evidence Insufficient

a. Insufficient to survive DV

In the following case, the court determined that the evidence was insufficient to support a verdict for punitive damages:

- Where insurer’s agent was negligent in efforts to procure insurance and negligently delayed acting on application for insurance, but did not do so intentionally or wantonly, there was no bad faith.

b. Insufficient to survive SJ

The following cases held that the forecast of evidence was sufficient to withstand the insurer’s motion for summary judgment:

- Where insured sustained fire loss, and insurer sought appraisal and paid appraiser’s award, and plaintiff asserts that defendants failed to conduct a reasonable investigation before demanding appraisal, and that their settlement offer was unreasonably low, and insured characterizes defendants’ action in initiating the appraisal process when he had been without the use of his home for approximately two months as unreasonable, given their duty to relieve the financial distress of their insured, “these examples of purportedly unreasonable actions do not rise to the level of aggravated conduct” required.

- Following a fire loss the agent visited the property and said he "wasn't sure" whether the loss was covered, apparently due to ambiguity in which structures were covered, and after checking with the insurer, informed insureds that their claim would be denied, and Plaintiffs thereafter had several discussions with agents during which a settlement figure of \$55,834.00 was proposed, subject to approval by insurer's office, and approval was denied, and insured-wife injured her back escaping from the fire and her recovery was slowed by the unusual living conditions, and she had to use vacation time to pursue settlement of claim, "Plaintiffs' argument that this is evidence of bad faith appears to be premised almost entirely on their contentions that defendant has not interpreted the policy correctly," and coverage issue was for the jury, "the claim was clearly the basis of an honest disagreement between the parties."
- In fire loss case, where insured alleged that insurer initially formed an intent to deny plaintiff's claim, and that insurer required plaintiff to follow all requirements of the policy including forcing him to undergo a deposition and to undergo an \$11,000 expense for an appraiser, to harass and intimidate insured to accept less than the full benefits, and insurer offered evidence that insured made misrepresentations (as to value of the premises, etc.), and officials determined that the fire was "probably the work of an arsonist," but insured was not specifically implicated, but suspicious factors were present (straw on premises), claim was not denied until some 19 months after the fire and insurer's investigation continued during that time, evidence was insufficient.
- Where the plaintiff sustained a fire loss, and insurer paid check with notation that it was full settlement, and insured deposited check, and insured claimed that insurer "acted in bad faith, in violation of G.S. 58-54.1-.13, by failing to inform her of her coverage, her rights, and its liability to her; by not attempting to settle promptly, fairly, and equitably; and by attempting to settle for less than the amount 'to which a reasonable man would have believed he was entitled.'," evidence is insufficient because the record reveals no concealment of facts and plaintiff had a copy of her policy.
- Where insured alleged that insurance agent assured insured that he had coverage effective on July 5, and insured obtained loan and bought car and was in accident on July 6, and insurer denied collision coverage prior to July 7, and agent said "If anything come (sic) up and we go to court, I'll deny everything that I said," evidence was insufficient.
- Where insurer's agent, in trying to repair damage to the insureds' property, caused additional property damage, and insurer investigated the insureds' claim that the repairs had been done improperly and determined that the claim was valid, but it refused to pay any amount above the policy limit to

correct the damage, there was no element of aggravation.

- Although insured alleged that agent deceived him as to measure of recovery under policy (full replacement cost or actual cash value), agent's statements are not in dispute and do not "support[] an inference of deception."

c. Insufficient to survive Motion to Dismiss

The following cases held that a claim for bad faith was not sufficiently pled:

- "The breach of contract represented by defendant's failure to pay is not alleged to be accompanied by either fraudulent misrepresentation or any other recognizable tortious behavior."
- In claim for nonpayment of claim for health benefits, alleging that insurer violated its covenant of good faith and fair dealing to the plaintiff, "Not only has plaintiff herein failed to sufficiently allege a tortious act, he has failed to allege any accompanying 'element of aggravation'."

3. Damages

Punitive damages are now limited by Chapter 1D, to the greater of \$250,000 or three times the actual damages. G.S. § 1D-25.

4. Attorneys fees and expenses

The insured's expenses in prosecuting the bad faith action are not recoverable.

5. Bad Faith failure to settle (third party)

Several cases address a liability insurer's potential exposure to "bad faith," or negligence, for failure to settle a claim against the insured.

The insurance carrier has the right to settle any claim covered by the policy. [Citing FRA] "The law imposes on the insurer the duty of carrying out in good faith its contract of insurance. The policy provision giving the insurer the right to effectuate settlement was put in for the protection of the insured as well as the insurer. It is a matter of common knowledge that fair and reasonable settlements can generally be made at much less than the financial burden imposed in litigating claims."

Powe v. Odell, 312 N.C. 410, 413 (1984) (addressing constitutionality of statute allowing additional interest when claim is covered by insurance). Regarding the insurer's duty to settle, our courts have also stated:

The insurance policy in the present case provides that State Farm may "settle or defend" any claim or suit as it considers "appropriate." . . . In North Carolina, "regardless of any contractual provision reserving to the insurer the exclusive right to settle a claim as it sees fit, any settlement must be made in good faith." Good faith is defined as "absence of malice . . . Honesty of intention, and freedom from knowledge of circumstances which ought to put [one] upon inquiry." Black's Law Dictionary 693 (6th ed. 1990).

...

The insurer has the duty to consider the insured's interest. In so holding, we recognize that an insurer may act in its own interest in settlement of the claim, and has statutory authority to settle claims without the consent of the insured.

Cash v. State Farm Mut. Auto. Ins. Co., 137 N.C. App. 192, 206 (2000) (insured's claim against his insurer for settling claim which insured believed to be fraudulent did not state claim against insurer).

In Wynnewood Lumber, the jury returned a verdict of \$20,000, and the insured sued the insurer for damages in excess of his insurance coverage. The court wrote:

The only suggestion of a tortious act is in the language used with reference to the defendant's negligently refusing to settle the Jones claim for \$1,000 or \$2,500. A causal examination of the policy makes it clear that the parties agreed that the defendant should have the sole right to compromise and settle claims brought against the plaintiff. There is no allegation that this power was exercised by the defendant fraudulently, oppressively, or otherwise than in good faith. That provision was evidently placed in the contract for the protection of the insurer, and gives the insurer the right to exercise its own judgment as to when a compromise and a settlement shall be made. Of course, it must be exercised in good faith and without any wrongful or fraudulent purpose. When properly exercised, it is binding upon the insured. It turns out that it would have been better for all parties, the plaintiff as well as the defendant, if the offer of a compromise had been accepted; but as is said in the brief of the counsel for the defendant, "This is a case where hindsight turns out to be better than foresight." It was a mistake of judgment, something not unusual in the affairs of this life. Such a mistake honestly made does not subject the person to legal liability.

Wynnewood Lumber Co. v. Travelers Ins. Co., 173 N.C. 269, 271 (1917) (emphasis added).

6. Bad Faith Breach of Duty to Defend

A refusal to defend can lead to an action for bad faith. Without aggravated conduct, however, the claim cannot survive. In King, the insurer refused to defend and to pay a judgment, and the insured sued seeking punitive damages. The Supreme Court affirmed an order striking the allegations regarding punitives, stating:

It is true that one of the stricken allegations was that the defendant's breach of its contract was "aggravated fraud," but no facts which, if true, would give rise to a cause of action for damages for deceit are alleged. Without such allegation, the charge of "aggravated fraud" is a mere epithet and does not alter the nature of the action from that of a mere suit for damages for breach of contract. Even where there is allegation and proof of actionable fraud and the jury has found the issue of fraud against the defendant, an award of punitive damages does not follow as a conclusion of law. Here, however, there is no allegation of facts giving rise to a right of action for deceit or any other tort.

King v. Insurance Co. of North America, 273 N.C. 396, 398 (1968).

7. Failure to Preserve Limits

An insurer may also be subject to a bad faith claim where it pays its coverage on some claims, and leaves the insured exposed on other claims. In Alford, the insurer settled some claims arising from accident, and another claimant sued and recovered a judgment against insured, in excess of remaining limits. The court held that the insurer was not liable on the judgment for entire limits of its policy, but was entitled to offset for the amounts already paid, stating:

It is not necessary in this case to determine whether the insurer is liable for mere negligent failure to settle or whether it is requisite to show good faith in failing to make settlement; nor is it necessary now to interpret the 1953 Act, G.S. 20-279.21, as relating to the bona fides of an insurer conducting negotiations and effecting settlements of claims made by the insurer. At the time this cause of action accrued, one who asserted arbitrary action on the part of the insurer had the burden of alleging and establishing the asserted bad faith. Plaintiff has neither alleged nor offered proof of the assertion here made that the insurance company acted arbitrarily in making settlement.

Alford v. Textile Ins. Co., 248 N.C. 224, 230 (1958). The Court further wrote:

The courts which have been called upon to consider the question are in agreement that an insurer may settle part of multiple claims arising from the negligence of its insured, even though such settlements result in preference by exhausting the fund to which the injured party whose claim has not been settled might otherwise look for payment. Nor may a court

require the insurance company to pay the fund into its register for ratable distribution among claimants.

Alford, 248 N.C. at 230.

8. Settling Insured's Deductible

Some liability policies have a deductible (i.e. an amount which the insured is required to pay before the insurer's coverage is invoked. This can raise an issue of bad faith. In Public Service Company, the deductible was \$100,000, and the insurer settled for \$101,500. The insured's suit was dismissed at summary judgment, and the Court of Appeals affirmed, stating:

The parties have cited no case law, and our research has revealed none, in which an insurer was found to have acted in bad faith when it settled a case for an amount suspiciously close to the deductible amount. However, this does not mean that an insurer can act with impunity in settling such a case. Regardless of any contractual provision reserving to the insurer the exclusive right to settle a claim as it sees fit, any settlement must be made in good faith. "Where a contract confers on one party a discretionary power affecting the rights of the other, this discretion must be exercised in a reasonable manner based upon good faith and fair play."

...

Specifically, an insurer is required to act in good faith in exercising its right to settle a claim against the insured. The insurer must give due regard to the interests of the insured, but this does not mean that the insurer must give more consideration or weight to the interests of the insured than its own interests. When an insurer brings an action against its insured for indemnity, the insurer bears the burden of showing that the settlement was made in good faith.

Nationwide Mut. Ins. Co. v. Public Serv. Co., 112 N.C. App. 345, 350 (1993). The Court held that since it was conceded that the settlement was reasonable, "there must be some allegation beyond the fact that, due to the deductible, defendant was liable for a much greater share of the settlement amount than the plaintiff was. In the absence of such an allegation, we find that there was no issue of material fact as to plaintiff's good faith in settling the Pulley action and reject defendant's first argument." Public Serv. Co., 112 N.C. at 351.

9. Not Assignable

An insured's bad faith claim is not assignable.

10. Standing

As a general matter, a non-party to the liability contract cannot maintain an action for bad faith. “In order to state a claim for punitive damages, a plaintiff must have a valid cause of action against the defendant in which at least nominal damages may be awarded were the plaintiff to recover. Because of our disposition of plaintiff’s claim against defendant Nationwide, Ms. Wilson has no cause of action against Nationwide. Thus, we hold that her claim for punitive damages was properly dismissed.” Wilson v. Wilson, 121 N.C. App. 662, 668 (1996). It is not clear whether a bad faith claim may be maintained by a non-insured for the insurer’s conduct following a judgment.