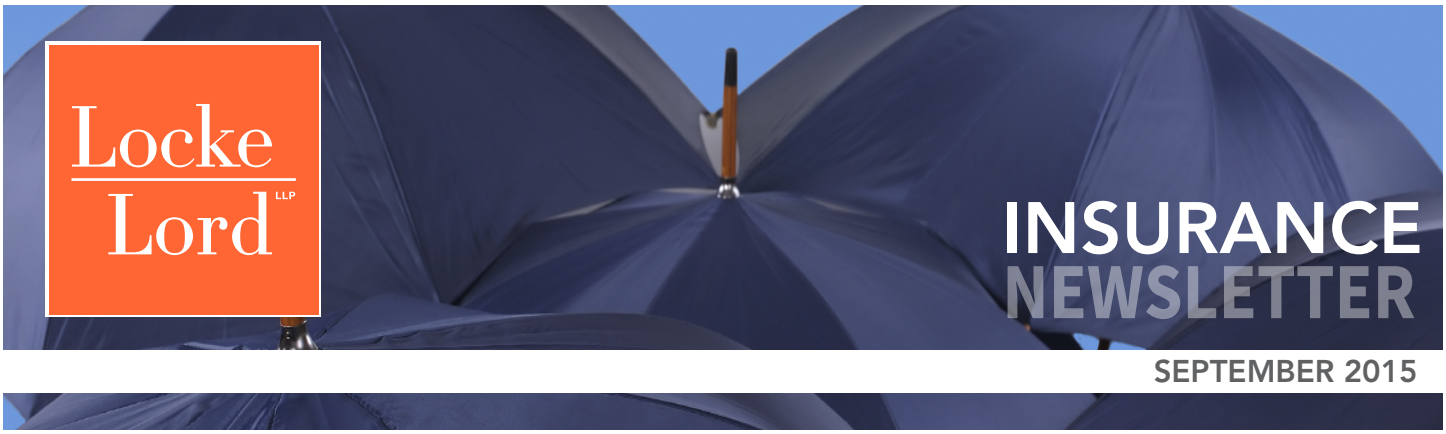

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Locke Lord's Insurance Newsletter provides topical snapshots of recent developments in the fast-changing world of insurance. For further information on any of the subjects covered in the newsletter, please contact one of the members of our Insurance team.

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Validus Round Two: Court of Appeals' Decision Holding That Wholly-Foreign Retrocessions Are Not Subject to Federal Excise Tax Turns On Closely Parsed Semantics

By: Christopher M. Flanagan and Rebecca R. Melaas

On May 26, 2015, the United States Court of Appeals for the District of Columbia upheld a District Court decision and ruled that the Internal Revenue Service could not impose excise tax on certain wholly-foreign retrocessions of insurance under Section 4371 of the Internal Revenue Code.[1] In reaching its decision, the Court of Appeals wrestled with the "correct" meaning of several terms in the statute in an attempt to glean whether Congress intended the statute to apply to certain wholly-foreign retrocession contracts. While initially hailed as an important victory for the taxpayer (and important precedent for other taxpayers), a close reading of the Court of Appeals decision reveals that its holding was more limited than the ruling of the District Court. While the decision gives both sides room to claim some margin of victory, it should be read taking into account its interaction with certain related income tax treaty provisions, and it potentially leaves unanswered questions regarding existing tax withholding provisions.

By way of background, Code Section 4371 generally imposes an excise tax on premiums paid to certain foreign insurers and reinsurers related to policies of insurance or reinsurance and indemnity bonds covering certain United States risks.[2] Because this excise tax is by its terms payable by "any person who makes, signs, issues, or sells any of the documents and instruments subject to the tax, or for whose benefit the same are made, issued, or sold," all parties in the chain of coverage should be concerned with the potential imposition of this tax. In addition, the Internal Revenue Service (IRS) has taken the position that this tax can apply multiple times through cascading layers of reinsurance with respect to the same ultimate risk, including where both parties to such reinsurance contracts are wholly outside the United States. Depending on the type of coverage, the rate for this tax can range from 1% to 4% of the premium paid.

Background of the Case

The current decision represents a second major victory for Validus, a Bermuda reinsurer, who was seeking a refund from the IRS of excise tax previously paid. In 2006, Validus paid premiums on nine retrocession policies that it entered into with respect to reinsurance it had previously issued related to certain U.S. risks written by a U.S. insurance company. During this period, Validus did not directly conduct business in the U.S. In February 2012, the IRS requested that Validus consent to the assessment of excise tax on those policies in the amount of $326,340. Validus paid the assessment, plus an additional $109,040 in interest, and then filed for a refund. Six months later, not having received any response from the IRS, Validus filed suit in the U.S. District Court for the District of Columbia.

The District Court granted summary judgment for Validus and held that the imposition of the Code Section 4371 excise tax with respect to the covered reinsurance policies was not permitted under the applicable statute, determining that "retrocessions" fell outside the literal definitions of reinsurance and other types of taxable insurance subject to this excise tax.[3] Left standing, this exclusion of retrocessions from the coverage of the Code Section 4371 tax, under the District Court's holding, would apply regardless of whether the cedent was a U.S. or non-U.S. person, a feature that some commentators felt may have extended the exclusion too far.

The Appellate Court Decision

In its decision, the Court of Appeals held that the excise tax assessed against Validus with respect to its retrocession contracts with other foreign insurers was not authorized by Code Section 4371, although, as stated above, on different, more narrow grounds than the District Court. After examining the plain language of the statute, and determining that both parties had offered plausible explanations as to the proper interpretation of various terms,[4] the Court of Appeals found the text of Code Section 4371 to be ambiguous as to whether Congress intended to tax wholly-foreign retrocessions such as those involved in the case (that is, where both the initial reinsurer and the retrocessionaire are non-U.S. persons). To resolve this ambiguity, the Court of Appeals turned to the legislative history of the statute, noting the long-standing judicial doctrine that, unless a contrary intent is apparent, congressional legislation is not meant to apply to transactions wholly outside the territorial jurisdiction of the United States, generally known as the "presumption against extraterritoriality." The Court of Appeals could not find any explicit evidence of Congress' intent to apply the Code Section 4371 excise tax to wholly-foreign retrocessions and, accordingly, applied the presumption against extraterritoriality to refuse to interpret the statute to allow the IRS to impose excise tax on wholly-foreign retrocessions. The court cited to the fact that the tax could otherwise cascade, as mentioned above, as an additional basis for concluding that extraterritorial application of the tax was not intended by Congress.

By focusing on this extraterritoriality feature, rather than drawing a distinction between retrocessions and other types of reinsurance as the District Court did, the Court of Appeals avoided the potential pitfall of excluding reinsurance even where the cedent was a U.S. person. Thus, a major distinction between the District and Appellate Court decisions is that the excise tax would apply under the Appellate Court's decision where a U.S. reinsurer retrocedes relevant coverage to a non-U.S. retrocessionaire, whereas the District Court's decision would have presumably excluded this transaction.

Takeaways

While clearly an important victory for Validus, this case could be viewed by the IRS as a partial victory as well, because of the potentially more limited grounds upon which it was decided, as distinguished from the District Court decision. As with the District Court decision, there remains the possibility of a further government appeal of this case (for example, if another federal circuit decision results in a split in the relevant circuits). However,

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[1] *Validus Reinsurance, Ltd. v. United States*, No. 14-5081 (D.C. Cir. May 26, 2015).

[2] One of the primary purposes of this statute when originally enacted was to help U.S. insurance companies better compete with foreign insurers by leveling the playing field between such U.S. companies, subject to U.S. income taxes, and their non-U.S. counterparts not so burdened.

[3] Note that the District Court stated that its decision was based upon the application of these definitions to a situation involving retrocessions, and was not predicated on Validus' argument that Congress did not intend and did not have the power to tax purely foreign-to-foreign transactions, an argument that, as discussed below, would form the ultimate basis for the Appellate Court's decision.

[4] The Court of Appeals devoted a significant portion of its opinion to the determination of the proper definition of the terms "cover" and "with respect to" in coming to its final determination.

the narrower holding of the Court of Appeals' decision may provide a middle ground sufficient to placate both sides of the issue. In the interim, taxpayers who have paid federal excise tax on wholly-foreign retrocessions should consider seeking a refund of such taxes based upon the current holding.

Although the Court of Appeals' decision determined that wholly-foreign retrocessions are not themselves subject to the Code Section 4371 excise tax, this determination may be tempered at least in part by the potential application of relevant income tax treaty provisions. Applicable treaty provisions may under appropriate circumstances exempt from this tax transactions entered into between a U.S. insured (or reinsured) and a non-U.S. insurer (or reinsurer). These provisions, however, often contain a carveout from this exemption for situations where the non-U.S. party subsequently reinsures with another non-U.S. party not entitled to a similar treaty exemption. Thus, while such a wholly-foreign transaction may not itself be subject to the Code Section 4371 excise tax under the rationale of the Court of Appeals' decision, it may nonetheless trigger the application of this tax to an earlier transaction that had originally claimed a treaty exemption (that is lost by virtue of the later transaction).

Further, as the application of Code Section 4371 to the various forms of cross border insurance and reinsurance plays out, taxpayers should be cognizant of any potential effects of the final determination regarding the applicability of this tax upon the existing tax withholding provisions of the Internal Revenue Code potentially applicable to these same cross border transactions. United States source insurance premiums paid with respect to a contract that is subject to the Code Section 4371 excise tax have traditionally enjoyed an exemption from the potentially applicable withholding provisions of Section 1441 of the Code. As the application of Code Section 4371 is pared back, taxpayers should consider the potential impact, if any, of these withholding provisions.

The Consumer Financial Protection Bureau: What Insurers Should Know

by Timothy V. Kemp

Q: When does the Consumer Financial Protection Bureau (CFPB) have authority over insurance companies?

The federal legislation commonly known as the Dodd-Frank Wall Street Reform Act, which created the CFPB, specifically carves out the regulation of insurance from the wide range of duties and powers of the agency. However, despite exclusions in the law for the "business of insurance" and for "any person regulated by a state insurance regulator", the CFPB has authority over insurance companies if: (1) they provide a "consumer financial product or service" such as financial advisory services, loans to policyholders and insurance premium financing; (2) they are covered by an "enumerated consumer law" such as the Fair Credit Reporting Act (FCRA), Real Estate Settlement Procedures Act (RESPA) and Fair Debt Collection Practices Act (FDCPA); or (3) they are operating as a "service provider" to a "covered person", as where an insurance industry participant operates as a debt protection contract administrator or assists in the design of a product offering for regulated financial institutions and their customers.

In addition, under Title X, the CFPB can take action against any company, including insurance companies, if it deems the company to have engaged in "unfair deceptive and abusive acts and practices", also known as "UDAAP". The CFPB has broad authority to interpret what constitutes a UDAAP violation and an equally broad ability to penalize companies for such violations. A review of the 70 or so enforcement actions completed by the CFPB to date reveals that a substantial number of them allege, often among other things, UDAAP violations. Even if a company is in technical compliance with other applicable laws and regulations, it may be found in violation of UDAAP standards.

And there are indirect ways the CFPB can and effectively does regulate companies it is not empowered to regulate directly, including insurance companies. For example, in issuing Bulletin 2012-03, the CFPB sets forth its expectations of regulated institutions or covered persons in the management of their vendors. Simply stated, this Bulletin imposed on regulated institutions the responsibility of ensuring that their vendors are and remain in compliance with applicable consumer laws. As regulated institutions have endeavored to meet the requirements of the Bulletin, questions have arisen as to its application not only to those acting as direct service providers to covered persons, but also to those vendors two and three steps removed from the regulated institution.

Q: Could the CFPB regulate insurance products offered in conjunction with loans (add-on products)? If so, how?

The Truth in Lending Act (TILA) specifically grants the CFPB authority to implement rules regulating financial products and services. The concern among insurance industry participants is that such rules could be used to indirectly regulate insurance products offered in conjunction with the underlying financial products or services.

The CFPB has already ventured into the regulation of products such as credit reporting and identity theft protection benefits sold as add-ons to credit cards. See http://files.consumerfinance.gov/f/201507_cfpb_stipulated-final-judgment-and-order_affinion.pdf and http://files.consumerfinance.gov/f/201507_cfpb_stipulated-consent-order-INTX.pdf as examples. Given that these add-on protection benefits appear to have been successfully brought under the CFPB's authority, add-on insurance and warranty products are the logical next step. Companies offering extended warranties on cars, gym equipment and similar higher-value consumer goods should be paying close attention to this line of enforcement actions by the CFPB because of their own connection to underlying consumer transactions. Arguably, the insurance companies flying closest to the flame are those already acting as vendors to covered persons or conducting activities covered by enumerated business laws.

Q: What are the trends to watch in regard to the CFPB enforcement actions?

The CFPB is still relatively new, and we are still discovering the extent of its authority, both actual and presumed. The easiest way to spot trends is to pay attention to every bulletin, enforcement action, press release and public statement emanating from the CFPB. All of these are disclosed publicly on the CFPB's website, http://www.consumerfinance.gov. While the exercise is somewhat like guessing where lightning might strike next, it is pretty easy to see enforcement trends as they are developing – in the kinds of products and companies in which the CFPB is taking an interest, the types of activities it finds particularly troublesome, the way in which it interprets the laws and regulations it is charged with enforcing, the measure and amount of penalties being collected, and the nature and degree of cooperation with other federal and state agencies.

In recent months, the CFPB has taken enforcement actions against companies engaged in a variety of industries for what it deems to be unlawful or deceptive acts or practices relating to consumer-facing activities in the areas of credit card terms, debt collection, marketing and advertising and business referrals. Generally, the CFPB has been considered to be more aggressive than predecessor agencies in the enforcement tools it chooses to use. Civil investigative demands, subpoenas, litigation and cross-agency referrals at both state and federal levels all are available to and commonly utilized by the CFPB.

And the stakes are higher. For non-culpable or negligent violations, the penalty may not exceed $5,000 for each day during which such violation continues. For reckless violations, the civil penalty may not exceed $25,000 for each day during which the violation continues. And for knowing violations, the civil penalty may not exceed $1 million for each day the violation continues. To date, the monetary penalties, restitution payments to consumers and other forms of monetary relief collected by the CFPB have totaled nearly $7 billion.

Q: What steps should insurance companies consider to minimize their risk of becoming the subject of an CFPB enforcement action?

First and foremost, a company should be vigilant and proactive. By the time a regulator discovers a company's problems and starts talking in terms of "bringing it into compliance", the company starts its negotiations from a position of weakness. When a company begins to observe an enforcement or policy trend, or even an "expression of concern" by the CFPB about a certain business practice, it should turn the magnifying glass inward to determine if it could withstand similar scrutiny by the CFPB or other regulators. If so, the challenge becomes one of identifying and isolating the source of concern, modifying policies, controls or procedures where necessary to correct the course of action, and taking whatever internal enforcement or remedial measures may be required to ensure the practice stops and any adversely impacted consumers are made whole. On a case-by-case basis, depending on the nature and extent of the problem identified and other important facts, self-reporting may be worth considering. A company should always want to get out in front of a known problem.

A company should also be attentive to its customers – paying attention to their experiences with your business, taking their complaints seriously and treating them the way every consumer should reasonably expect to be treated. Remember that the CFPB's primary objective is to protect consumers and its view of business and how it should be conducted is formed accordingly. For many companies, it is counter-intuitive to see themselves through the eyes of a consumer or a regulator charged with protecting the consumer, but that is what it must do. Every internal discussion about business practices that, if commenced or discontinued, may impact consumers should include regulator and consumer expectations and not only whether the proposed practice (or discontinuance of the practice) will be accretive to the bottom line. A savvy business lawyer can help his or her client find creative ways to balance the objectives of the business with the need to maintain compliance with the myriad applicable laws and regulations and yes, regulator and consumer expectations.

All of this presupposes that a company has a compliance program in place appropriate for its size, structure and risk profile. Any company that has not yet developed a compliance program, with both front-end compliance and follow-up auditing components, is likely to be vulnerable in any number of areas. A company can be as vigilant or customer-sensitive as it wants, but if there is no compliance framework in place to set company policy, to detect vulnerabilities before they become problematic, to address potential risks, to monitor the effectiveness of policies or controls and to enforce or remediate where necessary, regulatory trend-spotting will be of little value.

The Iran Sanctions Program: Is There Relief in Sight for Re/Insurers Under The Iran Nuclear Agreement?

By John C. Fusco

The U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) administers complex and comprehensive trade and financial sanctions against the Government of Iran. The Iran sanctions prohibit virtually all direct and indirect transactions involving Iran, the Government of Iran, persons who ordinarily reside in Iran, and entities either located in Iran or formed under Iranian law.

The Iran sanctions also prohibit the exportation, re-exportation, sale, or supply of goods to a person in a third country undertaken with knowledge or reason to know that the goods are intended specifically for supply, transshipment, or re-exportation — directly or indirectly — to Iran or the Government of Iran.

Although the Iran sanctions are broad, there are several well-developed exemptions, general licenses, and statements of licensing policy that permit U.S. businesses and persons to undertake transactions that would otherwise be prohibited. The sanctions targeting Iran are also unique because the secretary of the treasury and the president are authorized to target foreign persons and foreign financial institutions that do business with Iran by imposing secondary sanctions against them.

The historic Iranian nuclear agreement memorialized in the July 2015 Joint Comprehensive Plan of Action (JCPOA) is a landmark step towards reopening the Iranian market for Western businesses. While it provides limited exceptions to the prohibition on certain insurance and reinsurance contracts, widespread relief for the U.S. insurance and reinsurance industry remains unlikely in the near future. Re/insurers should therefore continue to screen new contracts and reexamine their compliance programs to avoid unintended violations of the Iran Sanctions Program going forward.

What are the U.S. sanctions?

U.S. sanctions cover a variety of purposes related to the country's internal and external affairs, ranging from weapons proliferation to human rights abuses within Iran to state sponsorship of terrorism and fomenting instability abroad. They target broad sectors as well as specific individuals and entities, both Iranian nationals and non-nationals who have dealings with sanctioned Iranians.

Financial/Banking: U.S. sanctions administered by the Treasury Department have sought to isolate Iran from the international financial system. Beyond a prohibition on U.S.-based institutions having financial dealings with Iran, Treasury enforces extraterritorial, or secondary, sanctions: Under the 2011 Comprehensive Iran Sanctions, Accountability and Divestment Act (CISADA), foreign-based financial institutions or subsidiaries that deal with sanctioned banks are barred from conducting deals in the United States or with the U.S. dollar. At the end of 2011, the United States prohibited importers of Iranian oil from making payments through

Iran's central bank, though it exempted a handful of countries that had made a "significant reduction" in their purchases. Other measures restrict Iran's access to foreign currencies so that funds from oil importers can only be used for bilateral trade with the purchasing country or to access humanitarian goods.

Oil Exports: Along with pressure on Iran's access to international financial systems, curtailing oil revenue has been the principal focus of the Obama administration as it stepped up pressure on nuclear nonproliferation. Prior to 2012, oil exports provided half the Iranian government's revenue and made up one-fifth of the country's GDP; its exports have been more than halved since. Extraterritorial sanctions target foreign firms that would provide services and investment related to the energy sector, including investment in oil and gas fields, sales of equipment used in refining oil, and participation in activities related to oil export, such as shipbuilding, ports operations, and insurance on transport. CISADA and related executive orders expanded restrictions that predated nuclear concerns.

Asset freezes and travel bans: Following the September 11, 2001, terrorist attacks, the United States froze the assets of entities determined to be supporting international terrorism. This list includes dozens of Iranian individuals and institutions, including banks, defense contractors, and the Revolutionary Guard Corps (IRGC). The IRGC's elite paramilitary Quds Force has been sanctioned for destabilizing Iraq and abetting human rights abuses in Syria for Iran's support of the government of Bashar al-Assad, and Syria's crackdown on that country's peaceful protest movement.

Additional Trade Sanctions: In addition to the trade and financial sanctions highlighted above, the United States and the European Union (EU) maintain sanctions that prohibit trade with Iran, including trade involving oil and other petroleum products and components that would assist Iran in the acquisition of chemical, biological, nuclear and other types of conventional weapons.

Congress provides the statutory basis for most U.S. sanctions, but it is up to the executive branch to interpret and implement them. While congressional legislation would be required to repeal these measures, the president, by citing "the national interest," has the authority to waive nearly all of them in whole or in part. Lifting terrorism-related sanctions would require the president to delist Iran as a state sponsor. The president is also able to hollow them out by removing individuals and entities from sanctions lists.

On July 14, 2015, Iran, the EU and the P5+1 (the United States, United Kingdom, France, China, Russia and Germany) reached a historic deal for Iran to wind down its nuclear program in exchange for sanctions relief. This agreement has been memorialized in the JCPOA. The JCPOA does not provide any immediate sanctions relief to Iran; instead, U.S. and EU sanctions will be withdrawn in a phased manner, based on Iran achieving certain nuclear milestones. The first phase of sanctions relief will take place when the International Atomic Energy Agency (IAEA) verifies that Iran has completed certain decommissioning steps relating to its nuclear weapons program. Further sanctions relief will follow based on the IAEA providing confirmation that Iran is complying with the JCPOA. Sanction relief will not be immediate and it will be a number of months before the first stage of U.S. and EU sanctions relief is implemented; however, the JCPOA is a landmark step towards reopening the Iranian market for Western businesses.

How does the JCPOA impact financial institutions such as insurers and reinsurers?

The Iranian Financial Sanctions Regulations define "U.S. financial institutions" to include: depository institutions, banks, savings banks, money service businesses, trust companies, insurance companies, securities brokers and dealers, commodities exchanges, clearing corporations, investment companies, employee benefit plans, and U.S. holding companies, U.S. affiliates, or U.S. subsidiaries of any of these entities. Covered institutions include those branches, offices, and agencies of foreign financial institutions that are located in the United States.

The sanctions prohibit the issuance of insurance policies and reinsurance contracts involving insurable risks subject to the sanctions program. This prohibits the collections of premiums from entities and potential individual insureds subject to the sanctions and claims cannot be adjusted or paid to the entities or individuals subject to the sanctions. Insurers and reinsurers must review policies and contracts as sanctioned individuals may be a party to the insurance transaction in a number of ways including: insureds and additional insureds; payers of the premium; beneficiaries; intermediaries and administrators; third party liability claimants; loss payees and banks or other financial institutions as lien holders or parties to the routing of payments or the place of deposit for the beneficiary. In short, every step of the policy and reinsurance contract must be reviewed to ensure that the Iran sanctions are not inadvertently violated.

The JCPOA has brought certain limited exceptions to the prohibition on insurance and reinsurance contracts. However, the exceptions are limited. The JCPOA will allow the U.S. and the EU to suspend sanctions on associated insurance and transportation services related to Iran's crude oil and petrochemical sales. To date, OFAC has issued limited waivers to non-U.S. persons and has not issued guidance clarifying the procedures for U.S. persons to obtain OFAC approval to provide insurance-related services.

Violations can be costly

Even unintentional violations may result in civil and criminal penalties. Any U.S. person who violates the sanctions may be subject to civil penalties of up to the greater of $250,000 or twice the transaction value, and criminal penalties for willful violations of up to $1 million and 20 years in prison. The value of the insurance transaction is typically measured by the premium or the claim amount. A single policy issued to an OFAC target could result in multiple violations due to the issuance of the policy, each subsequent receipt of the premium or the payment of the loss.

Compliance programs

Every insurer and reinsurer should consider putting in place a set of internal controls and developing a written compliance program to avoid OFAC violations. The programs must contain a thorough and continuous risk assessment of the insurers' business and take into account the geographic region and activities. The insurer should appoint an OFAC Compliance person to run OFAC screens and handle OFAC issues for the company. Regular training of employees, agents, reinsurance intermediaries and independent adjusters on updates to U.S. Sanctions and OFAC regulations must be mandatory. New policies must be screened against the OFAC sanctions and Specially Designated Nationals list to ensure that the potential insured is not a sanctioned entity. All policies currently in effect must be screened on a regular basis to screen current insureds who may become a sanctioned party. Finally, insurers and reinsurers must use policy exclusions to limit exposure in the event a policy provision would cover a prohibited transaction. By following these steps, insurers and reinsurers can avoid unintended and costly violations.

Allocation of Covered and Uncovered Claims: Recent Decisions on Burden Shifting and Pre-Approval Requirements

By Kelly Sinner Biggins

Ongoing efforts by insurers to recover amounts paid for uninsured losses after settlement or judgment have resulted in extensive litigation over allocation issues. Conflicting opinions have arisen over which party bears the burden of establishing which portion of a settlement or judgment is attributable to covered versus uncovered losses.

Burden Shifting

The majority view finds the burden of proof lies with the policyholder to allocate between covered and uncovered claims.[1] However, courts will consider the facts and circumstances of each case to determine whether the burden should be shifted to the insurer.[2] Of particular importance is whether one party controls the pertinent information and litigation and/or is in a superior position to know about looming allocation issues.[3] Recent decisions have considered the following factors in determining the burden holder: (i) whether the right to allocate was set forth in a reservation of rights letter;[4] (ii) whether the policyholder was provided notice in writing of the need to allocate any potential settlement or judgment; (iii) whether the policyholder was advised of any potential divergent interests; (iv) whether the policyholder had knowledge of the import of allocating any potential settlement or the need to request a special verdict form that provides for allocation; (v) whether the insurer was actively involved in the settlement process; or (vi) whether the insurer took pro-active steps for the use of a special verdict form at trial.

These issues were considered in a recent construction defect action, *Uvino v. Harleysville Worcester Insurance Company*.[5] The homeowners (the Uvinos) sued the contractor (JBI) for construction defects and related claims, and JBI's insurer, Harleysville, agreed to defend under a reservation of rights.[6] Shortly before trial, Harleysville sought to intervene for the purpose of submitting special interrogatories to the jury (i.e., a special verdict form) to allocate between damages related to the repair and replacement of JBI's faulty work versus damages to other property.[7] Harleysville argued intervention was necessary because the "burdensome prospect of undertaking subsequent litigation to allocate covered damages favored allowing Harleysville to intervene to submit interrogatories at trial".[8] JBI opposed the motion, arguing that it would be prejudiced by confusion caused by the special verdict interrogatories.[9] JBI argued Harleysville faced no prejudice because it could resolve the coverage issues in a later proceeding.[10] The court denied Harleysville's intervention request and no party made any further attempt to submit special interrogatories to the jury.[11]

JBI moved to disqualify counsel provided by Harleysville, arguing that Harleysville's motion to intervene "revealed a conflict of interest because JBI's counsel could defeat liability for Harleysville without defeating liability for JBI."[12] The court granted JBI's motion to disqualify, which required Harleysville to hire independent defense counsel for JBI.[13]

At trial, a jury found JBI liable and awarded damages in favor of the Uvinos.[14] A general verdict was used and the court made no determination whether the losses were covered under the Harleysville policy.[15] Shortly thereafter, Harleysville disclaimed coverage and the Uvinos initiated an action seeking a judgment that Harleysville must indemnify JBI for the damages.[16]

Following a determination that the claims at issue may include claims covered under the Harleysville policy, the court considered

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[1] *See e.g., Perdue Farms, Inc. v. Travelers Cas. & Surety Co. of Am.*, 448 F.3d 252, 263 (4th Cir. 2006) ("[T]he burden is on the insured to prove the amounts attributable to covered claims"); *UnitedHealth Group Inc. v. Columbia Cas. Co.*, 47 F. Supp. 3d 863, 873-874 (D. Minn. 2014) (holding that the insured had the burden of proving what portion of a $350 million settlement, if any, was paid to settle covered claims and what portion was paid to settle uncovered claims); *Raychem Corp. v. Fed. Ins. Co.*, 853 F. Supp. 1170, 1176 (N.D. Cal. 1994) (holding the insured bears the prima facie burden to produce evidence that the settlement related to covered claims under the policy); *Nodaway Valley Bank v. Cont'l Cas. Co.*, 715 F. Supp. 1458, 1467 (W.D. Mo. 1989) *aff'd*, 916 F.2d 1362 (8th Cir. 1990); *State v. Allstate Ins. Co.*, 45 Cal. 4th 1008, 1036 (Cal. 2009); *Executive Risk Indem., Inc. v. Cigna Corp.*, 74 A.3d 179, 183 (Pa. Super. Ct. 2013) (insured bears burden of allocating settlement amount between covered and uncovered claims); *Comsys Info. Tech. Servs., Inc. v. Twin City Fire Ins. Co.*, 130 S.W.3d 181, 198 (Tex. App. 2003) ("Because the insured can recover only for covered events, the burden of segregating the damage attributable solely to the covered event is a coverage issue for which the insured carries the burden of proof."); *Mut. of Enumclaw Ins. Co. v. Dan Paulson Const., Inc.*, 169 P.3d 1, 10 (Wash. 2007) ("Absent a successful bad faith claim and the resulting coverage by estoppel, the insured 'still has the burden of proving how much of the [settlement] should be allocated to covered claims'").

[2] There are circumstances under which the burden can shift to the insurance company, such as when the insurer appointed counsel to defend the policyholder and failed to ensure use of a special verdict form (which requires a jury to answer specific questions and breaks down the judgment) to help guide the allocation process (*see e.g., Duke v. Hoch*, 468 F.2d 973 (5th Cir. 1972); *World Harvest Church v. Grange Mut. Cas. Co.*, No. 13AP-290, 2013 WL 6843615, at *4 (Ohio Ct. App. Dec. 24, 2013) (holding that burden to allocate shifted to insurer where policyholder was represented by both insurer-appointed counsel and personal counsel, insurer failed to advise policyholder about the specific apportionment issue, and insurer-appointed counsel did not seek special verdict allocating claims)), or when the insurer breached a duty to defend (*see e.g., Am. Med. Response Nw., Inc. v. ACE Am. Ins. Co.*, 31 F. Supp. 3d 1087, 1097-98 (D. Or. 2014) (stating that as a general matter, the burden is on the insured to allocate, but noting certain circumstances where insurer may be required to shoulder the burden such as if the insurer breached a duty to defend); *Narragansett Elec. Co. v. Am. Home Assurance Co.*, 999 F. Supp. 2d 511, 522 (S.D.N.Y. 2014) ("When a party is found liable for breach of the duty to defend, the general rule in Massachusetts is that the insurer is liable for all defense costs and, in the event a claim is covered, the entire resulting judgment or settlement, unless the insurer can prove the allocation among covered and uncovered claims."); *Automax Hyundai South LLC v. Zurich Am. Ins. Co.*, 720 F.3d 798, 806 (10th Cir. 2013)). There are also cases where the burden can shift from the insurer back to the insured. *See e.g., TIG Ins. Co. v. Premier Parks, Inc.*, No. Civ.A.02C04126, 2004 WL 728858, at *7 (Del. Super. Ct. Mar. 10, 2004) (unpublished) (defending insurer who fails to seek a damages allocation will bear initial burden of showing that a lump-sum verdict represents damages for uncovered claims, but when the insurer meets this burden, the burden shifts to the policyholder to prove what portion of the verdict represents damages for covered claims).

[3] For example, when a policyholder controls the underlying litigation and negotiates the settlement, it is in a better position to know how the parties valued claims and it can also shape the record on the issue of allocation. *See e.g., UnitedHealth Group, Inc. v. Columbia Cas. Co.*, 941 F. Supp. 2d 1029, 1036-37 (D. Minn. 2013); *Am. Med. Response Nw., Inc., v. Ace Am. Ins. Co.*, 31 F. Supp. 3d 1087, 1098 (D. Or. 2014) ("As a party to the underlying settlements, [the policyholder was] in the best position to know the bases for settlements in the underlying cases. Therefore, [the policyholder had] the burden to prove the underlying settlements were for covered claims.").

[4] Some states hold that the right to allocate is waived if it is not included in a reservation of rights letter.

[5] *Uvino v. Harleysville Worcester Ins. Co.*, No. 13 Civ. 4004, 2015 WL 925940 (S.D.N.Y. Mar. 4, 2015.)

[6] *Uvino*, 2015 WL 925940, at **1-2.

[7] *Uvino*, 2015 WL 925940, at *2.

[8] *Uvino*, 2015 WL 925940, at *2.

[9] *Uvino*, 2015 WL 925940, at *2.

[10] *Uvino*, 2015 WL 925940, at *2.

[11] *Uvino*, 2015 WL 925940, at *3.

[12] *Uvino*, 2015 WL 925940, at *3.

[13] *Uvino*, 2015 WL 925940, at *3.

[14] *Uvino*, 2015 WL 925940, at *3.

[15] *Uvino*, 2015 WL 925940, at *3.

[16] *Uvino*, 2015 WL 925940, at *3.

the allocation issue.[17] The court stated that the "insured generally has the burden of identifying covered damages", but noted the burden "may be shifted to the insurer" if, for instance, "the insurer did not adequately make known to the insured the availability and desirability of receiving a special verdict, or if it is not clear that the insured was apprised its interest in receiving a special verdict".[18]

The court concluded that Harleysville, by its actions, did not cause the burden to shift to it: "Harleysville, which moved to intervene for the purpose of requesting special interrogatories to forestall a coverage-allocation dispute and therefore made known both the availability of the interrogatories and the parties' divergence of interests, did not fail in its fundamental responsibilities to its insured such that the burden of proving allocation should shift to Harleysville."[19] Nevertheless, the court concluded that, although the Uvinos failed to identify covered damages within the jury award at the trial stage, Harleysville was not entitled to summary judgment because of the possibility that "the parties or court relied on Harleysville's statements regarding the expectation that an allocation trial would ensue in the absence of special verdict".[20] As such, the court held that the Uvinos could proceed with a post-verdict allocation proceeding at which they retained "the heavy burden of adducing proof competent to 'establish in the mind of the factfinder a reasonable certainty that damages … awarded by the jury flow naturally from the cause of action established under the policy of coverage.'"[21]

The court in *Transched Systems Limited v. Federal Insurance Company* also considered the burden associated with allocation of covered and uncovered claims.[22] In *Transched*, a judgment creditor brought an action against a judgment debtor's liability insurer, seeking a declaration that the insurer was required under the debtor's policy to pay a jury award against the debtor insured.[23] In considering cross-motions for summary judgment, the court considered the majority rule that the burden rest with the insured, but stated that the burden "arises only after it has been demonstrated that a portion of the verdict or settlement is covered by the policy or policies and a portion is not."[24] The court further stated that "where a suit contains the potential for both covered and uncovered claims, the insurer has a duty to inform its insured that allocation in the form of a special verdict is available and potentially advisable."[25]

In reviewing the relevant facts, the court determined that there was no evidence in the underlying action one way or another that the insurer discussed allocating through a special verdict form, that the insured did not propose an allocated verdict form, and that the third party judgment creditor did propose a special verdict form that asked the jury to allocate damages to each claim but was not successful in persuading the Delaware court to use it.[26]

Based on these facts, the court noted that "it is not necessarily in the insurance company's best interest to have an allocated verdict where there are covered and uncovered claims", particularly where it is the insurer's position that it is the insured's burden to allocate.[27] If there is no allocation, the court stated, the insurance company can argue that the insured failed in its burden.[28] The court noted that this conflicting interest has caused other courts to place the duty on the insurer to inform its insured that it should consider a special verdict form asking the jury to allocate the damages.[29] The court ultimately concluded that the insured's failure to request a special verdict, under the representation and advice from counsel paid by its insurance company, could not shift the burden to allocate the damages award post-verdict on the third-party judgment creditor.[30]

Upon determining that the third party creditor was relieved of the burden to allocate, the court was then faced with how the jury's damages award should be apportioned. The court noted that, "[i]ronically, the case law tells us that apportionment is a question of fact to be decided at trial".[31] However, since the court stated that there had been "much litigation" already, the court did not believe more was necessary, especially since evidence at an apportionment trial would be from the underlying suit at which the third party creditor already prevailed.[32] The court aptly noted that the "very uneconomical concept of litigating facts in multiple trials is the reason why apportionment of either a settlement or verdict 'between covered and non-covered claims is typically resolved through negotiation and private agreement, rather than litigation, as litigation costs can be astronomical".[33] For this reason, the court ordered the parties to mediate the allocation amount.[34]

Based on these cases, the issuance of a reservation of rights letter, without anything more, can be insufficient to protect an insurer from the shifting burden.[35] Rather, an insurer should take pro-active steps to ensure the policyholder is on notice of allocation issues and aware of the need to take certain actions to allocate a settlement or request a special verdict form to allocate a judgment at trial.

Pre-Approval of Proposed Allocations

Although apportionment may best be resolved through negotiation or private agreement, recent rulings indicate reluctance by courts to prematurely "greenlight" or pre-approve proposed allocations. However, this issue must be balanced with the reluctance of some courts (and the difficulty) to allocate after settlement or verdict. As such, the timing in which any request for allocation may be made is important.

Generally, insureds do not have the option of forcing the insurer to join the underlying litigation. Rather, issues concerning insurance coverage are typically addressed in separate declaratory relief actions, which can be filed concurrently with the underlying action, but are often stayed in the event the litigation of the declaratory judgment action has any prejudicial effect on the insured's defense of the underlying action.

In one California case brought by an insured against subcontractors and insurers, the insured asserted a cause of action against the

[17] *Uvino*, 2015 WL 925940, at **4, 7-8.
[18] *Uvino*, 2015 WL 925940, at *7.
[19] *Uvino*, 2015 WL 925940, at *8.
[20] *Uvino*, 2015 WL 925940, at *7.
[21] *Uvino*, 2015 WL 925940, at *8.
[22] *Transched Sys. Ltd. v. Fed. Ins. Co.*, 67 F. Supp. 3d 523 (D.R.I. 2014).
[23] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 525-526.
[24] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 533 (quoting *Cont'l Cas. Co. v. Canadian Universal Ins.*, 924 F.2d 370, 376 (1st Cir. 1991)).
[25] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 533 (citing *Duke v. Hoch*, 468 F.2d 973, 979-980 (5th Circ. 1972)).
[26] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 533-534.
[27] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 533-534.
[28] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 534.
[29] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 533-534 (citing *Duke v. Hoch*, 468 F.2d 973 (5th Cir. 1972)).
[30] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 534.
[31] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 534.
[32] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 534.
[33] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 534.
[34] *Transched Sys. Ltd.*, 67 F. Supp. 3d at 534.
[35] Courts have held that issuance of a reservation of rights letter, without anything more, was insufficient to protect the insurer from the shifting burden. *See e.g., TIG Ins. Co. v. Premier Parks, Inc.*, No. Civ.A.02C04126, 2004 WL 728858, at **7-8 and n.50 (Del. Super. Ct. Mar. 10, 2004) (reservation of rights letter generally indicating that certain claims may fall outside the coverage grant or be excluded from coverage not enough to protect insurer from shifting burdens); *see also Duke v. Hoch*, 468 F.2d 973, 979 (5th Cir. 1972).

defendant insurance companies seeking a declaration of rights and obligations related to a dispute over allocation of the defense fees and costs of the insured between the insurer defendants and subcontractor defendants.[36] The insured sought for the court "to determine the formula for allocation and not just a determination of an actual and present dispute concerning an insurer's duty to allocate and/or a duty to pay for fees and costs incurred by an insured".[37] However, since the determination of how to allocate was "entirely contingent on the resolution of the related construction defect cases by settlement or judgment determining the allocation of responsibility for the claimed defects and the amounts incurred for the defense against a case that has reached a final judgment or settlement", the court determined the cause of action was premature because it improperly sought an advisory opinion as to how to allocate both the present and future defense costs incurred in defending against the pending construction defect claims/actions.[38]

Additionally, courts will typically allow the insurer to participate in the allocation process and will not issue advisory opinions on allocation in the insurer's absence. For example, a court in the District of New Jersey recently denied an insured's motion for partial summary judgment against its insurer where the motion sought a ruling on the effect of a provisional settlement governing allocation of covered-versus-uncovered losses reached between the insured and a third party.[39] The insured sought judgment that the provisional settlement agreement regarding the allocation between the insured and uninsured portions of loss would be binding.[40] In essence, the insured asked the court for a "greenlight to move forward in its settlement" with the third party and for assurance that the agreement would lead to favorable circumstances for its signatories.[41] The court denied the motion as seeking an advisory opinion and because it sought an endorsement of the insured's and the third party's allocation of covered-versus-uncovered losses, which implicated disputes between the insured and insurer, and would require factual development in order to be resolved.[42]

Further, the case of *TIG Insurance Company v. Premier Parks, Inc.*, which held that the insurer's conduct prevented its right to seek a post-settlement allocation, exemplifies the importance of the timing of a request to allocate (as well as the need for pro-active involvement by an insurer).[43] In that case, TIG sought a declaration that either no coverage was available for any of the claims asserted against its insured or, in the alternative, that the court should allocate the general damages award from the underlying action against the insured between covered and non-covered claims based on the evidence adduced from trial.[44]

In rejecting TIG's request, the court noted TIG's failure to direct the attorneys TIG engaged to defend its insured to draft appropriate jury interrogatories to allocate damages as between covered and uncovered claims.[45] The court concluded that it could not "reasonably be expected to perform a post-verdict allocation of damages as between covered and uncovered claims when the record provides little, if any, evidence of the jury's methodology in reaching its damages awards."[46] The court further held that it was not satisfied that further proceedings would "illuminate a record darkened by ambiguity" and that the jury's verdict could not be "dissected beyond what appears on the face of the verdict sheet because TIG did not, when it had the chance, provide the jury with the opportunity to explain itself."[47]

These examples reiterate the courts' inability to issue advisory opinions and demonstrate the reluctance by some courts to pre-approve potential allocations where underlying facts remain at issue or where the allocation is not agreed to by both the insured and its insurer. Whether the time for allocation may or may not be "ripe", however, should not factor into any decisions by an insurer to expeditiously reserve its rights for an allocation and notify the policyholder in writing about the need for a special verdict or allocated settlement or to take affirmative steps to procure an allocated verdict or settlement (such as seeking intervention to request a special verdict form or initiating a declaratory relief action).[48]

Conclusion

In sum, determining the scope of covered versus uncovered losses is a complex, fact-based issue. When dealing with "mixed" cases involving potentially covered and uncovered losses and potential allocation issues, insurers should be aware that reservation of rights letters, on their own, may not provide protection against failing to prevent a general verdict or allocation of a settlement and the corresponding consequences. Instead, insurers should pro-actively enforce reservation of rights letters by communicating in writing with policyholders about allocation issues including, specifically, whether certain actions need to be taken to request an allocation of a settlement or a special verdict form at trial, advising the insured of potential divergent interests and, if necessary, taking steps to procure an allocated settlement or special verdict. Such pro-active steps may prove critical to preventing the burden to allocate from residing with the insurer.

[36] *Centex Homes v. Adland Venture*, No. PC-20130353, 2015 WL 4282412 (Cal. Super. Ct. Mar. 6, 2015) (trial order).
[37] *Centex Homes*, 2015 WL 4282412, at *4.
[38] *Centex Homes*, 2015 WL 4282412, at *4.
[39] *Nat'l Mfg. Co. v. Citizens Ins. Co. of Am.*, No. 13-0314, 2015 WL 1735423 (D.N.J. Apr. 15, 2015) (unpublished).
[40] *Nat'l Mfg. Co.*, 2015 WL 1735423, at *3.
[41] *Nat'l Mfg. Co.*, 2015 WL 1735423, at *3.
[42] *Nat'l Mfg. Co.*, 2015 WL 1735423, at **2-3.
[43] *TIG Ins. Co. v. Premier Parks, Inc.*, No. Civ.A.02C04126, 2004 WL 728858, at **1, 7-8 (Del. Super. Ct. Mar. 10, 2004) (unpublished).
[44] *TIG Ins. Co.* at *1.
[45] *TIG Ins. Co.* at **1-2.
[46] *TIG Ins. Co.* at *1.
[47] *TIG Ins. Co.* at *7.
[48] Keep in mind that special verdict questions may not be able to resolve all coverage issues. For example, coverage may turn on policy language or an issue that has no relevance to the underlying lawsuit.

ACCOLADES

- **Nick DiGiovanni** (*Chicago*) was named Lawyer of the Year by Best Lawyers in America® 2016 in Insurance Law. **Jonathan Bank** (*Los Angeles*), **Christopher Barth** (*Chicago*), **Jon Biasetti** (*Chicago*) and **Bill Kelty** (*Washington DC*) were also listed in Best Lawyers in America® 2016 for Insurance Law. **More >>**
- **Rob DiUbaldo** (*New York*) has again been recognized as a "Rising Star" in the areas of insurance, civil litigation and alternative dispute resolution by New York's and New Jersey's Super Lawyers' publication. **More >>**

ARTICLES & QUOTES:

- "**A Guide for Insurers on Creating and Maintaining a Cybersecurity Plan**," Bloomberg BNA Privacy and Security Law Report, August 24, 2015 – **Elizabeth Tosaris** (*San Francisco*) author.
- On August 11, Locke Lord's Privacy and Cybersecurity Group released the latest edition of its White Paper, "**Everyone's Nightmare: Privacy and Data Breach Risks**." The paper discusses legal and regulatory privacy, data security and breach notification developments, exposures presented by data breaches, privacy issues arising out of new technologies, recent major breaches and court decisions, and lines of insurance potentially impacted. **Click here to view the White Paper**.
- "Status of Insurance-Linked Securities Market," Business Insurance, August 2015 - **Albert Pinzon** (*New York*), quoted.
- "**CT Continuing Push to Attract Captives by Amending Laws**," FORC Journal, July 2015 - **Alan Levin** and **Aaron Igdalsky** (*both Hartford*), authors.
- We are happy to provide the 2015 edition of our **Excess and Surplus Lines Law Manual**. This edition reflects all of the pertinent changes in the surplus lines laws and regulations of the 50 states and U.S. territories during the past year. The manual is available at **http://surplusmanual.lockelord.com/** - **John Dearie** (*New York*), editor.
- "**The Limited Reach Of Pre-Answer Security Requirements For Unauthorized Insurers**," Mealey's Emerging Insurance Disputes, Vol. 20, #12 June 18, 2015 – **Thomas Bush** (*Chicago*), author.

PRESENTATIONS AND SPEAKING ENGAGEMENTS

- **Brian Casey** (*Atlanta*) is chairing the "State of the Service Contract Industry" session at the upcoming **GWSCA Second Annual Conference on Warranty & Service Contracts** taking place in Chicago from September 16-18. He will also be presenting "Private Equity Firm Transaction Primer for Service Contract Providers."
- **Laurie Kamaiko** (*New York*) is speaking at the upcoming **PLUS Cyber Liability Symposium** on September 17, 2015 in Chicago. The conference focuses on hot issues shaping the professional liability marketplace today. She will participate in a panel discussion on "Emerging Cyber Risks: Terrorism, Crime & Ransomware."
- **Ben Sykes** (*Chicago*) is speaking at the **PBM Oversight & Part D Audit and Medicare Advantage Compliance Summits** on September 24th. The session is entitled "Regulatory Update: Part D and PBM Oversight Mandates for 2016 and Beyond."
- **John Costello** (*Chicago*) and **Brian Casey** (**Atlanta**) are presenting "TCPA/DNC: The LIDMA Telemarketing Compliance Guide" at the **2015 LIDMA Annual Conference**, taking place September 27-29, 2015 in Nashville, TN.
- **Brian Casey** (*Atlanta*) will be moderating a panel entitled "Attracting Internal and External Investment to Extended Warranty Product Development" at the **6th Annual Extended Warranty & Service Contract Innovations Conference** in Nashville, TN on September 28-29, 2015. Locke Lord will also be sponsoring this conference.
- At the upcoming RESPRO Annual Regulatory Seminar taking place in Austin, Texas from September 28-30, **Molly McGinnis Stine** and **John Kloecker** (*both Chicago*) will be presenting "Everything Old is New Again – Cyber Risks and Risk Management Issues." **Tim Kemp** (*Chicago*) and **Al Bottalico** (*Los Angeles*) will also be presenting "Enterprise Risk Management: Getting Your House in Order." **More >>**
- **John Kloecker** (*Chicago*) will be speaking at **INSURETrust's 2015 Cyber Risk Management Boot Camp**, in Atlanta, on October 6, 2015. The panels will address Current Coverage Issues in Cyber Insurance and Regulatory Update.
- **Elizabeth Tosaris** (*San Francisco*) will be a panelist at the **Association of Insurance Compliance Professionals Annual Conference** in New Orleans on October 11-15, 2015. The panel will present "Taking Care of Business: Life, Annuity and Health."
- **Ted Augustinos** (*Hartford*) is moderating a panel entitled "When the Stakes are High: Solutions for Cyber and Terrorism Risks" at **The 2015 Symposium on Captive Insurance in Connecticut** taking place on October 15.
- Locke Lord will sponsor the cocktail reception at the **Reinsurance Association of America Re Claims Seminar** in New York on October 15-16, 2015. **Nick DiGiovanni** (**Chicago**) and **Robert DiUbaldo** (*New York*) will be facilitators in the KGM Re Case Study and **Jeanne Kohler** (*New York*) will present "Privilege Issues between Reinsurers & Insurers – What Is Discoverable?"
- **Denise Hanna** (*Washington DC*) and **Baird Allis** (*Chicago*) will be presenting "Evolving World of Payor and Provider Joint Ventures" during the **CAHP Conference** (California Association of Health Plans) on October 20, 2015 from 2:45 PM - 4:00 PM.
- **Jon Biasetti** (*Chicago*) will be a panelist at the **AHLA Institute for Health Plan Counsel** in Chicago on October 26-27, 2015. The panel will present "In It Together: Emerging Joint Venture Structures for Hospitals and Insurers."
- Matthew Furton and Julie Young will be participating in the 2015 ARIAS·U.S. Fall Conference and Annual Meeting and speaking on November 12th on the topic of "SCOTUS on Arbitration – Past and Future." **More >>**

EVENTS:

- **Molly McGinnis Stine** (*Chicago*) is attending the upcoming **PLUS Cyber Liability Symposium** on September 17, 2015 in Chicago.
- Locke Lord will sponsor the **Mortgage Bankers Regulatory Compliance Conference** in Washington, D.C. on September 20-22, 2015. **Timothy Kemp** (*Chicago*) will attend.
- Locke Lord LLP will sponsor and participate as an exhibitor at the **CEFLI Annual Meeting** in Orlando, FL September 16 - 18, 2015. **Paige Waters** (*Chicago*) is the affiliate member and will attend.
- Locke Lord will sponsor the **American Council of Life Insurers (ACLI) Annual Conference** in Chicago, IL on October 11-13, 2015. **Carey Barney** (*Los Angeles*) will attend.
- **Paige Waters** (*Chicago*) and **Elizabeth Tosaris** (*San Francisco*) will attend the **Association of Insurance Compliance Professionals Annual Conference** in New Orleans on October 11-15, 2015.
- Locke Lord is hosting a dessert reception at the **CAHP Conference** (California Association of Health Plans) at The Pointe at the JW Marriott Desert Springs on Tuesday, October 20, 2015 from 8:30-11:00pm. **Elizabeth Tosaris** (*San Francisco*) is attending and part of the planning for this event.
- Locke Lord will sponsor the **2015 Advisen Cyber Risk Conference** in New York, NY on October 20, 2015. **Laurie Kamaiko** (*New York*), **Ted Augustinos** (*Hartford*) and **Molly McGinnis Stine** (*Chicago*) will attend.
- Locke Lord will sponsor the **Fasano 2015 Life Settlement & Longevity Conference** in Washington, D.C. on November 2, 2015. **Brian Casey** (*Atlanta*) and **Robert Underhill** (*New York*) will attend.
- Locke Lord will co-sponsor with BDO and Sandler O'Neill the M&A RoundTable on November 11, 2015 at Locke Lord's New York midtown office on 750 Lexington Avenue.
- Locke Lord will host its popular cocktail reception in the upcoming **NAIC Fall National Meeting** in Washington, D.C. on November 19-22, 2015. Please join our colleagues for an exciting evening with cocktails & hors d'oeuvres.

ANNOUNCEMENTS:

- In August Locke Lord's **Paulette Brown** took over as American Bar Association (ABA) President for the next year. Paulette is the first woman of color elected to the top post in the organization's history. Paulette is a Labor and Employment Partner based in Locke Lord's Morristown (*New Jersey*) office and Co-Chair of the Firm's Diversity & Inclusion Committee, is nationally known for speaking out to eliminate bias in the U.S. legal system and for her fight against subtle racism, discrimination and small slights known as "micro-inequities." **More >>**

- **Alfred W. Bottalico** (*Los Angeles*), former deputy commissioner for the financial surveillance branch of the California Department of Insurance with 38 years of regulatory experience, has joined Locke Lord's global regulatory and transactional insurance practice group in Los Angeles as an insurance specialist. Mr. Bottalico has experience in all aspects of financial regulation and examination of insurance companies, including statutory accounting, auditing, and California Insurance Code requirements. He has been involved with the National Association of Insurance Commissioners ("NAIC") Solvency Modernization project since its inception, and has worked closely on the creation of the ORSA Model Law, ORSA Guidance Manual, the Corporate Governance Model Act, and amendments to the Model Holding Company Act.

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