1990

Insurance Law

Christopher Kerns
Partner, Sedgwick, Detert, Moran and Arnold, Chicago, IL

Gretchen Sievers

Follow this and additional works at: http://lawecommons.luc.edu/luclj

Part of the Insurance Law Commons

Recommended Citation
Available at: http://lawecommons.luc.edu/luclj/vol21/iss2/11

This Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in Loyola University Chicago Law Journal by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.
Insurance Law

Christopher Kerns*
and Gretchen Sievers**

TABLE OF CONTENTS

I. INTRODUCTION .................................................. 445
II. THE INSURER'S DUTY TO DEFEND AND
     INDEMNIFY .................................................. 446
     A. Effect of Policy Disclaimer of the Initial
        Permission Rule ........................................ 446
     B. Loading and Unloading Clauses ..................... 451
     C. The Pollution Exclusion ............................. 453
     D. Failure to File with the Illinois Commerce
        Commission a Certificate of Cancellation for
        Expired Policy ........................................ 458
III. LIABILITY INSURANCE ............................................ 461
     A. Definition of "Occurrence" ......................... 461
     B. Claims Made Requirements ......................... 465
     C. Excess Carrier's Liability for Post-Judgment
        Interest .............................................. 468
IV. HEALTH INSURANCE: ASSIGNMENT OF HMO
     BENEFITS .................................................. 470
V. THE PRIORITY STATUS OF SHAREHOLDERS IN THE
     LIQUIDATION PROCEEDINGS OF INSOLVENT
     INSURANCE COMPANIES ................................... 474
VI. LEGISLATION ................................................... 478
     A. Alien Insurers ....................................... 478
     B. Long-Term Care ..................................... 478
VII. CONCLUSION .................................................. 478

I. INTRODUCTION

This Article addresses the significant developments in Illinois insurance law. During the Survey year, the Illinois Supreme Court
considered issues relating to the effect of an insurer's disclaimer of the initial permission rule\textsuperscript{1} and insurance company liquidations.\textsuperscript{2} Illinois appellate courts resolved important issues regarding the meaning of "loading and unloading" for common carrier liability coverage purposes;\textsuperscript{3} the interpretation of the pollution exclusion in the comprehensive general liability policy as applied to third party polluters;\textsuperscript{4} and the obligations of an insurer whose policy is lapsed, but who has failed to file a certificate of cancellation with the Illinois Commerce Commission.\textsuperscript{5} Illinois appellate courts also considered the definition of "occurrence" in a liability policy;\textsuperscript{6} claims made requirements for reporting purposes;\textsuperscript{7} an excess carrier's liability for post-judgment interest;\textsuperscript{8} and the right of health care providers/assignees to recover payment from HMOs.\textsuperscript{9} Finally, the Illinois General Assembly passed legislation mandating that alien insurers maintain a deposit of assets within the State,\textsuperscript{10} and it added long-term health care within the classification of life or endowment insurance in the Insurance Code.\textsuperscript{11}

II. THE INSURER'S DUTY TO DEFEND AND INDEMNIFY

A. Effect of Policy Disclaimer of the Initial Permission Rule

Illinois' financial responsibility statute\textsuperscript{12} regulates taxicab drivers under the Illinois Vehicle Code.\textsuperscript{13} Under the statute, a taxicab

\begin{itemize}
\item 1. See infra notes 12-48 and accompanying text.
\item 2. See infra notes 261-83 and accompanying text.
\item 3. See infra notes 49-75 and accompanying text.
\item 4. See infra notes 76-109 and accompanying text.
\item 5. See infra notes 110-141 and accompanying text.
\item 6. See infra notes 142-78 and accompanying text.
\item 7. See infra notes 179-98 and accompanying text.
\item 8. See infra notes 199-222 and accompanying text.
\item 9. See infra notes 223-59 and accompanying text.
\item 10. See infra note 285 and accompanying text.
\item 11. See infra notes 285-86 and accompanying text.
\item 12. ILL. REV. STAT. ch. 95 1/2, para. 8-101 (1983). The Illinois financial responsibility statute provides, in pertinent part:

\begin{quote}
[The] surety of [a] bond shall provide for payment of each judgment by the owner of the motor vehicle . . . provided each said judgment shall have been rendered against such owner or any person operating the motor vehicle with the owner's express or implied consent, for any injury to or death of any person or for damage to property other than such motor vehicle, resulting from the negligence of such owner, his agent, or any person operating the motor vehicle with his express or implied consent. . . .
\end{quote}

ILL. REV. STAT. ch. 95 1/2, para. 8-104(2) (1983).

\item 13. Financial responsibility statutes are remedial laws which require proof of drivers' financial ability to cover potential liability. 12A G. COUCH, R. ANDERSON and M. RHODES, COUCH ON INSURANCE § 45.733 (2d ed. rev. 1981) [hereinafter COUCH]. Such statutes are intended to protect the public from loss by injury or death caused by the
company must obtain omnibus coverage for all its motor vehicles.\textsuperscript{14} In 1973, Illinois adopted the initial permission doctrine,\textsuperscript{15} which provides that when a named insured gives initial permission to another to drive the insured vehicle, the insured's policy will provide coverage to any subsequent driver.\textsuperscript{16} Under the initial permission doctrine, an insurer provides coverage even when the subsequent driver deviates from the scope of authority originally granted him by the insured, as long as the subsequent driver did not engage in theft or tortious conversion to gain access to the car.\textsuperscript{17} In \textit{American Country Insurance Co. v. Wilcoxon},\textsuperscript{18} the Illinois Supreme Court held that a surety may not exclude coverage under the terms of a surety bond issued pursuant to the Illinois financial responsibility statute regulating taxicab drivers when those terms are contrary to the initial permission doctrine.\textsuperscript{19} Thus, a private limiting contract, such as a surety bond, cannot negate the financial responsibility statute.\textsuperscript{20}

In \textit{Wilcoxon}, a cab company purchased a bond from American Country (the "surety") to comply with the Illinois financial responsibility statute.\textsuperscript{21} The taxicab company leased one of its cabs

\begin{itemize}
  \item negligence of an insured or the insured's agent, servant, or independent contractor.
  \item \textit{Id.} at 342, 297 N.E.2d at 167-68.
  \item \textit{Id.}
  \item \textit{Id.} at 241, 537 N.E.2d at 289.
  \item \textit{Id.} at 232, 537 N.E.2d at 285.
  \item \textit{Id.} at 232, 537 N.E.2d at 285. The bond provided that the surety could satisfy any judgment "resulting from negligence of such Owner/Principal[,] his agent, or any person operating the motor vehicle with his express or implied consent, in the penal sum of Two Hundred Fifty Thousand Dollars." \textit{Id.} The term "express or implied consent" was defined in an unsigned rider attached to the bond:

\begin{quote}
(c) \textit{Express or implied consent} is a motor vehicle described in this instrument which is being used with the express or implied consent of [the insured cab company] when it is being used by (i) an employee of [the insured cab company] while operating said motor vehicle in the course and scope of his employment; (ii) a lessee of [the insured cab company] while operating said motor vehicle pursuant to a written lease. This bond shall apply to any permittee [sic], sublessee, or bailee or an employee or lessee of [the insured cab company]. It is the specific [sic] agreement and intention of [the surety] and [the insured cab company] that the doctrine known as the Initial Permission Doctrine shall not apply (emphasis added).
\end{quote}

\textit{Id.} at 232-33, 537 N.E.2d at 285. The court noted that this definition was "nearly incomprehensible." \textit{Id.}
to a driver/lessee for a 24-hour period.\textsuperscript{22} Under the terms of the lease agreement, the cab company provided insurance coverage for both the driver and the cab company.\textsuperscript{23} The lease also provided that the lessee agreed to be the sole driver of the taxicab.\textsuperscript{24} Despite the terms of the lease, the driver gave possession of the leased cab to a third party.\textsuperscript{25} While the third party was driving the cab, he struck and injured a pedestrian, resulting in a personal injury suit brought by the pedestrian against both the cab company and the driver.\textsuperscript{26} The insured cab company provided notice of the personal injury litigation to the surety under the terms of the bond.\textsuperscript{27} The surety, however, disclaimed coverage under the terms of the bond for any judgment against the insured cab company because the third party driver was not the lessee who was permitted to drive the cab under the terms of the lease.\textsuperscript{28}

The surety subsequently filed a declaratory judgment suit against the pedestrian, the insured cab company and the third party (collectively, the "appellees"), alleging that it had no obligation to indemnify the insured cab company because the third party driver was not the original lessee.\textsuperscript{29} The surety argued that parties to an insurance contract specifically may avoid the initial permission rule.\textsuperscript{30} Further, the surety maintained that the bond clearly applied only to an employee or lessee of insured cab company operating pursuant to a written lease.\textsuperscript{31} Moreover, the lessor's transfer of possession of the rented cab to a person who was not the insured cab company's agent or employee was without the knowledge or consent of the insured cab company.\textsuperscript{32} Therefore, the surety maintained that the bond served notice that the initial permission doctrine would not apply.\textsuperscript{33}

The appellees contended that the initial permission rule applied to extend coverage to all successive drivers that operated a vehicle used in public transportation,\textsuperscript{34} and that an insurance company

\begin{itemize}
  \item \textsuperscript{22} Id. at 233, 537 N.E.2d at 285.
  \item \textsuperscript{23} Id. at 233, 537 N.E.2d at 285-86.
  \item \textsuperscript{24} Id. at 233, 537 N.E.2d at 286.
  \item \textsuperscript{25} Id.
  \item \textsuperscript{26} Id.
  \item \textsuperscript{27} Id. at 232, 537 N.E.2d at 285.
  \item \textsuperscript{28} Id.
  \item \textsuperscript{29} Id. at 231, 537 N.E.2d at 285.
  \item \textsuperscript{30} Id. at 235, 537 N.E.2d at 286.
  \item \textsuperscript{31} Id.
  \item \textsuperscript{32} Id.
  \item \textsuperscript{33} Id.
  \item \textsuperscript{34} Id.
\end{itemize}
may not contract away the application of the initial permission rule. Additionally, the appellees asserted that the Illinois financial responsibility statute mandates that restrictive terms in an insurance contract may not impair omnibus coverage.

The trial court granted summary judgment for the surety and held that the surety owed no duty to pay or indemnify the insured cab company under the terms of the bond. On appeal, the Illinois Appellate Court for the First District reversed. The appellate court held that the initial permission doctrine applied despite the lease provision forbidding the original driver to permit anyone else to drive the taxicab. In effect, the appellate court held that the insured cab company gave its constructive consent to the lessee to permit the third party to operate the cab.

In affirming the appellate decision, the Illinois Supreme Court held that parties to an insurance contract or surety bond cannot privately contract away obligations imposed by the financial responsibility statute. Therefore, cab owners and their sureties could not exclude successive cabdrivers from coverage. The majority reasoned that the plain requirements of the financial responsibility law reflected a legislative intent to compensate those injured through the negligence of cabdrivers who drive cabs owned by others. According to the court, the rationale underlying the initial permission rule is that an insurance contract is as much for the

---

35. *Id*. at 235, 537 N.E.2d at 287. The appellees relied on two Illinois Supreme Court decisions to demonstrate that an insurer could not exclude coverage through such a disclaimer. *See* United States Fidelity and Guar. Co. v. McManus, 64 Ill. 2d 239, 356 N.E.2d 78 (1976); Maryland Casualty Co. v. Iowa Nat'l Mut. Ins. Co., 54 Ill. 2d 333, 297 N.E.2d 163 (1973); *see also supra* note 12 (ILL. REV. STAT. ch. 95 1/2, para. 8-104(2)).


37. *Id*. at 234, 537 N.E.2d at 286.

38. *Id*. at 234-35, 537 N.E.2d at 286.

39. *Id*.

40. *Id*. The appellate court stressed that the importance of the financial responsibility statute transcended the private agreement between the surety and the cab company because the statute served to protect the public. *Id*. at 234, 537 N.E.2d at 286. According to the court, the insured cab company and the surety privately could not agree to diminish the effect of the Illinois statute in their private agreement because the Illinois legislature had codified the initial permission doctrine in the financial responsibility statute. *Id*. at 235, 537 N.E.2d at 286.

41. *Id*. at 241, 537 N.E.2d at 289. "The effect of a financial responsibility act may be to invalidate an exception contained in the policy, which would otherwise be valid, and thereby provide coverage which would otherwise not exist." *Couch, supra* note 13, at § 45.743.

42. *Wilcoxon*, 127 Ill. 2d at 241, 537 N.E.2d at 290.

43. *Id*. at 239, 537 N.E.2d at 288 (citing Stewart v. Industrial Comm'n, 115 Ill. 2d 337, 341, 504 N.E.2d 84 (1987); City of Springfield v. Board of Election Comm., 105 Ill. 2d 336, 341, 473 N.E.2d 1313 (1985)).
public's benefit as for that of the insured.\textsuperscript{44}

The court further reasoned that cab owners and their insurers would be able to avoid the workings of the financial responsibility statute if they were permitted to limit their statutorily imposed liability through terms of their insurance contract.\textsuperscript{45} The majority concluded that when a financial responsibility law requires insurance coverage, any provisions contained in a bond or policy that conflict with law are void, and the statute controls.\textsuperscript{46} Thus, the clause in the contract that negated the applicability of the initial permission doctrine was void because it conflicted with the financial responsibility law.\textsuperscript{47}

In \textit{Wilcoxon}, the divided Illinois Supreme Court advanced public policy arguments to provide indemnity protection for loss suffered by third parties. In accomplishing this result, the court negated the surety's attempt to circumvent the Illinois financial responsibility statute. The court expressed its unwillingness to permit parties to an insurance contract to deprive the public of the statutorily required indemnity protection. In protecting both the public

\textsuperscript{44} Wilcoxon, 127 Ill. 2d at 240, 537 N.E.2d at 289.

\textsuperscript{45} Id. at 241, 537 N.E.2d at 289.

\textsuperscript{46} Id. at 241, 537 N.E.2d at 289. \textit{See} COUCH, supra note 13, at § 45.738 (2d ed. rev. 1981) (when a policy is executed under a financial responsibility statute, provisions of the policy that conflict with the statute are void because the policy cannot operate to cut off the rights of injured third persons); Harper v. City Mut. Ins. Co., 67 Ill. App. 3d 694, 385 N.E.2d 75 (1st Dist. 1978) (approval of policy provision does not validate the provision if it violates statute); Bertini v. State Farm Mut. Auto. Ins. Co., 48 Ill. App. 3d 851, 362 N.E.2d 1355 (1st Dist. 1977) (statutes that are in full force when insurance policy is issued control, and conflicting policy provisions are void). Chief Justice Moran argued in the dissent that the majority incorrectly interpreted the initial permission doctrine. \textit{Wilcoxon}, 127 Ill. 2d at 244, 537 N.E.2d at 291 (Moran, J., dissenting). The dissent asserted that the majority used the 1973 \textit{Maryland Casualty} decision, which interpreted a private contract of insurance to interpret a statutory provision passed in 1957. \textit{Id.} As a result, by means of judicial legislation, the majority had raised the rule of contract construction recognized in \textit{Maryland Casualty} to substantive law. \textit{Id.} at 246, 537 N.E.2d at 292. Further, the dissent maintained that the Illinois legislature could not have intended that the financial responsibility statute would mandate the initial permission doctrine, because Illinois had not recognized that doctrine when the legislature passed the law in 1957. \textit{Id.}

\textsuperscript{47} Wilcoxon, 127 Ill. 2d at 241, 537 N.E.2d at 289. The clause is set forth \textit{supra} note 21. The court analogized the present case to a similar California case. \textit{Id.} at 241-242, 537 N.E.2d at 289-90 (citing Atlantic Nat'l Ins. Co. v. Armstrong, 65 Cal. 2d 100, 416 P.2d 801 (1966)). In \textit{Armstrong}, a car rental agreement limited use of rented cars to the lessee or his family or employees. \textit{Id.} A nonlessee driver was involved in an accident while driving the car with the lessee's permission. \textit{Id.} The insurer attempted to disclaim coverage under restrictive terms of the lease that limited coverage to certain classes of permissive users. \textit{Id.} The California Supreme Court held that the restrictive terms were invalid because they conflicted with California's Financial Responsibility Act. \textit{Id.} at 242, 537 N.E.2d at 290.
and insurance purchasers, the court reaffirmed that the insurers will not be permitted to frustrate the legislative intent behind financial responsibility laws by use of inconsistent policy provisions.48

B. Loading and Unloading Clauses

Liability policies on trucks and commercial vehicles frequently include clauses that provide indemnification for losses incurred resulting from "loading and unloading."49 Illinois courts have adopted the complete operations doctrine50 in interpreting the term of "loading and unloading" for liability purposes.51 Under this doctrine, the loading and unloading clause applies to any movement of the goods from the moment the insured possesses them until the insured delivers them to their destination.52 In *Merit Insurance Co. v. Parent Building Materials*,53 the Illinois Appellate Court for the First District considered whether, under the complete operations doctrine, an automobile liability insurance policy's loading and unloading clause provides coverage for an injury suffered one full day after completion of the unloading.54 The court held that the injury need not be contemporaneous with the unloading when negligence is involved.55

48. Id. at 241, 537 N.E.2d at 289-90. Cf. Bisco v. Liberty Mut. Ins. Co., 176 Ill. App. 3d 280, 530 N.E.2d 1163 (3d Dist. 1988), leave to appeal denied, 124 Ill. 2d 553, 535 N.E.2d 912 (1989). In Bisco, a delivery service purchased statutorily required insurance for its delivery van. Bisco, 176 Ill. App. 3d at 282, 530 N.E.2d at 1164. The insurance policy contained an unambiguous exclusion for damages incurred while the van was being repaired or serviced. Id. A body shop employee, who was driving the van to his employer's shop for repairs, struck a vehicle driven by the plaintiff. Id. The insurer denied coverage under the policy based on the vehicle repair exclusion. Id. The plaintiff urged the court to compel the insurer to provide coverage under various financial responsibility statutes. Id. Although the body shop employee had the insured's permission to operate the van at the time of the collision, the Illinois Appellate Court for the Third District held that use of the insured's van at the time of the accident did not fall within the purview of the financial responsibility statutes. Id. The court noted that at the time of the collision, the van was not being used in the business of transportation. Id. at 283, 530 N.E.2d at 1164. Thus, even though operation of the vehicle ordinarily would activate statutorily compulsory insurance provisions, the use of the van in this instance was outside the purview of the statutes. Id. at 283, 530 N.E.2d at 1165-66.

49. 6B J. APPLEMAN, INSURANCE LAW and PRACTICE § 4322 (Buckley ed. rev. 1979) [hereinafter APPLEMAN]. As with the construction of all clauses, the terms "loading" and "unloading" must be construed according to the ordinary and popular meaning of such terms. See generally 12 COUCH, supra note 13, at § 45.738.

50. 12 COUCH, supra note 13, at § 45:128. Any occurrence during or arising out of the process of unloading is covered. Id.


52. 12 COUCH, supra note 13, at § 45:128.


54. Id. at 967, 531 N.E.2d at 1016.

55. Id. at 969, 531 N.E.2d at 1017.
In *Merit Insurance Company*, the insured was a plasterboard supplier who had an insurance policy that provided comprehensive automobile liability and comprehensive general liability coverage.\(^{56}\) The insured sold and delivered sheets of plasterboard for use at a construction site.\(^{57}\) The insured's employees unloaded the plasterboard and left.\(^{58}\) A subcontractor suffered injuries when a stack of the plasterboard fell on him a day after it was delivered.\(^{59}\) Subsequently, the subcontractor filed suit against the insured, alleging that the insured improperly stacked the plasterboard sheets after delivery.\(^{60}\) The insured tendered the lawsuit's defense to its automobile liability insurance carrier, which accepted the defense under a reservation of rights.\(^{61}\) The insurer then filed a declaratory judgment suit, alleging that the insurance policy issued to the insured did not provide liability coverage for the occurrence.\(^{62}\)

The insurer argued that it had no duty to indemnify the insured because the incident did not occur during nor did it arise out of the unloading, as the policy required.\(^{63}\) The insurer stressed that the insured had completed the unloading of the plasterboard one full day before the injury.\(^{64}\) In contrast, the insured maintained that the insurer should provide coverage because the insured's loading and unloading allegedly caused the subcontractor's injuries.\(^{65}\)

The trial court granted summary judgment in the insured's favor.\(^{66}\) The appellate court affirmed and held that the insurer should defend the insured under the "loading and unloading" clause.\(^{67}\) The appellate court explained that the accident must have occurred during and must be causally connected with the process of loading and unloading to come within the scope of a pol-

---

\(^{56}\)  *Id.* at 967, 531 N.E.2d at 1016. The auto liability portion of the policy contained the following endorsement:

The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of . . . bodily injury or . . . property damage to which this insurance applies, caused by an occurrence and arising out of the ownership, maintenance or use, *including loading and unloading*, of any automobile . . . .

\(^{57}\)  *Id.* at 966, 531 N.E.2d at 1016.

\(^{58}\)  *Id.*

\(^{59}\)  *Id.*

\(^{60}\)  *Id.*

\(^{61}\)  *Id.*

\(^{62}\)  *Id.* at 966-67, 531 N.E.2d at 1016.

\(^{63}\)  *Id.* at 967, 531 N.E.2d at 1016.

\(^{64}\)  *Id.*

\(^{65}\)  *Id.* at 966, 531 N.E.2d at 1016.

\(^{66}\)  *Id.* at 976, 531 N.E.2d at 1016.

\(^{67}\)  *Id.* at 969, 531 N.E.2d at 1018.
icy's "loading and unloading" clause. Illinois had never adopted a standard to apply to an allegation of a completed but negligent unloading. The court, however, followed a Louisiana case, which held that a court should inquire into whether the act causing injury was a part of the "unloading" process. Accordingly, the court concluded that the relevant inquiry was whether the negligent stacking was part of the unloading process.

The court stated that the complete operations doctrine requires a determination of whether the accident in question arose out of the defective delivery or would not have occurred but for that defective delivery. An injured party or the insured need prove only that the events giving rise to the claim arose out of the vehicle's use and were related to such use. Therefore, the injury did not have to be contemporaneous with the unloading. Although the injuries occurred one day after the insured had stacked the plasterboard, the court held that the insured was covered because the injury allegedly arose out of a negligent unloading.

Insurers will likely attempt to restrict policy terms in light of the court's expansive interpretation of the loading and unloading clause in Parent Building Materials. From the insurer's perspective, inserting the word "active" into the term "loading and unloading," or imposing a time restriction for coverage, might serve to accomplish the insurer's intent.

C. The Pollution Exclusion

In 1980, Congress passed the Comprehensive Environmental Response Compensation and Liability Act ("CERCLA").
CERCLA authorizes designated governmental agencies to clean up hazardous waste sites and surcharge "responsible parties." Once designated as either "responsible parties" or "potentially responsible parties" by the United States Environmental Protection Agency ("USEPA") under CERCLA, insureds have sought coverage from their comprehensive general liability insurers for environmental clean-up costs. Many insurers have disclaimed coverage under their policies by invoking the pollution exclusion, which is a standard exclusion in comprehensive general liability policies. The pollution exclusion excludes "coverage for damages that arise out of the discharge of irritants, contaminants, or pollutants into the air, water or land, except when the discharge is sudden and accidental." Courts in various jurisdictions have had difficulty in applying the pollution exclusion to environmental clean-up claims because of differing interpretations of the exclusion's language.

In United States Fidelity and Guaranty Co. v. Specialty Coatings Co., the Illinois Appellate Court for the First District considered whether an insurer has a duty to defend and indemnify for cleanup costs when the pollution was caused by third parties and when the comprehensive general liability policy contained a pollution exclusion. The court held that the pollution exclusion clause was ambiguous, and, as a result, the insured was obligated to provide coverage.

United States Fidelity and Guaranty (the "insurer") issued comprehensive general liability ("CGL") policies to Specialty Coatings Company, a producer of industrial coatings, and to Specialty Chemical Company, a manufacturer of sealants and adhesives (collectively, the "insureds"). The insureds tendered to the insurer the defense of three separate legal claims brought by governmental agencies seeking reimbursement for clean-up costs. Ostrager and Newman, Handbook on Insurance Coverage Disputes § 8.01 (2d ed. 1988) [hereinafter Ostrager & Newman].

Id. A responsible party can be held strictly liable for clean-up costs without regard to whether that party caused or contributed to the pollution problem if that party has either generated, transported, or exercised control over the hazardous waste. Id. Governmental suits seeking reimbursement for clean-up costs are regulatory, rather than suits for "damages." Id. at § 8.03[c][2].

Id. at § 8.01.

7A. Appleman, supra note 49, at § 4499.05.

Id.

Id.


Id. at 381, 535 N.E.2d at 1073.

Id. at 388, 535 N.E.2d at 1078.

Id. at 381, 535 N.E.2d at 1073.
entities arising out of environmental pollution.\textsuperscript{87}

The insurer denied coverage based on its pollution argument,\textsuperscript{88} declined to defend,\textsuperscript{89} and filed a declaratory judgment action against the insureds.\textsuperscript{90} The insurer argued that the pollution exclusion barred recovery for damages caused by a third party polluter.\textsuperscript{91} Aside from the pollution exclusion argument, the insurer maintained that the policy required it to defend “suits” only, and

\textsuperscript{87} \textit{Id.} The claims concerned alleged violations of State and federal environmental statutes resulting from the delivery to a recycler of industrial waste for disposal. \textit{Id.} The recycler disposed of the waste by open dumping at its property. \textit{Id.} Three separate claims were filed against the insureds, including:

1. The Attorney General of Illinois sought injunctive relief, alleging that the open dumping created a pollution hazard in violation of the Illinois Environmental Protection Act. \textit{ILL. REV. STAT.} ch. 1111/2, paras. 1012, 1021 (1987);
2. The United States Environmental Protection Agency (“USEPA”) issued a PRP (potentially responsible party) letter, notifying the insured that as a generator, it was potentially responsible for costs of cleaning up the waste disposal site under CERCLA. The USEPA did not file a complaint, but scheduled a meeting with the insured to discuss settlement; and
3. A third-party action against the insured concerning its contribution to chemical waste pollution of surface and below-ground water and soil at industrial waste sites in Gary, Indiana.


\textsuperscript{88} The pollution exclusion provided, in pertinent part:

This insurance does not apply . . . to bodily injury or property damage arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land, the atmosphere or any watercourse or body of water; but this exclusion does not apply if such discharge, dispersal, release or escape is sudden and accidental.

\textit{Id.} at 384, 535 N.E.2d at 1075.

\textsuperscript{89} The duty to defend language specified:

[T]he Company shall have the right and duty to defend any suit against the Insured seeking damages on account of such bodily injury or property damage, even if any of the allegations of the suit are groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient, but the Company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the Company’s liability has been exhausted by payment of judgments or settlements.

\textit{Id.} at 388-89, 535 N.E.2d at 1078.

\textsuperscript{90} \textit{Id.} at 381, 535 N.E.2d at 1073. The insurer alleged that no “property damage” had occurred, as defined by the policy. \textit{Id.} at 382, 535 N.E.2d at 1074. The policy provided that “[t]his insurance does not apply . . . to property damage to . . . [p]roperty used by the insured.” \textit{Id.} at 390, 535 N.E.2d at 1079.

\textsuperscript{91} \textit{Id.} at 384-85, 535 N.E.2d at 1075-76. The insurer urged the court to interpret the language “sudden and accidental” in the pollution exclusion as another division of the First District Appellate Court had done the previous year. \textit{Id.} at 386-87, 535 N.E.2d at 1076-77 (citing International Minerals and Chem. Corp. v. Liberty Mut. Ins. Co., 168 Ill. App. 3d 361, 522 N.E.2d 758 (1st Dist. 1988), \textit{leave to appeal denied}, 122 Ill. 2d 576, 530 N.E.2d 246 (1988). The \textit{International Minerals} court held that the pollution exclusion is inapplicable only when the discharge was unintended and unexpected and when the resulting dispersal of pollutants occurred abruptly. \textit{International Minerals}, 168 Ill. App. 3d at 375-76, 522 N.E.2d at 767-68. The \textit{International Minerals} court defined “accidental”
that the potentially responsible party ("PRP") letter was not the equivalent of a "suit." Further, the insurer asserted that "damages" were legal damages only and did not include injunctive relief, civil penalties, response costs or economic loss. Finally, the insurer argued that the insureds had not been sued for property damage as defined by the policy. Based on the above reasons, the insurer asserted that it was not required to provide coverage.

The insureds countered that the exclusionary language was ambiguous and did not specify whether coverage is provided only when the insureds actively caused the pollution. The insureds maintained that rules of construction required all policy ambiguities to be construed in their favor. The trial court agreed with the insureds and held that the insurer was required to provide coverage. The appellate court affirmed on several grounds.

First, the appellate court held that the pollution exclusion was ambiguous and therefore did not apply, regardless of whether the insureds were active polluters. The to mean the exclusion would not apply if the release of the pollution was unintended and unexpected by the insured. Id.


93. Specialty Coatings, 180 Ill. App. 3d at 390-91, 535 N.E.2d at 1079. The insurer maintained that the statutory schemes pursuant to which injunctive relief, cleanup and response costs were requested distinguish equitable relief from relief for pure property damage. Id. at 393, 535 N.E.2d at 1081 (citing Mraz v. Canadian Universal Ins. Co., 804 F.2d 1325 (4th Cir. 1986)).

94. Id. at 392-93, 535 N.E.2d at 1081.

95. Id.

96. Id. at 384-85, 535 N.E.2d at 1075-76.

97. Id. at 386, 535 N.E.2d at 1076.

98. Id. at 383, 535 N.E.2d at 1074.

99. Id. at 381, 535 N.E.2d at 1073.

100. Id. at 385, 535 N.E.2d at 1076. The court reviewed the underwriting history of the pollution exclusion and noted that the circumstances did not make clear whether the pollution exclusion was intended to apply to third party polluters. Id. Additionally, the court held that the pollution exclusion's "sudden and accidental" exception was a restatement of the definition of occurrence and should only serve to preclude coverage for damages which are expected and intended by the insured. Id. at 387-88, 535 N.E.2d at 1076-77. The court emphasized that the historical background of the pollution exclusion revealed that the insurance industry's underwriting intent was to clarify the definition of
court construed the policy language ambiguities against the insurer. The court emphasized that it would construe such ambiguities in light of the contract's main purpose, i.e., to provide coverage to the insureds. This is particularly true when ambiguities occur in an exclusion because insurers limit coverage through exclusions.

Second, the court held that the insurer was obligated to defend actions contemplated by a PRP letter. The "property used" exclusion did not serve to deny coverage just because the insureds did not own or conduct business on the contaminated property.

Finally, the appellate court held that the definition of "damages" was ambiguous to the non-legal community. Consequently, the term occurrence and exclude expected and intended damages. Id. at 387, 535 N.E.2d at 1077 (citing Pendygraft, Plews, Clark and Wright, Who Pays for Environmental Damage: Recent Developments in CERCLA Liability and Insurance Coverage Litigation, 21 IND. L. REV. 117, 154 (1988)).

101. Id. at 388, 535 N.E.2d at 1078. The court rejected the definition of "sudden and accidental" adopted in International Minerals, 168 Ill. App. 3d 361, 522 N.E.2d 758 (1st Dist. 1988); see supra note 91. Instead, the court held that the term "sudden and accidental" meant unexpected or unintended regardless of a specific period of time. Specialty Coatings at 387, 535 N.E.2d at 1077. The court distinguished International Minerals because the insured therein was charged with active polluting conduct; the insured in Specialty Coatings was not. Id. at 387, 535 N.E.2d at 1077.

102. Specialty Coatings, 180 Ill. App. 3d at 384, 535 N.E.2d at 1075. A comprehensive general liability policy was especially susceptible to such a construction because its purchaser presumably supposed it would provide broad coverages. Id.

103. Id.

104. Id. at 389, 535 N.E.2d at 1079. The court recognized that the USEPA's decision to seek first the insured's voluntary compliance did not eliminate the potential liability for cleanup costs and damages to be incurred. Id. The insured undertook voluntarily the same actions in responding to the PRP letter that it would have been required to undertake if the matter were in litigation. Id. See generally OSTRAGER & NEWMAN, supra note 77, at § 8.04[c][1].


106. Id. at 391-92, 535 N.E.2d at 1080 (citing Continental Ins. Co. v. Northeastern Pharmaceutical and Chem. Co., 842 F.2d 977, 986 (8th Cir. 1988), cert. denied, 109 S. Ct. 66 (1988)). Therefore, the court defined "damages" as "[t]he estimated reparation in money for detriment or injury sustained; compensation or satisfaction imposed by law for a wrong or injury caused by a violation of a legal right." Id. at 391-92, 535 N.E.2d at 1080 (citing WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 571 (rev. ed. 1986)).
Loyola University Law Journal [Vol. 21

was construed in the insureds' favor.107

Specialty Coatings, the first Illinois case to interpret the pollution exclusion as applied to third party or "innocent" polluters, is a triumph for insureds seeking coverage for environmental pollution. The court based its opinion on strong public policy considerations.108 The court was unwilling to deny coverage to an insured who was not an active polluter and whose only alleged connection to the polluting was hiring another company to dispose of its waste.109 To that end, the court employed a strategy of relying on extrinsic evidence to find ambiguity in every section of the policy in order to allow coverage.

D. Failure to File with the Illinois Commerce Commission a Certificate of Cancellation for Expired Policy

In 1973, Illinois law required insurers of common carriers to file proof of liability insurance coverage and certificates of cancellation with the Illinois Commerce Commission.110 The purpose of this requirement was to protect the public from uninsured common carriers.111 In Country Mutual Insurance Co. v. Millers National Insurance Co., the Illinois Appellate Court for the Fourth District considered whether an insurance company that did not file a required certificate of cancellation with the Illinois Commerce Commission for its expired policy must contribute to losses sustained by

---

107. Id. at 391, 535 N.E.2d at 1080.
108. For example, had the court ruled that PRP letters were not lawsuits, insureds might be encouraged to refuse to cooperate with the USEPA in order to provoke litigation and to obtain insurance coverage. Id. at 389, 535 N.E.2d at 1079.
109. In contrast, the insured in International Minerals, 168 Ill. App. 3d 361, 376, 522 N.E.2d 758, 768 (1st Dist. 1988), allegedly polluted by allowing toxic wastes from barrels on its own land to escape into the surrounding land and water. The Specialty Coatings court apparently was more inclined to find coverage for the "innocent" polluter, rather than the International Minerals "active" polluter. Specialty Coatings, 180 Ill. App. 3d at 385, 535 N.E.2d at 1077.
110. ILL. REV. STAT. ch. 95 1/4, para. 18-701 (1973). Section 18-701(a) provides, in pertinent part:

Security for the protection of the public

(a) No motor carrier of property shall operate any motor vehicle for which a certificate or permit is required by this Chapter unless it has on file with the Commission and in effect good and sufficient indemnity bonds or insurance policies . . . .

Id.
the current liability insurer.\footnote{Id. at 1013, 534 N.E.2d at 152.} The court held that an insurance company was not obligated to contribute simply because it did not file a certificate of cancellation for a lapsed policy.\footnote{Id. at 1017, 534 N.E.2d at 154-55.}

Millers National Insurance Company (the "first insurer") issued a policy of Truckers Liability Insurance to Fairview Cartage, a common carrier.\footnote{Id. at 1014, 534 N.E.2d at 153. The policy was in effect from May 31, 1973 to May 31, 1974. Id.} In compliance with the statutory requirements, the first insurer filed an unsigned certificate of liability insurance with the Illinois Commerce Commission.\footnote{Id. at 1015, 534 N.E.2d at 153.} The first insurer did not have any record demonstrating that the insured had renewed the policy and did not receive a premium after the policy's expiration date.\footnote{Id. at 1015, 534 N.E.2d at 153.} Eight years after the first insurer's policy expired, a vehicle leased to the previously insured common carrier was involved in a traffic accident.\footnote{Id. at 1015, 534 N.E.2d at 153.} At the time of the accident, the insured common carrier had a liability insurance policy in effect with Country Mutual Insurance Company (the "second insurer").\footnote{Id. The certificate contained details about the first insurer's policy. Id.} A person who had been injured in the accident filed suit against the insured common carrier, and the second insurer undertook the defense.\footnote{Id. The first insurer declined the tender because its policy was not in effect. Id.}

Once the second insurer learned of the first insurer's certificate of insurance, it unsuccessfully tendered the defense to the first insurer.\footnote{Id. The second insurer argued that the language in the certificate of insurance required an insurer to file a notice of cancellation before a policy will actually be cancelled. Id. at 1015, 534 N.E.2d at 153-54. The second insurer further alleged because the certificate of insurance on file with the Illinois Commerce Commission had not been cancelled, the first insurer's policy was still effective. Id. at 1015, 534 N.E.2d at 154. Therefore, the second insurer asserted that the first insurer was obligated to reimburse the second insurer for the amount it had expended in defense costs and settlement of the underlying action. Id.} Ultimately, the second insurer settled the suit against the insured common carrier for $925,000.\footnote{Id. at 1017, 534 N.E.2d at 154-55. Following the settlement, the second insurer filed a complaint for declaratory judgment against the first insurer. Id. The second insurer sought a declaration that the first insurer's policy was still in effect because the first insurer failed to file a notice of cancellation with the Illinois Com-
Thereafter, the first insurer filed a notice of cancellation of its policy with the Illinois Commerce Commission.123 The second insurer urged the court strictly to construe the statutory language.125 It argued that the first insurer's policy was still in effect because the first insurer had not cancelled the certificate of insurance on file with the Illinois Commerce Commission.126 Therefore, the second insurer maintained that the first insurer should reimburse it for the amount paid out in settlement of the underlying litigation as well as for its reasonable defense fees and expenses.127 The first insurer countered that coverage could not exist simply because it failed to file a notice of cancellation with the Illinois Commerce Commission.128 Further, the first insurer asserted that certificates of insurance do not create liability between insurance carriers but serve only to protect the public from the risk of uninsured common carriers.129

The trial court held that the second insurer had not shown that the first insurer had ever filed the unsigned certificate of insurance with the Illinois Commerce Commission.130 Moreover, even if the second insurer established the first insurer had filed the certificate, that filing alone would not grant the second insurer enforceable contract rights.131 The court noted that the second insurer issued its policy without relying on the first insurer's certificate of insurance.132 Thus, the late filing of the notice of cancellation could not create liability between the carriers.133

The appellate court affirmed and held that the first insurer was not required to reimburse the second insurer merely because a certificate of insurance was on file with the Illinois Commerce Commission.134 The court noted that although no one had filed a notice of cancellation, the underlying policy had lapsed several years

123. Id.
124. Id.
125. Id. at 1017, 534 N.E.2d at 155 (citing National Indem. Co. v. Pennsylvania Nat'l Mut. Ins. Co., 363 So. 2d 151 (Fla. Dist. App. 1978), cert. denied, 370 So. 2d 461 (Fla. 1979)).
126. Id. at 1015, 534 N.E.2d at 153-54.
127. Id. at 1015, 534 N.E.2d at 154.
128. Id. at 1016, 534 N.E.2d at 154.
129. Id.
130. Id.
131. Id.
132. Id.
133. Id.
134. Id. at 1017, 534 N.E.2d at 154-55.
before the accident.\textsuperscript{135} In contrast, the second insurer had an active policy with and had received premiums from the insured common carrier.\textsuperscript{136} Moreover, the second insurer issued its policy without relying on the uncanceled certificate.\textsuperscript{137} The existence of a certificate of insurance did not give any contract rights to the second insurer.\textsuperscript{138}

Accordingly, the court held that the second insurer would receive an undeserved windfall if the court allowed the second insurer to avoid losses it knowingly undertook to insure.\textsuperscript{139} In addition, the court stressed that one purpose of the certificate filing requirement was to protect the public.\textsuperscript{140} Here, the public was protected because there was never any time when the carrier lacked insurance.\textsuperscript{141}

In \textit{Millers National}, the court acknowledged that had the common carrier been uninsured at the time of the loss, the result in the favor of the first insurer would likely have been different. However, where the issue is contribution between insurers, the court will apply equitable principles to deny an undeserved windfall to the insurers who knowingly undertake to insure a risk without knowledge of or reliance upon a lapsed policy.

\section*{III. LIABILITY INSURANCE}

\subsection*{A. Definition of "Occurrence"}

In an occurrence policy, an insurer indemnifies its insured if the negligent act or omitted act occurs within the policy period, regardless of the date of discovery.\textsuperscript{142} The insurer determines the amount of coverage available under such a policy based in large part on the number of occurrences giving rise to an insured's liabil-

\begin{thebibliography}{9}
\bibitem{135} Id. at 1017, 534 N.E.2d at 155.
\bibitem{136} Id.
\bibitem{137} Id.
\bibitem{138} Id. at 1017-18, 534 N.E.2d at 155-56 (citing Insurance Co. of North Am. v. Morgan, 406 So. 2d 1227 (Fla. Dist. Ct. App. 1981), \textit{aff'd sub nom.} Canal Ins. Co. v. Ins. Co. of North Am., 424 So. 2d 749 (Fla. 1982)).
\bibitem{139} Id. at 1017, 534 N.E.2d at 155.
\bibitem{140} Id. (citing Johnson v. R and D Enter., 106 Ill. App. 3d 496, 499, 435 N.E.2d 1233, 1234-35 (1st Dist. 1982); Illinois Casualty Co. v. Krol, 324 Ill. App. 478, 481-82, 58 N.E.2d 473, 475-76 (1st Dist. 1944)).
\bibitem{141} Id. at 1018, 534 N.E.2d at 155-56. Finally, the appellate court asserted that this holding would not lessen the significance of the legislative purpose; rather, the holding only resolved a controversy over which of two insurers should be liable for an insured's losses. \textit{Id.} at 1017, 534 N.E.2d at 155.
\bibitem{142} 6B \textsc{Appelman}, \textit{supra} note 49, at § 4262.
\end{thebibliography}
In general, one set of occurrence policy limits, and one deductible, applies to each occurrence if all applicable policy terms and conditions are satisfied. Thus, the appropriate definition of "occurrence" is critical. In Mason v. Home Insurance Co., the Illinois Appellate Court for the Third District held that the term "occurrence" in an insurance policy referred to the cause of damages, rather than the relatedness of the individual claims.

In Mason, the insured owned and operated a restaurant. Over a three-day period in 1983, patrons of the insured ate sandwiches contaminated with botulinal toxin. The patrons showed signs of botulism poisoning approximately eleven hours after consumption of the tainted food. The injured patrons subsequently filed suit against the insured. At the time of the injuries, The Home Insurance Company of Illinois (the "primary insurer") provided the insured with primary business owner's coverage. The primary policy provided a $500,000 aggregate limit of liability. Additionally, the insured had excess liability insurance coverage through International Insurance Company (the "excess insurer"). The excess policy provided that the limit of liability coverage for each occurrence of personal injury liability, property damage liability, and advertising liability was $1,000,000. Additionally, the excess policy established a $1,000,000 aggregate limit for each annual period with respect to products hazard coverage.

143. OSTRAGER & NEWMAN, supra note 77, at § 704.
144. Id.
146. Id. at 461, 532 N.E.2d at 530.
147. Id. at 456, 532 N.E.2d at 527.
148. Id.
149. Id. at 462, 532 N.E.2d at 531.
150. Id. at 456, 532 N.E.2d at 527.
151. Id. at 456-57, 532 N.E.2d at 527. The primary policy was not at issue at the appellate level. Id. at 457, 532 N.E.2d at 527.
152. Id. at 458, 532 N.E.2d at 528.
153. Id. at 457, 532 N.E.2d at 527. The excess policy was the only policy in question at the appellate level. Id. at 457, 532 N.E.2d at 527. The excess policy defined "occurrence" as follows:

With respect to Coverage 1(a) and 1(b) 'occurrence' means either an accident or happening or event or a continuous or repeated exposure to conditions which unexpectedly and unintentionally causes injury to persons or tangible property during the policy period. All damages arising out of such exposure to substantially the same general conditions shall be considered as arising out of one occurrence.

154. Id.
155. Id. The excess policy defined "Products Hazard" as follows:
As a result of a coverage dispute with both insurers over the limits of liability, the injured patrons filed a declaratory judgment action to determine the amount of available coverage.\textsuperscript{156} The patrons argued that each sale and consumption of botulism-tainted food constituted a separate occurrence under the policy terms.\textsuperscript{157} Therefore, the patrons asserted that they were each entitled to up to $1,000,000 for injuries sustained.\textsuperscript{158} The patrons also argued that the aggregate limitation of the products hazard provision did not apply because the occurrence did not take place away from the premises.\textsuperscript{159} Rather, the patrons maintained that they suffered personal injuries on the premises at the moment that each of them consumed contaminated food items.\textsuperscript{160} The insurers, on the other hand, maintained that the various incidents of food poisoning constituted a single occurrence.\textsuperscript{161} Thus, regardless of the number of patrons injured, coverage was limited to $1,000,000.\textsuperscript{162} According to the insurers, the occurrence that gave rise to all the claims was the method in which the insured prepared the food.\textsuperscript{163} The insurers asserted that there was only one occurrence because all the patrons allegedly suffered injuries through exposure to the same conditions.\textsuperscript{164} Additionally, the excess insurer argued that the products hazard limitation applied and sought to limit recovery to the annual aggregate of $1,000,000, irrespective of the number of occurrences.\textsuperscript{165} The insured contended that it would be sheer speculation to conclude that the injuries occurred when the patrons ate the food at

\textsuperscript{1}[p]roducts hazard' means (a) the handling or use of or the existence of any condition in or a warranty of goods or products manufactured, sold, handled or distributed by the named insured or by others trading under its name, if the occurrence happens after possession of such goods or products has been relinquished to others by the named insured or by others trading under its name and if such occurrence happens away from the premises owned by, rented to or controlled by the named insured . . . .

\textit{Id.}

\textsuperscript{156} \textit{Id.} at 456, 532 N.E.2d at 527.
\textsuperscript{157} \textit{Id.} at 457-58, 532 N.E.2d at 527-28.
\textsuperscript{158} \textit{Id.} at 458, 532 N.E.2d at 528.
\textsuperscript{159} \textit{Id.}
\textsuperscript{160} \textit{Id.} at 459, 532 N.E.2d at 528. The patrons asserted that the language of the policy did not require a determination that all claims arose out of the same occurrence. \textit{Id.} at 459, 532 N.E.2d at 529. They argued that there was "no continuous or repeated exposure to conditions" contained in the policy's definition of "occurrence." \textit{Id.}
\textsuperscript{161} \textit{Id.} at 458, 532 N.E.2d at 528.
\textsuperscript{162} \textit{Id.}
\textsuperscript{163} \textit{Id.} at 459, 532 N.E.2d at 528.
\textsuperscript{164} \textit{Id.}
\textsuperscript{165} \textit{Id.} at 462, 532 N.E.2d at 530.
the insured's restaurant, because medical documents showed that the patrons did not exhibit symptoms of botulism poisoning until at least eleven hours after eating the tainted food. Accordingly, the insured argued that the patrons became ill away from the premises and that the products hazard provision applied.

Under one approach, the court determines the number of occurrences by referring to the cause or causes of damage, rather than to the number of individual claims or injuries. In deciding the declaratory judgment action, the trial court employed a cause approach to define "occurrence." The court held that all of the patrons' claims constituted a single occurrence. The trial court also held that all of the patrons' claims fell within the products hazards provision of the policies. On these bases, the trial court granted summary judgment for the insurers and denied the patrons' cross-motion for summary judgment.

The patrons appealed against the excess insurer only. The appellate court reversed and held that the patrons' claims did not arise out of a single occurrence. Instead, the insured's service of separate portions of tainted food to individual patrons resulted in multiple occurrences under the policy's definition. The insured could not be liable until it served the tainted food, which consti-

---

166. Id. at 462, 532 N.E.2d at 531.
167. Id.
168. Id. at 459-60, 532 N.E.2d at 529 (citing Michigan Chemical Corp. v. American Home Assurance Co., 728 F.2d 374 (6th Cir. 1984)).
169. Id. at 458, 532 N.E.2d at 528. The trial court determined that the cause of the injuries was the improper preparation of tainted food. Id. at 460, 532 N.E.2d at 528. As a result, the liability section of the primary policy restricted recovery to $500,000 and the liability section of the excess policy restricted recovery to $1,000,000 for all claims. Id. at 458, 532 N.E.2d at 528.
170. Id.
171. Id. For this reason as well, total coverage was limited to $500,000 in the primary policy and $1,000,000 in the excess policy. Id.
172. Id.
173. Id. The patrons did not contest the trial court's ruling that the primary policy limited coverage to $500,000. Id.
174. Id. at 459, 532 N.E.2d at 529. According to the appellate court, the circumstances did not present one continuous cause, but several separate acts. Each time the restaurant provided contaminated food to a different customer, additional exposure was created, constituting a separate occurrence. Id. The court analogized Mason to Michigan Chem. Corp. v. Home Assurance Co., 728 F.2d 374 (6th Cir. 1984). In Michigan Chemical Corp., an insured accidentally shipped flame retardants in bags that were identical to livestock feed bags. Id. at 376. Over 40,000 animals had to be destroyed after they had consumed the flame retardant. Id. The court of appeals held that each shipment constituted a distinct act from which liability arose. Id. at 383.
175. Mason, 177 Ill. App. 3d at 461, 532 N.E.2d at 530.
In Mason, the court acted to maximize insurance coverage in an effort to guarantee that injured parties would recover for their losses. Although it is unknown whether other districts will follow the Third District’s lead, courts may apply Mason to the environmental and toxic tort insurance cases now proliferating in the Illinois judicial system. The Illinois Supreme Court ultimately will be forced to address this significant coverage issue as conflicting opinions from other appellate districts are likely.

B. Claims Made Requirements

Under a “claims made” policy, an insurer must indemnify an insured for only those claims asserted within the policy period. Although the insurance industry has attempted to use plain English in its insurance policies to clearly communicate the terms of insurance policies to consumers, insurers have had difficulty in simplifying policy language, as was evident in St. Paul Insurance Company v. Armas. In Armas, the court held that it would consider the various terms and endorsements of the policy with other documents relating to coverage to determine the meaning of when a claim is made. Because several of the documents conflicted in

176. Id.
177. Id. at 463, 532 N.E.2d at 531. The parties agreed that for the purposes of the products hazard provision, “occurrence” referred to the suffering of bodily injury. Id. at 462, 532 N.E.2d at 530. The Mason court analogized to the decision of Zurich Ins. Co. v. Raymark Indus., 118 Ill. 2d 23, 514 N.E.2d 150 (1987). In Raymark, the Illinois Supreme Court determined that bodily injury occurs when asbestos fibers are inhaled and retained in the lung, rather than when asbestosis is detected. Id. at 45, 514 N.E.2d at 161.
179. Ostrager & Newman, supra note 77, at § 4.02[b][4]. Under a standard claims made policy, a claim is made when suit is filed against the insured. A. Windt, Insurance Claims and Disputes § 1.07 (2d ed. 1988). On the other hand, some policies provide that a claim is not made until notice of the lawsuit is given to the insurance company. Id. An insured’s failure to provide notice of the claim to an insurer within the policy period can result in a loss of coverage. Ostrager & Newman, supra note 77, at § 4.02[b][4].
180. Id. at 674-75, 527 N.E.2d at 924.
their interpretation of when a claim is made, the court could not construe the resulting ambiguities in favor of either party and remanded the case for further proceedings.\textsuperscript{182}

The case arose in January 1985, when St. Paul Insurance Company ("the insurer") issued a physician's professional liability claims made policy to an insured, which was purportedly written in plain English.\textsuperscript{183} The insured cancelled the professional liability coverage approximately eight months later.\textsuperscript{184} Although the insured's agent corresponded with him and offered to sell extended coverage on three separate occasions, the insured did not purchase such coverage, and termination of the policy was effective as of October 1, 1985.\textsuperscript{185}

\textsuperscript{182} Id. at 676, 527 N.E.2d at 925.

\textsuperscript{183} Id. at 670-71, 527 N.E.2d at 922-23. The policy was effective from January 15, 1985 to January 15, 1986, and had a retroactive date of January 15, 1983. Id. at 671, 527 N.E.2d at 922. The professional liability policy made reference to several provisions concerning when a claim is made:

\textit{When you're covered}

To be covered the professional service must have been performed (or should have been performed) after your retroactive date that applies. The claim must also first be made while this agreement is in effect.

\textit{When is a claim made?}

A claim is made on the date you first report an incident or injury to us or our agent . . .

\textsuperscript{Id. at 673, 527 N.E.2d at 923. The policy also contained provisions concerning when a claim should be reported to the insurer:

\textbf{WHAT TO DO IF YOU HAVE A LOSS}

\textit{Someone is Injured or Something Happens Which Can Result in A Liability Claim}

If there's an accident or incident covered under this policy you . . . must:

Tell us or our agent what happened as soon as possible. Do this even though no claim has been made but you . . . [are] aware of having done something that may later result in a claim.

\textsuperscript{Id. Additionally, the policy had an optional reporting endorsement provision which, if purchased, would provide coverage for a specified period of time after cancellation or nonrenewal of the policy:

\textit{Optional reporting endorsement}

Your professional coverage may end because one of us chooses to cancel or not renew it. If this happens, you have the right to buy an optional extension of coverage. It's called a reporting endorsement.

This reporting endorsement will cover: . . .

Claims that are first made or reported to us after the ending date of this agreement and before the reporting endorsement ends.

\textsuperscript{Id. at 675, 527 N.E.2d at 925. The policy, however, did not contain a definition section. "Loss" was not defined anywhere in the policy. \textit{Id. at 673, 527 N.E.2d at 923-24.}}

\textsuperscript{184} Id. at 671, 527 N.E.2d at 922.

\textsuperscript{185} \textit{Id. The insured signed a cancellation form that provided, in pertinent part: "No claims of any type will be made against the Insurance Company under the policy for losses which occur after the date of cancellation shown above." Id. at 674, 527 N.E.2d at 924.}
A third party filed a medical malpractice suit against the insured on August 7, 1985, while the policy was in effect. The malpractice plaintiff, however, did not serve the insured until March 31, 1986. On April 16, 1986, the insured reported the suit to his agent. The insurer declined coverage because the insured had not reported the claim during the policy period. The insurer then filed a declaratory judgment suit against insured and the medical malpractice plaintiff and requested that the court determine the rights and liabilities of the parties.

The trial court granted summary judgment to the insurer, holding that the insurer owed no duty to defend or indemnify the insured in the medical malpractice litigation. The insured appealed and argued that conflicting policy language, either standing alone or read together with the cancellation form and correspondence with his agent, created an ambiguity as to when a claim is made under the terms of the insurance policy. The insurer countered that the court should disregard the language of the cancellation form and correspondence between the insured and his agent and limit its interpretation of the insurance policy to the policy's four corners. The appellate court held that the policy contained ambiguities concerning when a claim is made and when an insured must report the claim to the insurer. Therefore, it reversed the trial court's order and remanded the case for further proceedings. The court reasoned that when an insurance contract consists of a policy and other documents executed as part of one transaction and accompanying the policy or incorporated by reference, the court must interpret the documents together to determine the meaning and effect of the contract. The court

186. Id. at 671, 527 N.E.2d at 922.
187. Id.
188. Id.
189. Id.
190. Id. at 671-72, 527 N.E.2d at 922-23.
191. Id. at 672, 527 N.E.2d at 923.
192. Id. at 673, 527 N.E.2d at 923.
193. Id. at 674, 527 N.E.2d at 924 (citing Susmano v. Associated Internists of Chicago, 97 Ill. App. 3d 215, 219, 422 N.E.2d 879, 882 (1st Dist. 1981)). The insurer also asserted that the language contained in the optional reporting endorsement applied to insurance coverage distinct from the policy. Id. at 675, 527 N.E.2d at 925. Therefore, the insurer argued that the language describing the endorsement should not be construed together with other conditions of the policy. Id.
194. Id. at 676, 527 N.E.2d at 925.
195. Id.
196. Id. at 674, 527 N.E.2d at 924 (citing J. M. Corbett & Co. v. Insurance Co. of North Am., 43 Ill. App. 3d 624, 357 N.E.2d 125 (1st Dist. 1976) (court will construe certificate of insurance and riders to policy together to determine meaning and effect of
praised the efforts of some insurance companies that attempt to write their policies in plain English.\textsuperscript{197} Despite these efforts, however, the court recognized that the ability to draft a policy in clear language is a deceptively complex undertaking.\textsuperscript{198}

Although it is appropriate for insurers to simplify their policy drafting, they should painstakingly undertake such drafting to assure consistency in the terms, conditions and exclusions in the policy documents. Insurers must carefully compare their marketing materials and other correspondence to prevent the result in \textit{Armas}. The case puts insurers on notice that the courts may look to all documents provided to an insured concerning coverage, including extraneous marketing correspondence, when interpreting a policy’s terms and conditions.

\textbf{C. Excess Carrier’s Liability for Post-Judgment Interest}

Insurers are regularly involved in disputes with each other over their respective responsibilities for all or a part of judgments in excess of the primary insurance limits.\textsuperscript{199} The insurers often argue over whether the insured was afforded a proper defense, whether the primary insurer properly handled the claim, or whether the primary insurer reasonably could have settled the matter prior to the judgment for an amount within its policy’s limits. In this \textit{Survey} year, the Illinois Appellate Court for the First District addressed whether the primary or excess insurer is responsible for

\textsuperscript{197} \textit{Armas}, 173 Ill. App. 3d at 676, 527 N.E.2d at 925. \textsuperscript{198} Id. \textsuperscript{199} Excess insurance is issued in the insurance industry with the expectation that the primary carrier will conduct the investigation, negotiation and defense of claims until its limits are exhausted. \textit{7c Appleman, supra note 49, at § 4682. An excess insurer is not liable for any part of the loss or damage which is covered by primary insurance; it is liable only for the amount of loss or damage in excess of the coverage provided by the primary policy or policies. \textit{16 couch, supra note 13, at § 62:48. An insurer’s excess policy may provide that its liability does not begin until the primary policy limits are exhausted. Id.}
Insurance Law

post-judgment interest accruing on that portion of the underlying judgment that exceeded the primary policy’s limit of liability.\textsuperscript{200} In \textit{Hartford Accident and Indemnity Co. v. Aetna Insurance Co.}, the Illinois Appellate Court for the First District held that primary insurance companies, not excess insurers, are responsible for post-judgment interest, unless a primary policy explicitly provides otherwise.\textsuperscript{201} In \textit{Hartford}, the primary insurer provided its insured, a cartage company, with automobile liability coverage in the amount of $1,000,000.\textsuperscript{202} Under the terms of its policy, the primary insurer provided that it would pay all interest that accrued after the entry of a judgment, in addition to its liability limits.\textsuperscript{203} The primary carrier’s obligation to pay interest would end when it had paid or tendered its policy limits.\textsuperscript{204} The excess insurer provided excess automobile liability insurance for the same period.\textsuperscript{205} Under the terms of the excess policy, the excess insurer stated that it would pay all interest that accrued after the entry of judgment until it had paid the limit of its liability.\textsuperscript{206}

A third party died in an automobile accident in which the insured was involved.\textsuperscript{207} Subsequently, the family of the decedent filed a wrongful death suit against the insured.\textsuperscript{208} A jury ultimately rendered a verdict against the insured in the wrongful death action.\textsuperscript{209} The judgment exhausted the primary policy limit and triggered the excess coverage.\textsuperscript{210} Both the insured and the decedent’s family cross-appealed the judgment.\textsuperscript{211} While the appeal was pending, the primary carrier entered into a partial settlement-partial satisfaction of judgment with the underlying plaintiff.\textsuperscript{212} The excess insurer also entered into a partial satisfaction with the underlying plaintiff.\textsuperscript{213} The excess insurer subsequently filed a complaint

\begin{itemize}
\item \textsuperscript{201} \textsuperscript{\textsuperscript{201}} \textit{Id.} at 668, 527 N.E.2d at 953.
\item \textsuperscript{202} \textit{Id.} at 667, 527 N.E.2d at 951.
\item \textsuperscript{203} \textit{Id.} at 667, 527 N.E.2d at 952.
\item \textsuperscript{204} \textit{Id.}
\item \textsuperscript{205} \textit{Id.} at 666, 527 N.E.2d at 951.
\item \textsuperscript{206} \textit{Id.} at 668, 527 N.E.2d at 952.
\item \textsuperscript{207} \textit{Id.} at 666, 527 N.E.2d at 951.
\item \textsuperscript{208} \textit{Id.}
\item \textsuperscript{209} \textit{Id.}
\item \textsuperscript{210} \textit{Id.}
\item \textsuperscript{211} \textit{Id.}
\item \textsuperscript{212} \textit{Id.} The primary carrier paid the underlying plaintiff $1,191,667, representing its policy limit plus accrued interest and minus the settlement discount. \textit{Id.}
\item \textsuperscript{213} \textit{Id.} The excess insurer paid $500,000, which was the amount of the judgment exceeding the primary policy, excluding accrued post-judgment interest. \textit{Id.}
\end{itemize}
against the primary carrier seeking a declaratory judgment on the issue of which insurer was responsible for the post-judgment interest.214 The excess insurer argued that the primary carrier should cover all post-judgment interest on that part of the judgment in excess of the primary insurer’s limits of liability.215

In resolving the declaratory judgment action, the trial court held that the primary insurer was relieved of the liability for all post-judgment interest because the insured had purchased excess coverage, which also provided for post-judgment interest.216 Thus, the trial court ordered the excess carrier to pay its pro rata portion of the interest.217 On appeal by the excess carrier, the first district reversed, holding that the primary carrier must pay the post-judgment interest unless the primary policy explicitly apportioned the liability.218 The appellate court determined that provisions of the primary policy explicitly relieved the excess insurer from liability for post-judgment interest.219 Under the terms of its policy, the primary carrier undertook to pay all interest accruing after the entry of judgment.220 Moreover, the primary policy did not contain any limitations in the event that excess insurance might apply.221

The Hartford decision turns upon the primary policy’s language regarding payment of interest on judgments by the insurer. Its application will be limited to cases involving similar policy provisions. The opinion also suggests that the primary insurer could have prevented the Hartford result by making certain drafting changes in the provisions. The court emphasized that both companies were sophisticated insurers writing both excess and primary coverage.222 Those drafting policy language should be careful to specify a pro rata sharing of interest between primary and excess insurers in order to carry out the underwriting intent.

IV. HEALTH INSURANCE: ASSIGNMENT OF HMO BENEFITS

Under Illinois law, beneficiaries of health maintenance organiza-

214. Id. The excess insurer argued that it was not liable for post-judgment interest that accrued on the portion of the underlying judgment for which it provided excess coverage. Id.
215. Id.
216. Id. at 666-67, 527 N.E.2d at 952.
217. Id.
218. Id. at 668, 527 N.E.2d at 953.
219. Id.
220. Id.
221. Id.
222. Id.
tions ("HMOs") can sue the HMOs if the insurers unreasonably or vexatiously delay payment of a claim. However, the statute governing unreasonable or vexatious delay does not address whether such a cause of action can be assigned by the HMO enrollee.

In *Loyola University Medical Center v. Med Care HMO*, the Illinois Appellate Court for the First District held that a health care provider who takes a valid assignment of benefits from an enrollee has standing to maintain a claim for damages if the HMO is found liable for unreasonable and vexatious delay in remitting the payment due to the assignee.

In *Loyola University*, an enrollee's premature newborn infant required treatment by a nonmember health care provider ("nonmember provider") because no member health care providers had the necessary facilities. The HMO confirmed the infant's eligibility

---

223. A health maintenance organization is defined in Illinois law as "any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." *Ill. Rev. Stat.* ch. 111 1/2, para. 1402(9) (1987). An enrollee of a health maintenance organization (an "HMO") must obtain medical services from one of a group of physicians and hospitals ("health care providers") who are under contract with the HMO. *Loyola Univ. Medical Center v. Med Care HMO*, 180 Ill. App. 3d 471, 473 n.1, 535 N.E.2d 1125, 1126 n.1 (1st Dist. 1989).

The HMO pays the health care provider for those medical services and the health care provider has no right of recourse against the enrollee. *Id.* See *Ill. Rev. Stat.* ch. 111 1/2, para. 1407.01 (1987). If an enrollee seeks treatment outside of the plan, as in an emergency where there are no available HMO health care providers, the HMO usually must pay that nonmember health care provider, subject to subscription certificate conditions. *Loyola Univ.* 180 Ill. App. 3d at 473 n.1, 535 N.E.2d at 1126 n.1. State law requires HMOs to provide health care coverage to newborn infants, including treatment for illness, injury, congenital defects, birth abnormalities and premature birth. *Id.* See *Ill. Rev. Stat.* ch 111 1/2, para. 1409.1(2) (1987).

224. *Id.* para. 1409A.


226. *Id.* at 482, 535 N.E.2d at 1132.

227. *Id.* at 473, 535 N.E.2d at 1126. During the course of admission, the insured executed a form entitled "Admitting Authorization Record." The "Admitting Authorization Record" provided:

Payment Guarantee/Assignment of Insurance Benefits. For and in consideration of hospital care to the above patient, I/we agree to pay the established rates of [the health care provider] and its physicians for all services, facilities, and supplies rendered hereunder. I hereby authorize insurance payment(s) to be made directly to the physician or physicians of the [health care provider] involved in the patient's care and to the hospital for services rendered, but the hospital payment shall not exceed the hospital's regular charge for this period of hospitalization. I understand that I am financially responsible for all hospital and physician charges not covered by my insurance plan.

*Id.* at 473-74, 535 N.E.2d at 1126-27.
for coverage and quoted the insured benefits. A nonmember provider treated the infant. Further, the nonmember provider produced monthly interim billings, which it sent to the HMO, and forwarded a final summation of itemized charges of $121,486.55 at the conclusion of the treatment. The HMO paid only $27,384.53 and refused to pay the balance.

The nonmember provider brought suit against the HMO to recover the outstanding balance. According to the nonmember provider, the HMO had vexatiously and unreasonably denied payment of the balance in violation of Illinois law, thereby entitling the nonmember provider to attorney fees and exemplary damages. The nonmember provider asserted its status as an assignee of all the enrollee's rights and benefits, and it contended that the assignment gave it standing to assert the claim. Further, the nonmember provider argued that once an insured incurs a loss, the nonassignability language does not bar assignments of the right to payment. The nonmember provider urged that the medical condition or injury requiring treatment is the "loss." Moreover, the nonmember provider contended that the enrollee can transfer the right to payment or reimbursement for that loss because it is a chose in action.

The HMO responded by filing a motion to dismiss, asserting that the nonmember provider did not have standing to raise a section 155 claim because only an enrollee can make such a claim. The HMO also argued that the assignment by the enrollee to the nonmember provider was void because the HMO's general policy required advance written approval before assignment of policy benefits. Further, the HMO stated that only an enrollee is enti-

228. Id. at 474, 535 N.E.2d at 1127.
229. Id. The nonmember provider also participated in certain quality review procedures required by law. Id.
230. Id.
231. Id.
232. Id. at 472-73, 535 N.E.2d at 1126.
233. ILL. REV. STAT. ch. 73, para. 767 (1987).
234. Loyola Univ., 180 Ill. App. 3d at 473, 535 N.E.2d at 1126.
235. Id. at 475, 535 N.E.2d at 1127.
236. Id.
237. Id. at 477, 535 N.E.2d at 1129.
238. Id.
239. Id.
240. Id. at 473, 535 N.E.2d at 1126.
241. Id. at 474, 535 N.E.2d at 1127. In support, the HMO cited the "[HMO] Subscription Certificate for Medicaid Recipients of the State of Illinois," which stated in pertinent part, "[n]o interest in the Group Service Agreement, in this Certificate, or in
tled to any benefit under the certificate. According to the HMO, it included the nonassignability clause in its policy to prevent the transfer of benefits that are personal to the enrollee. Therefore, if an enrollee were permitted to assign the benefits to a third party before a loss is incurred, the enrollee would alter the risk underwritten by the HMO. The trial court denied the HMO's motion to dismiss the section 155 claim but certified three questions for interlocutory review. The appellate court granted a permissive interlocutory appeal, and the appellate court affirmed the trial court's decision.

The court held that a health care provider who takes an assignment of benefits from an assembly enrollee has standing to maintain a claim for damages from the HMO, including damages for unreasonable and vexatious delay in payment. The court stated that an enrollee's assignee succeeds to the same position as the enrollee and is not a true third party. Other courts have held that section 155 claims are transferable under a general assignment of

---

any Identification Card issued pursuant thereto is assignable without prior written consent of [the HMO]" Id. at 476, 535 N.E.2d at 1128.
242. Id. at 476-77, 535 N.E.2d at 1127.
243. Id. at 477, 535 N.E.2d at 1128.
244. Id. at 477, 535 N.E.2d at 1128-29. “Loss” was not defined in the HMO's certificate. Id. at 477 n.2, 535 N.E.2d at 1129 n.2. The HMO argued that the insured's loss is the actual rendering of medical services. Id.
245. Id. at 473, 535 N.E.2d at 1127. The certified questions were:

(1) Whether the language contained in [the health care provider's] “Payment Guarantee/Assignment of Insurance Benefits” is sufficiently unambiguous, as a matter of law, to constitute a valid assignment of all contractual rights to reimbursement for those services rendered by [the health care provider] to [the insured's infant] during the entire course of [the insured's infant's] admission, absent any other contradictory evidence regarding [the insured's] intent to assign benefits.

(2) Whether [the insured's] execution of the assignment of benefits prior to the point where [the health care provider] had completed its course of treatment constitutes the transfer of a right to payment when a loss under the policy is imminent to be incurred, is not prevented by [the HMO's] general policy provision prohibiting an insured's assignment of benefits before a loss has occurred.

(3) Whether [the health care provider's] status as an assignee of [the insured's] subscription certificate benefits entitles it to assert a claim against [the HMO], pursuant to ILL. REV. STAT. (1985) ch. 73, § 767, for the damages sustained from [the HMO's] alleged vexatious and unreasonable failure to settle [the health care provider's] claim for services rendered to [the insured's infant].

Id. at 474-75, 535 N.E.2d at 1127.
246. Id. at 472-73, 535 N.E.2d at 1126.
247. Id. at 482, 535 N.E.2d at 1132. The appellate court remanded the case to the trial court.
248. Id.
249. Id. at 480, 535 N.E.2d at 1131.
benefits.\textsuperscript{250} According to the appellate court, the HMO could not limit its statutory liability by calling the assignee a third party.\textsuperscript{251} Therefore, the nonmember health care provider had standing to bring a claim under section 155.\textsuperscript{252}

In addition, the court held that the enrollee must evidence her intention to transfer to the nonmember provider all of the enrollee's rights to reimbursement under the policy for covered services.\textsuperscript{253} The nonmember provider's continuing course of treatment was an ongoing performance of the consideration it gave for the execution of the assignment.\textsuperscript{254} The appellate court reasoned that absent evidence of a contradictory intention, the words of the Admitting Authorization Record\textsuperscript{255} operated as a full assignment of the right to reimbursement.\textsuperscript{256} Here, the enrollee assigned her present conditional right to the insurance proceeds.\textsuperscript{257} A valid assignment of a conditional right is enforceable in equity;\textsuperscript{258} therefore, the assignment attaches to the balance under an existing contract as it becomes due and payable to the assignor.\textsuperscript{259}

The impact of \textit{Loyola University} remains to be seen. Permitting bona fide assignees the right to payment under section 155, however, should serve to expedite payment by insurers to health care providers. In addition, the recognition of the assignability of rights under health care benefits contracts, despite contrary policy language, strengthens the provider's hand in insurance collection disputes.

\section{V. The Priority Status of Shareholders in the Liquidation Proceedings of Insolvent Insurance Companies}

When insurance companies become insolvent or bankrupt, State
law governs the priority of claims against the companies. In the case of In re Liquidation of Security Casualty Co., the Illinois Supreme Court considered whether defrauded shareholders could take assets out of the order provided by Illinois’ statutory scheme for liquidated companies under the Insurance Code. The court held that they could not.

In Security Casualty, the Illinois Department of Insurance informed Security Mutual Casualty Company ("Security Mutual") that it would face sanctions and could be liquidated, if it failed to increase its capital by year's end. The directors of Security Mutual converted the company to stock ownership in order to raise the needed capital. Five months later, the Securities and Exchange Commission halted trading in Security America stock.
In the following months, Security America shareholders filed a number of suits, alleging that the company had defrauded them in the sale of Security America stock.\textsuperscript{268} In addition, the Illinois Director of Insurance filed suit seeking the liquidation or rehabilitation of Security Casualty; the suit alleged that Security Casualty was insolvent and had a negative net worth of $20,000,000.\textsuperscript{269} Finally, after a circuit court determined that Security Casualty was actually insolvent, the court entered an order of liquidation that authorized the Director of Insurance to liquidate Security Casualty.\textsuperscript{270}

The shareholders moved to intervene in the Security Casualty liquidation proceedings.\textsuperscript{271} They wanted the court to impose a constructive trust on the proceeds of the Security America stock offering.\textsuperscript{272} Numerous parties, including the Director of Insurance (in his capacity as liquidator of Security Casualty), argued that a constructive trust should not be imposed because the statute provided a comprehensive and exclusive distribution scheme.\textsuperscript{273} The circuit court held for the shareholders and imposed a constructive trust on almost $8,000,000 of the Security Casualty estate.\textsuperscript{274} The court reasoned that the shareholders’ funds were identifiable and had come first into Security Casualty’s possession through federal securities law violations and then into the Director’s possession, as liquidator.\textsuperscript{275} The circuit judge ruled that Security Casualty never acquired equitable title to the funds. Because a constructive trust is created as the impropriety occurs, the funds thus fell outside the statutory distribution scheme of section 205.\textsuperscript{276} In effect, the cir-
cuit court’s decision advanced the shareholders’ claims ahead of all others.277

On direct appeal,278 the Illinois Supreme Court reversed, holding that under Illinois’ statutory scheme, the constructive trust could not be imposed for the shareholders’ benefit.279 In so holding, the court looked to the legislative intent of the statutory scheme, which was to distribute an insolvent insurer’s general assets on an equitable priority basis.280 After considering the legislative intent of section 205(1), the court concluded that the legislature had not contemplated any other forms of relief inconsistent with the priorities of the section.281 The court stressed that although both investors and lenders expose themselves to business insolvency risks, only investors are deemed to assume the extra risk of illegal or fraudulent issuance of securities.282 Consequently, by imposing a constructive trust, the court would have shifted the risk of illegally or fraudulently issued securities from investors, where the risk properly lies, to those who chose not to expose themselves to the potential burdens and benefits of owning stock.283

The Security Casualty decision illustrates the rigidity of the comprehensive and exclusive distribution scheme provided by the Insurance Code. Security Casualty appears to be a straightforward application of the Illinois statutory scheme for distribution of an insolvent insurer’s general assets. Creditors, shareholders and policyholders of insolvent reinsurers will have an uncompromising understanding of the application of Illinois law to asset distribution.

277. Id. at 444, 537 N.E.2d at 780.
278. Id. at 437, 537 N.E.2d at 776. The court permitted the direct appeal under Illinois Supreme Court Rule 302(b) because the case involved the public interest. ILL. S. CT. R. 302(b), ILL. REV. STAT. ch. 110A, para. 302(b) (1987).
279. 127 Ill. 2d at 442, 537 N.E.2d at 779.
280. Id.
281. Id. at 445, 537 N.E.2d at 780. Because section 205(1) establishes a rule of absolute priority, the court held that no succeeding class of claimants may share in the distribution of assets until the claims of those with senior interests are satisfied in full. Id. at 444, 537 N.E.2d at 780. The court emphasized that the imposition of a constructive trust would provide the shareholders a super-priority ahead of all other claimants in the liquidation proceedings. Id. The funds that the shareholders wanted to have impressed with a constructive trust were assets of the company in liquidation; therefore, the shareholders’ claims were subject to the section 205(1) priority schedule. Id. at 446, 537 N.E.2d at 782.
282. Id. at 447, 537 N.E.2d at 781.
283. Id.
VI. LEGISLATION

A. Alien Insurers

The Survey year also saw the Illinois General Assembly approve legislation requiring out-of-State insurers ("alien insurers") to maintain a deposit of assets in trust within the State of Illinois.\(^{284}\) The new law will help to protect the public against insolvent insurers who fail to fund judgments against policies issued in the State. The responsibilities and obligations of troubled alien insurers under policies issued in the State will be met to the extent of the required deposit.

B. Long-Term Care

The Illinois General Assembly also approved legislation that will include long-term health care within the classification of life or endowment insurance or annuity contracts.\(^{285}\) Long-term health care consists of professional nursing care, custodial nursing care, and non-nursing custodial care provided in a nursing home or at an insured's residence.\(^{286}\) Through this legislation, the General Assembly established a statutory and regulatory framework to be applied to long-term care policies. This law will subject long-term care policies to the same limitations and restrictions as life insurance policies.

VII. CONCLUSION

Illinois courts decided several significant cases during this Survey year. The Illinois Supreme Court underscored the application of the initial permission doctrine and clarified the priority status of shareholders during liquidation proceedings. Also of note were appellate decisions refining the scope of the pollution exclusion, inter-

\(^{284}\) ILL. REV. STAT. ch. 73, para. 672a (1988). The statute requires that the trusted assets equal:

1. the sum of its minimum capital and surplus;
2. the amount of its liabilities to policyholders, net of reinsurance for which credit is allowed minus:
   a) the sum of the amount of all of its general state deposits;
   b) the amount of its special state deposits;
   c) the amount of its reinsurance recoverable on paid losses;
   d) the amounts of its notes and bills receivable;
   e) the amount of agents' balances and uncollected premiums;
   f) and the amount of its funds held by or deposited with reinsureds.

\(^{285}\) Id. para. 672b.

\(^{286}\) Id. para. 616.
preting for the first time the term "occurrence" in a liability policy, and determining excess insurers' liability for post-judgment interest. The Illinois Appellate Court for the First District also addressed the difficulty inherent in an insurer's attempt to simplify claims made policy language. Finally, the Illinois General Assembly passed important legislation, particularly with regard to alien insurers.