

Compliance Review

Ongoing Compliance Updates for Investment Advisors

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Errors & Omissions Insurance Coverage for Investment Advisors

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Errors and omissions (“E&O”) insurance can help protect your company and its directors, officers and employees from the claims of clients alleging mistakes or misconduct in connection with investment advisory services. In the current economic environment, client expectations are higher than ever, and there are a wide range of lawyers and law firms that specialize in claims against financial institutions and advisors. This combination adds risk to the legal liability profile of even the most careful and experienced investment adviser. E&O insurance is a key tool for managing this risk.

This article describes the main types of E&O coverage that investment advisers are likely to purchase. It provides suggestions for what to keep in mind as you consider whether to buy E&O insurance at all, as well as which type of policy to purchase. The article covers:

- The reasons for buying E&O coverage
- How to evaluate the insurance companies that offer E&O coverage
- The types of coverage that might benefit an investment adviser
- How E&O policies work, including how insurers

promise to respond to claims against a policyholder

- How a larger business can structure E&O coverage using excess insurance policies
- The characteristics of the most “policyholder-friendly” policies
- Typical insuring clauses in E&O policies and how these clauses may relate to your coverage
- How insurance companies use exclusions to make important exceptions to their coverage promises
- How to present and pursue a claim for coverage under your E&O insurance to maximize its potential value

In this article, the most important policy and coverage features to look for will be preceded by the ► symbol.

Why Buy E&O Insurance?

Well-managed professional services businesses buy E&O insurance—also called professional liability insurance—to mitigate the risk of a substantial claim against the business by a disappointed client.

E&O insurance can reassure a professional services business that cash will be available to provide a responsible defense against a claim and to pay any settlement or judgment that results from a claim.

An investment adviser can be vulnerable to a variety of types of charges, such as:

- A claim that a client suffered investment losses, did not achieve as much gain as was due, lacked access to funds, or was harmed in some other way because the adviser recommended or selected an unsuitable investment.
- A claim that a client was damaged because the adviser breached its fiduciary duty to the client, either through self-dealing or some other breach of the client's trust.
- A claim that the adviser gave investment advice or executed a client's instructions carelessly or negligently, which resulted in some kind of loss for the client.
- A claim that the adviser breached its client agreement.

For investment advisers, the risks of a substantial claim may be particularly acute: The potential losses arising from such a claim, especially if brought by a corporate retirement plan or a wealthy individual client, could be millions of dollars. Although E&O insurance may not live up to the "sleep easy" promises that some E&O insurers make, an adviser with a reliable insurer is generally far better situated to weather severe challenges than an uninsured adviser is.

1. Selecting an Insurer

When selecting an E&O insurer, an investment adviser should make sure the insurer offers high-quality policy provisions, demonstrates overall financial strength, indicates a long-term commitment to the E&O business, and has a reputation for responsiveness in handling claims.

The quality of the policy provisions—in other words, broad, understandable coverage—is a core attribute of any insurance policy. Not all E&O policies for investment advisers are the same. Some insurers offer disadvantageous policy terms—for example, terms that require the policyholder to limit its coverage claims in order to avoid having to

litigate against its insurer to obtain coverage, with uncertain chances of success.

Some aspects of E&O policies are negotiable. For example, an investment adviser may improve its E&O coverage by requesting that the insurer issue endorsements (amendments) to the policy to expand the coverage to fit the adviser's business and needs.

Financial strength is another important quality to seek in an insurer. While there are several ways to measure an insurer's financial strength, claims-paying ability is probably the most relevant to a prospective policyholder. Because claims made against a particular E&O policy may not be resolved and paid by the insurer until years after the policy expires, the long-term claims-paying ability of an insurer is essential. The claims-paying ratings services of A.M. Best Company and the views of an experienced broker are among the most valuable resources when you're evaluating this criterion.

Other qualities to seek in an insurer include commitment to E&O coverage lines (so that the insurer will be available to issue renewals for many years, if desired by the policyholder) and a reputation for responsiveness to claims.

Types of Coverage for Investment Advisers

E&O insurance is likely to be the most appropriate type of insurance for claims arising from investment advisory and investment management services. Depending upon the circumstances, other types of insurance policies may also apply. For example, in a situation involving deliberate wrongdoing by an employee of an advisory firm, it's possible that a crime or employee dishonesty policy, or a fidelity bond, may provide coverage. In addition, some advisers purchase blended or multiline policies that provide a variety of coverages.

Frequently, neither the business principals nor the lawyers in an investment advisory firm are aware of the full array of insurance protection that the institution has purchased. It's a mistake to assume that there is no insurance coverage for a particular type of claim, even a claim that doesn't appear to fit into any of the standard categories of risk for which business entities have traditionally purchased insurance.

An investment adviser may wish to purchase the following additional types of liability coverage (which need not be directly relevant to protecting the firm's professional advisory activity):

- Directors and officers (“D&O”) coverage. For investment advisory firms that are corporations or certain types of partnerships, D&O insurance covers claims against the corporate entity and individual directors, officers and employees for alleged breaches of fiduciary duty or other failures in management of the corporate entity.
- ERISA liability coverage. Also called fiduciary coverage, ERISA liability coverage protects the sponsors of retirement plans, and their agents for the operation of such plans, from claims that they've breached their duties under ERISA (the federal pension statute).
- Employment practices liability (“EPL”) insurance. This type of insurance provides coverage for claims of improper employment-related actions, such as wrongful discharge, employment discrimination and sexual harassment.
- Commercial general liability (“CGL”) insurance. CGL insurance covers the policyholder's liability for damages due to bodily injury, property damage, personal injury (such as libel, slander or defamation) and advertising injury (typically, libel or infringement of a title or slogan in an advertisement).

E&O, D&O and ERISA liability policies share many common characteristics. These policies are discussed in greater detail in this article, and are referred to collectively as “financial lines policies” or “financial lines coverage.”

How Liability Insurance Policies Work

There are typically two types of liability insurance policies: “occurrence” policies and “claims-made” policies. Occurrence policies will respond if a specified event (typically, injury to the claimant) occurs during the policy period, even if the claim is

made years later. In contrast, claims-made coverage responds only if a claim is first made while the insurance policy is in effect.

All current financial lines policies are written on a claims-made basis. That is, each E&O policy is in force for a given period, usually one year, and any claims commenced during that policy period are applied to that policy, regardless of how long it may take to defend and resolve the claim. Thus, the purpose of purchasing new policies annually is to insure against potential new claims, not to keep insurance in force for claims that were previously asserted and are still pending. Of course, after a claim has been made, it normally is too late for an uninsured defendant to commence the process of purchasing insurance to cover the claim.

Under most financial lines policies, the insurer has an obligation to pay the policyholder's defense costs, subject perhaps to a deductible or a retained limit. Under such policies, the policyholder chooses its counsel, generally subject to the consent of the insurer, and the insurer pays the defense counsel's attorneys' fees (often on an ongoing basis). Occasionally, such policies provide instead that the insurer will conduct the defense itself, using counsel of the insurer's choosing and at the insurer's expense.

Claims may be resolved by settlement or by judgment. A core feature of any liability policy is to indemnify the policyholder for that expense, subject to any applicable policy limit. Such payments are commonly termed “indemnity” payments, to differentiate them from the payment of legal costs and other defense expenses. Some financial lines policies promise to pay any settlements or judgments “on behalf of” the policyholder—that is, the insurer will pay the claimant directly. Other policies promise to indemnify the policyholder for the sums that the policyholder has already paid in settlements or judgments. The “pay on behalf of” policies are generally more favorable to the policyholder

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because the policyholder does not need to pay up front and then seek reimbursement from the insurer.

Financial lines policies generally provide coverage to both the insured business entity and its employees, directors, officers and other agents. When claims are lodged against an individual officer, director or employee, it is frequently the case that, under bylaws or applicable statutes, the business entity must hold the individual harmless from any judgment or settlement, and must also pay the individual's defense costs. Accordingly, many liability policies (a) provide direct coverage to individuals in circumstances where the employer does not indemnify the individual, whether due to financial incapacity or because the claim is of a type that is not eligible for such indemnity; (b) insure the business entity for the cost of indemnifying such individuals when such indemnification is provided; and (c) insure the business entity for covered claims asserted against it alone.

When the policyholder has multi-insurer coverage, the issuer of the "primary" (i.e., the lowest) policy usually takes the lead—or at least the initial—role in responding to the claim. Although a primary policy typically pays the "first dollar" of covered claims, the policyholder's rights to indemnity and reimbursement are often subject to a deductible amount. When the insurer pays the first dollar of defense costs and indemnity directly to defense counsel and the claimant, the insurer bills any applicable deductible amount back to the policyholder. Frequently, however, the insurer will begin to make payments only after the policyholder has paid a specified amount, which is known as "self-insured retention."

Excess Insurance

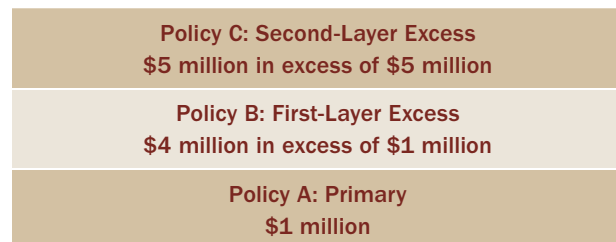
Businesses frequently purchase insurance from multiple insurers, often called "excess insurance." There are many reasons to purchase excess insurance. For example, insurers are commonly unwilling to issue policies beyond a certain size. If a business seeks more insurance than any single insurer is willing to provide, then the business must make more than one insurer part of the coverage program.

There are other reasons why a policyholder might prefer to buy coverage from multiple carriers even if a single insurer were willing to cover the entire

account. The policyholder may wish to diversify its exposure to the credit risk posed by insurers. Pricing may be more favorable if the coverage is divided among many insurance firms. The insured may wish to have certain features apply to part, but not all, of the coverage program. Or the insured may wish to establish or maintain business relationships with multiple key insurers.

In a typical multi-insurer coverage program within a single policy period, the policyholder purchases a primary policy for the period and then adds other policies in excess of the primary policy. The additional policies begin to provide coverage after a predetermined amount of coverage has been provided by the primary coverage (and other underlying coverage, if applicable).

For example, a policyholder might obtain a \$1 million primary policy ("Policy A"), a first-layer excess policy with limits of \$4 million in excess of \$1 million ("Policy B"), and a second-layer excess policy with limits of \$5 million in excess of \$5 million ("Policy C"). Such a multi-layer structure is depicted by the following diagram:



A single claim of \$500,000 would be covered entirely by Policy A. If the claim were for \$3 million, \$1 million would be paid from Policy A and \$2 million would be paid from Policy B. A claim of \$15 million would be larger than the total available coverage, so only \$10 million would be paid: \$1 million from Policy A, \$4 million from Policy B and \$5 million from Policy C.

Contracts and State Law

In the following sections, we discuss some standard provisions that you are likely to see in financial lines policies. In considering these provisions, it is critical to remember two things: First, these are contracts. That means that if the contract language differs from the contracts described below, the coverage will be different. Second, insurance is a

matter of state law, and the laws of each state are different. A provision in an insurance policy might mean one thing when read under the legal rules that apply to insurance policies in New York, and a different thing in California, Florida, Texas, etc.

That also means that you may need to seek advice from a competent lawyer who is highly experienced in handling claims under Financial Lines Policies if you have a significant claim.

2. Basic Insuring Agreements

Every liability insurance policy has one or more “insuring agreements” that set the scope of the coverage the insurer provides. Financial lines policies for investment advisers vary considerably in their coverage, so it is important to review the specific insuring agreements and related definitions of any insurance policy you are considering. We will illustrate this by dissecting an E&O insuring agreement clause from a specimen policy issued by the Zurich Financial Services Group (“Zurich”):

The [insurer] shall pay on behalf of the “Investment Advisers” and their “Individual Insureds” all “Loss” which they shall become legally obligated to pay resulting from any “Claim” first made against them during the “Policy Period” ... for any “Wrongful Act” occurring prior to the end of the “Policy Period,” but solely in rendering or failing to render “Investment Advisory Services.”

a. Insurer Pays “Loss”

As the quoted language shows, the Zurich specimen policy calls for the insurer to pay “loss,” which is defined (along with “claim expenses”) as follows:

“Loss” means “Claim Expenses,” monetary judgments and settlements, including punitive or exemplary damages (except where uninsurable under applicable law), but does not include taxes, fines, penalties or the multiplied portion of trebled or other multiplied compensatory damages.

“Claim Expenses” means any reasonable and necessary fees, costs and expenses resulting from the investigation, adjustment, defense and appeal of a “Claim” ... and any reasonable and necessary fees charged by any lawyer designated by the [insurer] or by the “Insured” with the written consent of the Company. “Claim

Expenses” shall not include salaries or wages of regular employees or officials of the “Insured” or the [insurer].

While “loss” is a commonly used term in the insuring agreements of financial lines policies, some policies may use alternative phrases such as “all sums which the Insured shall become legally obligated to pay” or, simply, “damages.” There are different ways to determine the loss that the insurer is obligated to pay, but it generally amounts to outlays for settlements and judgments plus defense costs.

Although the Zurich specimen policy covers punitive damages, many states do not permit insurance to cover punitive damages. Because it’s not always possible to know in advance which state’s law might apply to a coverage claim, it’s hard to predict whether an insurer’s promise to cover a punitive-damages award will, in fact, be enforceable. For this reason, policyholders that operate in jurisdictions where punitive-damages awards are common may want to purchase policies from insurers in jurisdictions that expressly permit coverage of punitive damages, in order to increase the odds that a punitive-damages award will be reimbursable.

Other exclusions may apply to the types of expenses that constitute insured loss, as discussed below.

- ▶ The broadest formulation of “loss” is generally the most favorable to the policyholder. Policyholders should look for policies that cover punitive damages, including multiplied damages, and that reimburse a wide range of possible expenses arising from the defense of a claim.

b. Because Of A “Claim”

An E&O insuring agreement typically requires reimbursable loss to result from a “claim,” as the Zurich specimen illustrates. There are many types of claims may expose the policyholder to liability. Accordingly, the most favorable E&O policies will include a broad range of events within the definition of “claim,” such as the following:

- Civil litigation against the insured
- Any written demand received by the insured for payment of money damages (note that purely oral demands usually are insufficient to amount to claims)

- Criminal proceedings against the insured
- Formal investigations by regulatory agencies

The type of investigation that constitutes a claim differs from policy to policy, but routine governmental inquiries are usually insufficient; any matters subject to a formal investigative order or accompanied by the filing of charges are classified as claims by most policies.

Policyholders may want to consider policies that exclude oral claims from the definition of a claim. This exclusion can relieve policyholders of the obligation to contact their insurers over matters that are “just talk.” The rule requiring a written demand also eliminates a possible “late notice defense” by the insurer, who could argue based on a spurious allegation that some reportable oral statement was made to the policyholder long before a written demand was made.

Typically, insurers attempt to treat claims that arise from the same or interrelated “fact patterns” as one and the same claim for policy definition purposes, even if the claims are brought by different claimants or are pending in different courts, and even if some of the claims are made after the policy period expires (as long as the first claim in the “batch” was made during the policy period).

For example, a major loss event tends to spur the filing of several lawsuits purporting to represent all of the injured claimants. In this situation, most policies would “batch” together all such actions as a single claim, made and reported as of the time that the first claim was made and reported. Once the policyholder has been subject to the first of what will become a group of claims, the insurer is likely to exclude coverage for such claims on renewal; therefore, the “batch clause” is favorable to the policyholder because it permits the insured to assign both the initial claim and all subsequent related claims to the initial policy. That said, disputes sometimes arise when an insurer asserts that a subsequent claim is related to an earlier claim and the policyholder disagrees. The policyholder should make sure that the batch clause is not overly broad.

- ▶ The best policies define claims broadly to include all civil and criminal actions and a

wide range of investigations. In addition, the policyholder should look for reasonable limitations on the insurer’s ability to batch claims together for coverage purposes.

c. “... first made And Reported against them during the ‘Policy Period’ ...”

As explained earlier, E&O policies are “claims-made policies, which means that only those claims made during the policy period are eligible for insurance. In order to ensure that claims apply to one policy only, E&O policies specify that a claim must begin during the policy period, as the Zurich specimen policy also requires. Thus, for example, if two or more lawsuits that begin in different policy years are batched and deemed to be a single claim, or if a written demand for money damages is made in one policy year and a civil complaint based on the demand is filed after that year ends, then the policy that was in effect when the earlier lawsuit began, or the written demand was made, will respond to the entire claim.

Insurers typically impose the additional requirement that policyholders must report a claim to the insurer during the policy period, although well-written policies usually include a short grace period for reporting when the claim is made just before the end of the policy period. Any policyholder who has “claims made and reported” insurance must ensure that all claims are promptly reported to the insurer by the time the policy period comes to an end.

Many claims-made policies permit the policyholder to notify the insurer of facts and circumstances that are reasonably likely to lead to a claim. If such circumstances exist and the policyholder can describe them in sufficient detail (usually specified in the notice provision in the E&O policy), then the insurance policy in effect at the time the notice of facts and circumstances was given will provide coverage for a subsequent claim, even if the claim is first made after the policy period ends.

- ▶ E&O policies should expressly define the grace period for reporting claims made near the end of the policy period. The policyholder should ask for an endorsement to this effect during the negotiation of a renewal if the existing policy lacks such a provision. In

addition, the policyholder should ensure that the notice provision includes the ability to give notice of facts and circumstances that are reasonably likely to lead to a claim.

d. "... for any 'Wrongful Act' ..."

A "wrongful act" is defined as:

[A]ny actual or alleged act, error, omission, neglect, misstatement or misleading statement or breach of duty unintentionally committed by any "Insured" or by any person for whom the "Entity Insured" is legally liable.

Most E&O policies adopt very similar definitions, but not all require the wrongful act to have been unintentional or negligent. Such a requirement can be troublesome for the policyholder because complaints and demand letters—which are the initial basis for determining coverage for a claim—frequently add hyperbolic allegations of intentional and deliberate wrongful conduct. Also, in the investment adviser field, liability sometimes can be imposed on a "no fault" basis (i.e., for conduct that subjects the adviser to liability but is not negligent).

- ▶ **The most favorable policies define a wrongful act such that the act need not have been negligent or unintentional to trigger coverage.**

e. In the Performance of or Failure to Perform Professional Services

The insuring agreement in the Zurich specimen requires that the wrongful act occur in connection with performing or failing to perform investment advisory services.

This is a typical requirement because E&O policies need to specify the professional conduct that's covered. Thus, the policy definition of "investment advisory services" is central to the scope of coverage. In the E&O insurance marketplace, a variety of definitions exist, with different degrees of restriction. For example, one specimen policy provides:

Investment Advisory Services means giving financial, economic or investment advice regarding investments in securities and/or rendering investment management services pursuant to a written contract defining the scope of such advice and/or services and the compensation to be paid therefor.

Another policy limits the covered professional services to those that are rendered in the capacity of an "investment adviser" as that term is defined in the Investment Advisers Act of 1940:

Investment Adviser Services means only those services performed or required to be performed by an Insured solely in its capacity as an investment adviser as defined in Section [202(a)(11)] of the Investment Advisers Act of 1940 for or on behalf of a customer of an Insured, pursuant to an agreement between such customer and such Insured for a fee, commission or other monetary consideration.

A third policy restricts investment management services (as distinguished from investment advisory services, for which coverage is also provided) to those performed by a registered investment adviser pursuant to an investment management contract meeting the following requirements:

... a written agreement wherein a client agrees to goals and strategies for the investment of the client's money, assisted by the Registered Investment Adviser, following a process which specifies investment goals, risk tolerance, allocation of investment among diversified asset classes and guidelines for the selection of money managers and ongoing monitoring and reporting.

- ▶ **The policyholder should seek a policy with a definition of investment advisory services that is at least expansive enough to encompass all services that the adviser is likely to conduct or be alleged by clients to conduct during the policy period. Moreover, any administrative requirements that the policy purports to place on the performance of investment advisory services should be in conformance with the adviser's actual practices, and should be stated in such a way that it is easy to demonstrate the policyholder's compliance.**

f. "Cost of Corrections" Coverage

A claim against an investment adviser for failure to execute the client's specific instructions should be covered under any satisfactory investment adviser E&O policy. Sometimes it's useful to address such a matter before it becomes the subject of a written demand or formal claim from the client. Some

carriers offer coverage that enables the investment adviser to offer a “cost of corrections” payment to its client prior to receiving any written demands. This type of coverage may be subject to restrictions, but if it’s procured and deployed deftly by the policyholder, it can be of considerable utility very useful in reducing or avoiding claims.

g. Add-Ons to Investment Adviser E&O Policies

The E&O liability policies offered to investment advisers often include options to add D&O, ERISA and EPL policies. As discussed earlier, an investment adviser may find such coverage useful even though it is not specifically related to providing investment advisory and management services.

Exclusions

Unfortunately, insurers do not always respond to claim notices of potentially expensive claims by acknowledging coverage unreservedly and working with their policyholders to resolve the claims on a mutually acceptable basis at a reasonable cost. They may instead respond by sending “reservation of rights” letters and purporting to reserve the right to deny coverage for as many reasons as the insurer can list, and any other reasons the insurer may conceive in the future.

Some common defenses, generally based on exclusions to coverage that have been spelled out in the policy, include the following.

a. Crime or fraud

Most financial lines policies do not cover deliberate wrongdoing. The language of these exclusions varies, and the differences in wording may well matter. Some key questions to consider are: whether negligent or reckless conduct is grounds for application of the exclusion; what or who determines whether crime or fraud has occurred in order to apply the exclusion (specifically, whether a final adjudication of fraud or other willful misconduct is required to trigger the exclusion, or whether the insurer can simply conclude that misconduct has occurred based on the facts); whether the wrongful conduct of one person can be used to exclude coverage for another insured person who is innocent; and which individuals’ wrongful conduct could be used to exclude coverage for the business entity.

- ▶ The best policies have exclusions that apply only to deliberate crime or deliberate fraud, and require that such conduct be established in fact, ideally by a final adjudication in a court. Such policies also provide that the exclusion applies separately to each insured individual, and that one individual cannot lose coverage based on the conduct or knowledge of another. They also provide that a business entity can only lose entity coverage if certain specified senior officers have engaged in a deliberate crime or fraud.

Most courts have concluded that the final adjudication must occur in the underlying case and that the issue cannot be litigated later in a coverage case. As a practical matter, this means that the exclusion will not apply if the parties to the underlying matter settle the case.

Some policies do not have the final adjudication requirement. Others state that the final adjudication may occur in the underlying claim or in another proceeding. Some say that the deliberate crime or deliberate fraud must have “in fact” occurred; mere allegations are not enough. Other policies exclude any crime or fraud, whether or not it was deliberate. These variations in language matter.

- ▶ Desirable policies require final adjudication in the underlying action in order to apply the crime/fraud exclusion. Policyholders should negotiate an endorsement to that effect upon renewal.

b. Rescission

Financial lines policies require that the applicant for such coverage represents (i.e., contractually assures) that its application for coverage is complete and accurate, on penalty of termination and exclusion of all coverage, an outcome termed “rescission.” This representation enables the insurer to exclude coverage in cases of outright deception (e.g., when the policyholder knows claims that the policyholder’s leaders know will be filed during the coming policy period but does not disclose them in the application).

However, this representation might also subject policyholders to rescission in less culpable circumstances—for example, where there has been an

inadvertent misstatement in the policyholder's financial statements that is not discovered and corrected until after the new policy is in force. At a minimum, insurers may use the threat of rescission claims to negotiate a discount in a settlement of fundamentally valid coverage claims with their policyholders.

Many policies include contractual protection against insurer rescission claims. Such contractual provisions may make it impossible for insurers to rescind their policies or deny coverage for claims. The language of such provisions varies considerably. It's important to review the applicable provisions of the policies when claims are made, as well as to consider these issues at the time of policy renewal.

- ▶ **The best contractual restrictions on rescission provide that (1) coverage can never be rescinded for any insured individual based on misrepresentations or omissions in the application; (2) coverage for particular claims can never be denied for individuals based on misrepresentations or omissions in the application (individuals lose coverage only if they fall within the exclusions of the policy, such as exclusions for deliberate crime or fraud established by a final adjudication); (3) coverage for particular claims can never be denied for the business entity to the extent that the coverage indemnifies an individual (corporate reimbursement coverage) who was not aware that a document included in the application contained a material misrepresentation or omission; and (4) coverage for particular claims can never be denied for the business entity itself (entity coverage) unless certain specified senior officers were aware that a document included in the application contained a material misrepresentation or omission; in these instances, the insurer is required to prove that the individual knew that such a document contained a material misrepresentation or omission.**

c. Wrongful profit earned by insured

Most financial lines policies also exclude wrongful profit or advantage. As with the deliberate crime or fraud exclusion, the language varies among policies.

For example, is a final adjudication required in the underlying case or in any case? Is it sufficient if the wrongful profit was "in fact" obtained? Can the conduct of one individual be imputed to another individual or to the business entity?

d. Return of fees or commissions; restitution

Most E&O policies have an express exclusion for professional fees or commissions (e.g., a client's claim that he or she was overcharged).

In a related exclusion, many policies bar coverage for sums that are restitutionary—i.e., repayment of money that the policyholder received from the claimant. If the fees and commissions of an investment adviser are refunded to a client who alleges some breach of duty by the adviser in connection with the fee-generating transactions, and if the policy does not exclude fees and commissions, then the insurer may seek to characterize such amounts as restitution of undeserved gains. The insurer would thus assert that such amounts do not qualify as "loss" within the meaning of its insurance policy, or that it would go against public policy to provide insurance coverage for such amounts.

The restitution exclusions that appear in many financial lines policies are subject to much dispute between policyholders and insurers because many policyholders believe that these exclusions are applied unfairly. For example, a client complaint seeking restitution might be largely groundless, but the investment adviser might think it prudent to settle for a significant sum to avoid the potential loss and the likely diversion of policyholder resources required to defend to preserve the resources the firm would use to defend the claim. The insurer, intent on applying the exclusion, might try to characterize the settlement payment as restitution rather than to treat it, more realistically, as the "nuisance value" of the complaint.

Sophisticated insurers are likely to realize that many of their restitution-based coverage defenses will ultimately be self-defeating. But until they do, investment advisers would be well advised to act prudently in fee disputes with clients and to try to avoid situations in which these disputes turn into full-blown claims.

e. Consequential or remote loss

Some E&O policies exclude coverage for consequential losses—for example, when a client claims that he or she would have made a different investment and earned a profit, had the adviser not steered the client another way. Such exclusions could lead to coverage disputes with insurers and are best avoided.

f. Other common exclusions

Several additional types of exclusions are common in E&O policies for investment advisers. One general category includes matters that are normally insured under other lines of coverage. Thus, it's typical to see exclusions for claims based on ERISA, for instances when advisers act as broker-dealers, for employment practices liability, for media-related torts, for intellectual property infringement and for the practice of law, accountancy or other professions.

As mentioned earlier, many financial lines policies exclude claims related to claims that were made prior to the inception of the policy (or some other specified date) or that were the subject of a notice given to another insurer prior to the inception of the policy. Many policies also contain exclusions for executive compensation, for lost profits from transactions in the securities of the investment adviser itself, and for claims arising from advice provided in connection with merger and acquisition activity.

Presenting a Claim

Even when a policyholder has a valid basis for coverage of a claim, the policy is likely to contain numerous conditions and terms relating to the submission of the coverage demand, the handling of the underlying claim, and other matters. Many of these conditions and terms merit the policyholder's scrupulous attention. The most important ones are discussed here.

a. Give immediate notice

Insurance policies typically require that insurers provide prompt notice of claims to the insurer; therefore, it is critical that a policyholder faced with a claim quickly identify the potentially applicable insurance policies. In some states, a delay in

providing notice of a claim can result in loss of insurance coverage. While some states' laws provide that a delay in giving notice will not result in a loss of coverage unless the insurer was prejudiced, no state permits a policyholder with a claims-made policy to wait to tender a claim until after the policy period (and any grace period for giving notice specified in the policy or granted by state law) has expired. In any event, it is always better to provide prompt notice in order to avoid disputes with the insurer over the timeliness of notice.

When considering notice issues, policyholders should also evaluate whether to provide a "notice of circumstances" under other policies that will apply if related claims are filed in the future.

b. Cooperate with the insurer

Most insurance policies provide that after a claim is made and tendered to the insurer, the policyholder has a duty to cooperate with its insurer and to provide information about underlying claims. This can be beneficial for the policyholder as well: In many instances, the policyholder will be able to obtain valuable assistance in litigation and settlement strategy from the insurer, which may have faced many more claims of the type at issue, or more claims from the same plaintiffs' counsel, than the policyholder's defense counsel has seen.

Many insurers assert that the duty to cooperate includes an obligation to disclose to the insurer privileged and confidential information relating to the defense of underlying claims. Whether the insurer is entitled to this information and can be given it without risking a waiver of the attorney-client privilege vis-à-vis the underlying claimant varies from state to state. Typically, if the insurer is defending the claim without a reservation of rights, the insurer shares the privilege and, in ordinary circumstances, is entitled to receive privileged communications. Otherwise, most well-advised policyholders decline to share privileged information, particularly in cases in which the insurer has reserved the right to deny coverage for the claim. The disclosure of privileged information to an insurer that is potentially adverse to the policyholder with respect to coverage matters may result in claims by third parties, including the plaintiffs in the

underlying action, that there has been a waiver of privilege protection. Moreover, it may be unwise to disclose such information to an insurer if the insurer has reserved the right to deny coverage on grounds that are related to the merits of the underlying claims. The insurer may be hoping that privileged information relating to the defense of an underlying claim will help it deny insurance coverage.

As a practical matter, it's usually necessary to share some information that is privileged or arguably privileged, including, for example, invoices for defense costs. Moreover, in connection with efforts to obtain insurer consent to settlements (discussed below), it is almost always desirable to be able to discuss with the insurers the strengths and weaknesses of the case and the potential range of damages, as part of the effort to obtain the insurers' consent to settlement (discussed below). Accordingly, most policyholders must consider carefully what privileged information is essential to share with their insurers, and then take appropriate precautions before doing so. Before sharing any such information, for example, it's often prudent to enter into a written confidentiality agreement that includes non-waiver provisions and that expressly limits the insurer's use of privileged information to purposes that are in the insurer's and the policyholder's common interests—such as the defense and resolution of the underlying claims.

c. Defend the underlying claim

As explained earlier, financial lines policies typically provide that the policyholder is responsible for conducting the defense of a claim subject to the insurer's reimbursement of defense costs (often on an ongoing basis).

Defense reimbursement policies often prohibit the policyholder from incurring defense costs or retaining defense counsel without the consent of the insurer. Some policies expressly provide that such consent may not be withheld unreasonably; in other policies, such a restriction is implied. Some lower court decisions have held that in the absence of such language, an insurer can avoid any obligation to pay defense costs simply by withholding consent. In our opinion, these cases are wrongly decided—but it is better to fix the problem at the time of policy renewal than to litigate about it later.

- ▶ **E&O policies should contain language stating that insurer consent to incurring defense costs or retaining defense counsel may not be withheld unreasonably.**

It's prudent for policyholders to inform their insurers about the identity of the lawyers who have been retained to defend claims, and to promptly seek consent both to the selection of counsel and to the incurring of defense costs. If the insurer reserves the right to deny coverage for a claim, the policyholder may have the unconstrained right to select defense counsel. The law on this point varies from state to state, however, so it's often better to make this a non-issue by obtaining consent.

d. Get the insurer involved in settlement and strategy decisions (If Insurer Has Not Denied Coverage)

Most financial lines policies provide that underlying claims cannot be settled without the consent of the insurer. Some policies provide that consent may not be withheld unreasonably; even if such language is missing, as a matter of law most courts will imply such a restriction on the insurer's right to consent to settlement. Either way, it's important to inform insurers before making settlement proposals, and it's critical to seek their consent—or at least to give them an opportunity to participate in settlement discussions and object—before agreeing to a final settlement. This point should be obvious, but many policyholders have found themselves in coverage disputes by engaging in extensive settlement negotiations, or even entering into settlements, without involving their insurers.

Ideally, the insurer will provide consent and agree to fund the settlement. At a minimum, the insurer ought to agree in writing not to assert that the settlement was entered without its consent or was unreasonable. If the insurer is reserving the right to deny coverage for other reasons, but also states that it is opposed to the settlement and that it will further be contesting coverage because it did not consent to the settlement and considers the settlement unreasonable, then the policyholder should carefully evaluate the law in the applicable jurisdiction.

In some jurisdictions, if an insurer has refused to consent to a reasonable settlement, the policyholder

has the right to make the settlement without losing coverage. Other jurisdictions hold that entering into such a settlement results in a loss of coverage unless the insurer has been offered, and has declined, the opportunity to defend the claims on the merits. In some jurisdictions, the policyholder may settle without insurer consent when the insurer is reserving the right to deny coverage. In those jurisdictions, the lack of insurer consent will usually not result in a loss of coverage as long as the settlement was made in good faith, was not collusive and was reasonable. In other jurisdictions, the insurer may escape coverage altogether if the policyholder settles. In still other jurisdictions, the law may be unclear.

In some jurisdictions, if the insurer withholds consent to a settlement within the limits of its policy, it may become liable for any resulting verdict even if the amount of the verdict exceeds the limits of its policy. In other jurisdictions, insurer liability for a verdict in excess of the limits of its policy may depend on proving that the insurer's refusal to consent to a settlement was made in bad faith.

Because the law on these issues varies from state to state, and the outcome in particular cases may depend on exactly what was done when, it's important to consider these kinds of issues carefully and to obtain advice from experienced counsel with experience in insurance coverage matters before concluding any settlements over an insurer's objections.

e. Be wary of settling for less than the full policy limits

E&O insurance premiums can constitute a material expense for an investment adviser. Of course, the greater the amount of coverage (i.e., the total limits of all policies, both primary and excess), the higher the premium; thus, it's important to determine an appropriate amount of insurance for your business. You'll want to avoid paying for unnecessary levels of insurance, but also to avoid being underinsured. Your broker will generally be a useful resource to help you assess the correct amount of E&O insurance for your business.

If you ever face a claim, it will be important not to squander through an ill-advised settlement. This section explains one potential danger raised by some proposed settlements.

Most coverage claims under financial lines policies are settled rather than litigated. Policyholders considering a settlement for an underlying claim that exhausts one or more E&O policies should be aware of a risk created by two recent coverage decisions in Michigan and California. In these cases, the courts held that a policyholder had forfeited all coverage under its excess policies because the policyholder had made a settlement with its primary insurer in which the primary insurer paid less than the full limit of its policy.

In our view, these cases were wrongly decided. In most jurisdictions, courts have held that a policyholder does not forfeit excess coverage by settling with the primary insurer for less than the full limit, as long as the policyholder is willing to pay the difference between the amount that the primary insurer paid and the limit of the primary policy.

Nevertheless, to avoid the risk of losing coverage for failure to exhaust the limits of the underlying insurance, a policyholder should carefully review the relevant language of all excess policies and consider applicable law in the relevant jurisdiction before making any settlements with primary insurers for less than full policy limits. If any of the excess policies state that coverage requires the underlying insurers to pay the full limits of their policies, (rather than payment by the insurers or the insured of such amounts), and the law in a particular jurisdiction is unclear, then the policyholder should be careful about making settlements with the primary insurer or any of the underlying excess insurers for less than the full limits of those policies.

One way to avoid this problem is to settle with all insurers at the same time. Proactive policyholders can mitigate this risk by persuading all their excess insurers to agree not to use such language as a basis to deny coverage as long as the full amount is paid either by underlying insurers or the policyholder.

- ▶ **The best solution for avoiding this type of risk is to negotiate better language with the insurers at the time of policy renewal. Many insurers have already prepared endorsements to solve this problem and will offer such endorsements at no charge upon request at the time of renewal. It is important to make the request, however.**

f. Be alert to dispute resolution provisions

Some coverage disputes cannot be settled on mutually acceptable terms and have to be resolved by a judge or arbitrator. Clauses in insurance policies that specify where and how disputes should be resolved may have a significant impact on the practical value of the policy to the policyholder.

Most policies issued by U.S. insurers do not specify a court or other forum where the parties are required to turn for resolution of a coverage dispute. Some, however, contain clauses that provide for an alternative dispute resolution (“ADR”)—i.e., a forum other than a state or federal court, such as non-binding mediation or binding arbitration.

Almost all policies issued by Bermuda insurers, and many policies issued in Europe by European insurers or by affiliates of U.S. insurers doing business in Europe, contain language requiring the parties to submit all disputes concerning insurance coverage to binding arbitration. Such policies typically provide for arbitration in London or Bermuda. Even for a policyholder with a single primary policy and no excess coverage, a policy with an arbitration provision that requires a separate arbitration in London is worth less than a policy without an arbitration clause. The time, effort and expense of pursuing a separate arbitration substantially reduce the policy’s value. Moreover, although a policyholder who prevails in the arbitration is entitled to an award of legal fees and other arbitration expenses under U.K. and Bermuda law, such awards typically do not add up to a full recovery of all the expenses of arbitration.

The drawbacks of arbitration for policyholders with a multilayer insurance program can be even greater. If some of the relevant insurance policies include arbitration clauses and some don’t, it may be necessary to litigate coverage disputes with insurers in multiple forums—needless to say, not a desirable feature. Another complicating factor is whether or not excess insurers’ “follow form” policies are subject to the arbitration provisions in underlying policies (as they would be subject to other terms in the underlying policies). The possible need to litigate related coverage questions against multiple insurers in multiple forums is not a desirable feature of an insurance program.

- ▶ The best solution for U.S. policyholders is to eliminate from their insurance programs policies with ADR clauses that allow the insurer to institute or require arbitration, and to purchase only policies with terms that permit the policyholders to resolve all coverage disputes can be resolved through a single litigation in a U.S. court. If that’s not feasible, the policyholder should get its excess insurers to agree to a single ADR forum for resolving coverage disputes under all insurance policies.

g. Engage the services of brokers and coverage counsel

Because selecting insurance can be so complicated, It’s important to seek help from an experienced insurance broker when purchasing financial lines policies or other commercial insurance programs.

A broker can help you identify the best insurance markets, obtain favorable policies and structure your insurance program. If a policyholder must give notice of a claim or of circumstances that may lead to a claim, a broker can offer assistance in presenting the claim (or potential claim) to the insurer and in communicating with the insurer’s personnel.

But it’s also important to understand what a broker can’t do. A broker is not a lawyer (and brokers with law degrees cannot act as your lawyer, because of ethical constraints). Thus, you should retain coverage counsel (with knowledge of the relevant jurisdiction) to advise you if disputes arise over coverage for a claim, or if you have a claim that you think might become problematic, or if you’re not sure whether to give a notice of circumstances.

There are other reasons to obtain coverage counsel as well. Investment advisers procuring large coverage programs, operating multiple business entities or otherwise facing unusual circumstances may want to retain counsel to advise on selecting an insurer, negotiating policy terms with the insurer, and navigating the many potential coverage pitfalls described earlier.

In looking for coverage counsel, you’ll want an attorney or firm that concentrates in insurance coverage matters—just as you would want someone with substantial experience in defending investment adviser claims to represent you in the

underlying lawsuit or arbitration. Preferably, your attorney would be someone who represents policyholders only and does not represent insurers in coverage claims.

When selecting coverage counsel, you may want to use a lawyer ranking service such as Chambers USA or The Legal 500, or consult your colleagues in the financial services sector for advice.

Conclusion

E&O insurance can be a critically important asset for an investment adviser. Not only can it protect a business from the cost of inadvertent mistakes, but it also can pay for the costs of defense (and settlement, if necessary) in response to a client who can demonstrate a loss.

Unfortunately, the ways of insurance are complex. The value of a given E&O policy cannot be judged by policy limits alone; in addition, the scope of coverage is central to the value of a policy, as is compliance with the required procedures for making a coverage claim. The field abounds with traps for the unwary both in evaluating coverage and in asserting and settling coverage claims.

The E&O coverage procurement process ends successfully when the policyholder has transferred a significant risk for an appropriate price, and has affiliated itself with a financially sound institution that will be obliged to provide critical financial and strategic resources if and when a client claim strikes.

Questions from Our Readers

1. We have one pension plan client (although we also give advice to 401(k) plans and participants). Do we need E&O insurance for this, in addition to our “regular” E&O insurance?

If your existing E&O coverage does not cover investment advisory services rendered to a pension plan or 401(k), then there is a gap in your coverage relative to your needs. Insurers often issue separate policies that cover liabilities under ERISA, which fiduciaries under such plans may face. Alternatively, the definition of “investment advisory services” in your E&O policy needs to be broad

enough to include the advice you are rendering to these plans.

2. If a prospect asks for a copy of my E&O policy title page, or for my E&O policy number, is that a red flag? Should I tell that prospect that I’m not interested in working with him or her?

We don’t think you should regard this sort of inquiry as a red flag. More likely, the fact that you have obtained E&O coverage will give you an advantage in selling your services. (After all, if you were a really bad risk, you probably wouldn’t be able to get insurance!) Instead of looking at the inquiry as a sign of a litigious prospect, consider it a reasonable part of a careful prospect’s due diligence. After you disclose the policy information, the prospect should have increased confidence in you.

3. Does the E&O policy cover me to defend myself against claims of fraud? i.e. are there ANY restrictions of when the policy will not cover you to defend yourself?

The answer **ought** to be yes, but it depends on specific policy provisions. Some policies, for example, cover only negligent acts, which would exclude a claim of intentional fraud. Many policies provide for a defense against a fraud claim, but if there is a finding or adjudication that fraud occurred, the defense will stop and the insurer will ask for a return of the defense funds that it paid.

4. We’re a small firm (\$700,000 in annual revenues). Doesn’t the mere fact that we have E&O insurance encourage lawsuit-happy clients to sue, knowing that there are “deep pockets” behind the firm?

The absence of insurance would not be likely to deter many potential plaintiffs, although it might deter some. More importantly, however, without E&O insurance, if the cash resources of your own business are limited, simply mounting a sound defense to a meritless claim might strain available financial resources (especially if the cash resources of your own business are limited). In other words, smaller businesses are probably in a weaker position than larger businesses to “self-insure” against significant claims.

5. How should we determine the right amount of E&O coverage? Is there a formula based on the firm's assets under management?

Your broker would be a good source for this information. An experienced broker will usually have access to statistical information about the amounts of coverage that comparable businesses have purchased, and may have data about the size of possible claims your firm could face.

6. Does the "cost of corrections" cover internal trade errors when we correct them immediately and incur a loss? For example, if we buy too many shares in an account and then owe money to the trading broker to correct the error, would that be covered?

Generally, yes—although this is one of those matters that depends on the specific applicable policy language.

7. Will the insurance company pay for defense costs if the claim is for less than the deductible?

Generally, no. If the deductible is large enough that it will take some time to exhaust, the insurer may retain counsel and start defending in the meantime; if the matter is resolved before you exceed the deductible, the insurer will ask you to reimburse it for the amounts it's paid.

8. Since coverage is based on the client's claim or complaint, does that mean that if our client uses the word "fraud" in a complaint, the policy will not cover the complaint (i.e., cover our legal costs to defend ourselves)?

If the complaint includes at least one covered claim, then the defense benefits should apply. If all the claims allege intentional fraud, you cannot be liable for negligence under the applicable legal theories, and if the policy is one that excludes fraud (i.e., covers negligence only), then you might not have coverage. However, as noted above, some policies will provide a defense against a fraud claim until there is an adjudication or a fact finding of actual fraud.

9. Can you expand on wrongful acts? Our policy defines a wrongful act as "any actual or alleged

act." Does this mean we don't have coverage if a client alleges some misconduct?

We would expect coverage to be available if the client alleges misconduct in your investment advisory business—that's why you buy insurance. Put another way, if a client alleges misconduct, the client is claiming some act or omission that creates liability. However, other parts of the insuring clause and/or the policy may restrict coverage—for example, by requiring that the actual or alleged act be in connection with investment advisory services, or by excluding coverage for certain types of conduct.

10. Can you explain "tail" coverage for lawyers and financial advisers?

E&O policies are claims-made policies, meaning that claims against the policyholder need to be made within the policy period to be eligible for coverage. If the insurance isn't renewed—whether because the insurer refuses or because the policyholder buys insurance elsewhere or goes out of business—then typically the insurer that sold the E&O policy will give the policyholder the opportunity to buy tail coverage, which insures against claims arising from the acts or omissions of the terminated old business during the policy period, as long as the claim is made during a specified period (usually, one to six years following termination). A one-time fee, typically equal to 100%–200% of the old annual premium, is often charged for tail coverage.

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