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"LOSS" CONTAINMENT UNDER THE FINANCIAL INSTITUTION BOND

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I. INTRODUCTION

You have just left your first meeting with representatives of the insured, a large bank. Your car is boiling from having baked in the sun for two hours. You have in your hands a hefty proof of loss, which convincingly documents a loan loss of $2,000,000. During the meeting, the insured's attorney had leeringly referred to certain unspeakable practices and unnatural acts of a former loan officer of the insured, who is identified in the more staid proof of loss as a dishonest "Employee." Quite clearly, this is a claim that will be as easy to deal with as a junkyard pit bull.

This article deals with difficult claim situations, such as the one sketched above, where the insured's claim initially appears to be covered under one or more Insuring Agreements, but where the facts also indicate the possible application of certain bond provisions affecting the potential for coverage, or where the loss might not be fully covered. There is virtually no room for error in these circumstances, and the way you deal with the claim is almost as important as the ultimate claim decision reached. This article begins, therefore, with some brief comments about style, and then sets forth the key issues insurers must analyze when considering such claims.

II. IT'S A CONTRACT, STUPID

When an insured manifests a high and relatively justified expectation of payment, it is important both to acknowledge obvious facts, but to concede

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nothing that one cannot positively verify. It is also important to set reasonable time frames within which the parties are to complete tasks essential to the investigation. But the most crucial point in any investigation of a serious fidelity claim is to stay focused on contract language and principles.

I say this because sureties have had the most success in convincing courts of their coverage position by insisting that courts apply each relevant word and phrase in a fidelity bond to the facts at hand. Good examples of this are the opinions in *Oritani Savings & Loan v. Fidelity & Deposit Co. of Maryland*,[1] *Alpine State Bank v. Ohio Casualty Co.*,[2] and *National City Bank v. St. Paul Fire & Marine Insurance Co*.[3] All of these decisions reversed the rulings of lower court judges who obstinately refused to keep their analyses of the facts in lock step with the text of the bond.[4] A close case, therefore, requires a close textual analysis of the bond at issue as applied to the underlying facts. By doing this, you will force the insured, as well as yourself, to pay rapt attention to the text of the bond. If you find that your application of contract principles to the facts of a claim is less than convincing, it might be a good time to pay the claim.[5]

But which contract principles? The short answer to this question is: The principles that prevail in the jurisdiction whose law will apply to the interpretation of the bond. Identifying that jurisdiction usually is easy, except where a large corporate insured, with subsidiaries or business divisions headquartered in other states, is involved.[6] Those corporate subsidiaries will often be additional insureds, and the resolution of at least one key fidelity bond issue — involving late notice — crucially depends upon which state's law applies concerning that issue.

Some states, like Massachusetts, New York, and Idaho,[7] strictly apply the thirty-day notice provision. Others, like California and Utah,[8] require

1. 989 F.2d 635 (3d Cir. 1993).

2. 941 F.2d 554 (7th Cir. 1991).

3. 447 N.W.2d 171 (Minn. 1989).

4. The lower court decisions are as follows: *Oritani*, 741 F.Supp. 515 (1990; 744 F.Supp. 1311 (1990); *Alpine*, 733 F.Supp. 60; *National City Bank*, 435 N.W.2d 57.

5. I am assuming here that you will be negotiating with a relatively honest insured. That will not, of course, always be the case. Oscar Wilde once said, only half in jest, that "I like persons better than principles and persons without principles better than anything in the world." O. WILDE, PLAYS, PROSE WRITINGS & POEMS 78 (1972).

6. RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 193 (1969).

7. *FDIC v. Ins. Co. of N. Am.*, 928 F. Supp. 54 (D. Mass 1996); *Utica Mutual Ins. Co. v. Fireman's Fund Ins. Co.*, 748 F.2d 118 (2d. Cir. 1984); *Viani v. Aetna Cas. & Surety Co*., 501 P.2d 706 (Idaho 1972)

8. *See FDIC v. Oldenburg*, 34 F.3d 1529, 1546 (10th Cir. 1994), and cases cited therein, requiring a fidelity insurer to demonstrate prejudice flowing from late notice as a condition to enforcing a late notice defense.

the insurer to show actual prejudice from being notified more than thirty days after a loss is discovered. Such prejudice can only be shown in a small number of cases, so millions of dollars can ride on the issue of which state's law will apply on the notice issue.

But notice is the only fidelity bond issue that is accorded such disparate treatment from state to state. Virtually all states apply similar general principles of contractual interpretation. There are certainly a few differences in applying adhesion contract rules, or in honoring a insurer's claim that the bond was jointly negotiated — and therefore not subject to an adhesion contract analysis. But those arguments matter little when the claim has not yet gone into litigation. No insured will be swayed at that juncture by an argument about joint negotiations, and no insurer will give much credence to a bank disguising itself as an insured widow or orphan. What will command attention is a cogent analysis of the language of the bond applied to undisputed facts. That deceptively simple relationship is governed by the following rules in virtually every jurisdiction: Some of the interpretive rules set forth in the California Civil Code are illustrative:

1) Section 1641:
   The whole of a contract is to be taken together, so as to give effect to every part, if reasonably practicable, each clause helping to interpret the other.

2) Section 1643:
   A contract must receive such an interpretation as will make it lawful, operative, definite, reasonable, and capable of being carried into effect, if it can be done without violating the intention of the parties.

3) Section 1644:
   The words of a contract are to be understood in their ordinary and popular sense, rather than according to their strict legal meaning; unless used by the parties in a technical sense, or unless a special meaning is given to them by usage, in which case the latter must be followed.

4) Section 1645:
   Technical words are to be interpreted as usually understood by persons in the profession or business to which they relate, unless clearly used in a different sense.

5) Section 1649:
   If the terms of a promise are in any respect ambiguous or uncertain, it must be interpreted in the sense in which the promisor believed, at the time of making it, that the promisee understood it.

6) Section 1651:
Where a contract is partly written and partly printed, or where part of it is written or printed under the special directions of the parties, and with a special view to their intention, and the remainder is copied from a form originally prepared without special reference to the particular parties and the particular contract in question, the written parts control the printed parts, and the parts which are purely original control those which are copied from a form. And if the two are absolutely repugnant, the latter must be so far disregarded.

7) Section 1654:
In cases of uncertainty not removed by the preceding rules, the language of a contract should be interpreted more strongly against the party who caused the uncertainty to exist.

8) Section 1655:
Stipulations which are necessary to make a contract reasonable, or conformable to usage, are implied, in respect to matters concerning which the contract manifests no contrary intention.

In applying such contract principles, sureties must be careful to prevent insureds from relying upon cases that no longer are applicable because of the changes in the 1980 or 1986 versions of the Financial Institution Bond. Nowhere is this more bothersome than in discovery cases, where obsolete decisions continue to be cited for the proposition that discovery does not take place "until the insured discovers facts showing that dishonest acts occurred and appreciates the significance of those facts." This is an erroneous interpretation of Section 3 of the Financial Institution Bond. It is still found in many letters from insureds' counsel, and even in important appellate opinions like *Federal Department Insurance Corp. v. Aetna Casualty & Surety Co*.[9] When ferreting out such arguments, it is advisable to cite key articles that provide a historical explanation of the discovery provision.[10]

9. 903 F.2d 1073, 1076 (6th Cir. 1990).

10. In this instance, a good source is Duncan L. Clore & Michael Keeley, *Discovery of Loss: The Contractual Predicate to the Claim, in* FINANCIAL INSTITUTION BONDS 89-119 (Clore ed. 1995). A curious feature of issues like discovery, and the meaning of "counterfeit" under Insuring Agreement (E), is the willingness of courts to decide cases by stating propositions rather than interpreting contract language. *See National City Bank*, 447 N.W.2d 171 (Minn. 1989); *One American Corp. v. Fidelity & Deposit Co. of Maryland*, 658 So.2d 23 (La. Ct. App. 1995); and *Liberty National Bank v. Aetna Ins. & Surety Co*., 568 F. Supp. 860, 862-63 (D.N.J. 1983). A similar tendency to ignore the text at hand, quite apart from the intent of its authors, is found in federal constitutional decisions. Robert Strauss, *Common Law Constitutional Interpretation*, 63 U. CHI. L. REV. 877 (1996).

With these rules in mind, we can turn to the ways in which a claim can be reduced or perhaps even denied although there is otherwise a good deal of merit to it.

III. DISCOVERY, TERMINATION, NOTICE AND PROOF OF LOSS REQUIREMENTS

A. Discovery — When is a Loss Discovered?

Regardless of whether a claim might otherwise be valid, if the insured's loss was discovered outside the coverage period of the bond at hand, there will be no coverage. Bond periods are now almost universally one year in length. The definition of discovery in Section 3 of the FIB is both a blessing and a curse to sureties. It is crucial to understand the inevitable plasticity of this definition.

Two recent cases can be seen to provide each party to the bond some leeway in arguing for a specific discovery date. The first of these, *Federal Department Insurance Corp. v. Fidelity & Deposit Co. of Maryland*,[11] holds that a loan loss can be deemed to be "discovered" within a given bond period, despite not being specified in the original notice letter or the proof of loss, if that loan "arose out of the same pattern of conduct or scheme that was originally discovered."[12] These quoted words are not found in the FIB, and the Fifth Circuit's formulation of this "discovery standard" was based in part on an obsolete deductible provision that was changed materially in 1986.[13] Despite this, sureties certainly should not assume that this case can be ignored.

Nor can the decision in *First Security Savings v. Aetna Casualty & Surety Co.*[14] be ignored. That case held that a "second" proof of loss cannot be construed to be an amendment of an earlier proof of loss if it adds a series of transactions not mentioned in the earlier submission.

It is impossible to know how a court will rule when loss transactions are first identified and first reported after the relevant bond period expires. First Security is a more sensible decision than *Federal Deposit Insurance Corp. v. Fidelity & Deposit Co. of Maryland*, but neither case is completely satis-

11. 45 F.3d 969 (5th Cir. 1995)

12. 45 F.3d at 974

13. For a full discussion, see Michael Keeley & Toni Scott Reed, *Superpowers of Federal Regulators: How The Banking Crisis Created an Entire Genre of Bond Litigation*, 31 TORT & INS. L.J. 817, 834-37 (1996). For a discussion of the judicial use of standards, rather than rules, as guides to proper decision-making, see Sullivan, *The Justices of Rules and Standards*, 106 HARV. L. REV. 24 (1992). Commercial law generally is a poor area for the use of standards.

14. 445 N.W.2d 596 (Neb. 1989)

factory. For example, Section 3 states that discovery occurs when the insured becomes aware of facts which would cause a reasonable person to assume that a loss has been or will be incurred. As shown directly below, this means that the insured might sometimes be forced to act (i.e., put the insurer on notice) when its knowledge of an employee's dishonest behavior is incomplete. If the insured is to be penalized for not acting on such incomplete knowledge, won't some courts also permit insureds to amend their proofs of loss to add transactions more or less similar to those originally identified? In other words, the price of forcing the insured to act on incomplete knowledge may sometimes be judicial liberality in allowing the insured to add transactions to its claim that were not mentioned in the notice letter or even the proof of loss.

Thus, one rule will not always work in this area.

B. Discovery — Who Can Bind the insured, and the Quality of Binding Knowledge.

What about the "mental" side of Section 3, the qualitative mental state necessary to trigger Section 5's Notice and Proof of Loss requirements? Is that mental state always easy to fix? Obviously not, particularly in light of an important new case.

Federal Deposit Insurance Corp. v. Insurance Company of North America[15] is destined to set the standard on this issue. The author of this opinion is Judge Robert Keeton, a former Harvard Law School professor who once wrote an influential article that helped advance the cause of insureds.[16] But he has acted quite differently in interpreting fidelity bonds. In *Federal Deposit Insurance Corp. v. Ins. Co. of N. Am.*, he granted INA's summary judgment motion, holding that the insured discovered the subject loss more than thirty days before providing notice to INA of the claim. In Massachusetts, as noted above, notice provisions are strictly enforced. So the result was a serious defeat for the FDIC, which claimed it had $4,000,000 at stake.

Judge Keeton's opinion, while clarifying certain aspects of Section 3, does not fully clear up the many discrete inquiries buried in the discovery test. Judge Keeton properly sees Section 3 as posing a three-part test. As his opinion is analyzed below, the knotty problems in interpreting Section 3 will be noted.

15. 928 F.Supp. 54 (D.Mass. 1996).

16. Robert Keeton, *Insurance Law Rights At Variance With Policy Provisions*, 83 HARV. L. REV. 961 (1970); *see also* Robert Keeton, *Reasonable Expectations in the Second Decade*, 12 FORUM 275 (1976).

The first subpart of this three-part discovery test is that the insured must "become aware" of facts constituting discovery of the loss. Judge Keeton did not decide whether the awareness in question is measured by a subjective or objective test, because in *FDIC* the insured was subjectively aware of all of the relevant facts. Judge Keeton stated as follows:

> Although in other contexts a consideration of the possible meaning of awareness might be essential to a decision under Massachusetts law, I conclude that it is unnecessary in the circumstances of this case. As I explain in Part V of the Memorandum, I conclude that in this case, it is indisputable that the Bank was actually aware of facts and had drawn inferences amounting to "discovery," as defined in the Bond, before December 16, 1989 [thirty days before the date notice was given to INA]. Thus, for the purposes of this case, I need not and do not decide whether the language in the bond would impose an obligation if a "reasonable person" would have become aware of such facts but no person for whose state of mind the Bank is legally accountable had become aware of such facts. The Bank, through its agents, actually was aware of facts constituting "discovery" before December 16, 1989, and thus it was obligated to inform INA at that time.[17]

This language is unclear, and the court sidesteps two issues that still are unsettled. First, this passage adumbrates the possibility that, as to the awareness element of the three-pronged discovery test, an insured might be charged with such awareness -- which would fix the discovery date -- even if those persons "for whose state of mind the bank is legally accountable" did not subjectively become aware of those facts.

Judge Keeton reached such a conclusion recently in *Boston Mutual v. Fireman's Fund*.[18] In *Boston Mutual*, which involved the discovery issue under a bond that did not contain a specific definition of discovery, he charged the insured with a limited duty of inquiry upon having obtained knowledge of certain facts that would cause a reasonable person to inquire further. Judge Keeton does briefly cite *Boston Mutual* in discussing the awareness issue. But his opinion does not clearly explain in any detail the circumstances under which the insured could be charged with awareness of facts that its accountable agents were not subjectively aware of. Sureties can, however, plausibly argue, in a proper case, that the insured was "aware" of a set of facts constituting discovery under Section 3 where (a) some of those facts were subjectively known by agents for whose knowledge the insured is legally accountable, and (b) the remaining facts were not known subjectively by those agents, but would have been subjectively known by them had they investigated further after becoming aware of the facts they did subjectively know.

17. 928 F.Supp. at 60

18. 613 F.Supp. 1090 (D. Mass. 1990)

The other question left dangling here is how to identify those persons "for whose state of mind the insured is legally accountable" under Section 3. Clearly the bank's janitor alone cannot possess knowledge sufficient to force the bank to provide notice of a claim, and thus put the bank in danger of not having the ability to recover on that claim later. The law of agency must apply here. On this issue, it is wise to consult sections 1-7 and 268-82 of the Restatement Second of Agency (1958), plus the many cases that cite those Restatement provisions. Perhaps the most cogent case describing agency requirements is *E. Udolf v. Aetna Casualty & Surety Co.*[19]. *Udolf* was a "termination of coverage" case, but it is applicable to Section 3 on the imputation of knowledge issue:

> The cases relied upon by the trial court and the cases cited by both the plaintiff and the defendants lack any meaningful analysis of the reasons that imputation was either appropriate or inappropriate under the facts of the particular cases. We conclude, however, that a proper analysis flows logically from the tension between the conflicting views presented by the plaintiff and the defendants. The plaintiff argues that the general rule imputing knowledge of an agent to a principal presumes the agent's loyalty in the performance of his duties. The corporation purchases fidelity insurance to protect itself from the risk that the employee will be disloyal. The plaintiff claims that it, therefore, would be "absurd" to hold that each employee so insured was an agent of the plaintiff whose duty it was to discover and report acts of dishonesty by other employees. Moreover, the plaintiff argues, if the neglect or reluctance of the insured's employees to report on one another relieved the insurance carrier of its liability, the corporation would be denied a remedy. The defendants' counterpoint is that, taken to its extreme, the plaintiff's contention would render "prior employee dishonesty" exclusions useless. Without employee imputation, the defendants argue, it would be impossible to charge an insured corporation with knowledge of an employee's prior wrongful actions.
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> The answer to this conundrum can be found in the cases relied upon by the trial court, although not explicitly articulated therein. We conclude that the knowledge of an employee may be imputed to an employer under an employee dishonesty insurance policy if the employee holds a position of management or control in the exercise of which a duty to report known dishonesty of a fellow employee can be found to exist either explicitly or by fair inference from a course of conduct. "'The knowledge of individual officers and employees at a certain level of responsibility will be deemed the knowledge of the corporation; where the level of responsibility begins must be discerned from the circumstances of each case . . . .'[20]

The second prong of Judge Keeton's discovery test is that the facts the insured is aware of would "cause a reasonable person to assume" that a loss

19. 573 A.2d 1222 (Conn. 1990).

20. *Id.* at 1223-24, *citing Gordon Selway, Inc. v. Spence Bros., Inc.*, 440 N.W.2d 907, 915 (Mich. Ct. App. 1989), *quoting* 18B AM. JUR. 2D, CORPORATIONS 1673, pp. 524-25.

had been or would be incurred. Here the opinion goes a good distance toward clearing up the potentially confusing pairing of the concept of a "reasonable person" with the mental state of an "assumption," the problem being that a reasonable person doesn't assume anything on the basis of unknown facts. In an interesting passage, Judge Keeton resolves this dilemma as follows:

> For present purposes, I assume without deciding, as FDIC asserts, that 'mere suspicion' of loss is not sufficient to constitute "discovery." That rule does not apply, however, to a suspicion that is coupled with awareness of information that, in the mind of an ordinarily prudent person would create more than a 'mere suspicion.' When an answer for the unknown cannot be obtained before it is necessary to take action, an ordinarily prudent person may choose to act on the 'assum[ption]' that a loss has occurred rather than on an assumption to the contrary. If an ordinarily prudent person would respond in this way to the need to make a hard choice that has to be made on incomplete information, the ordinarily prudent person would then be 'assum[ing]' that loss has occurred. Thus, 'discovery,' as that concept is defined in the Bond, would have occurred.
>
> This interpretation of "assume" is reinforced by the fact that "assume" applies to a loss that "has been or will be incurred." Common sense tell us that "knowledge," or even "belief with reasonable certainty," would rarely if ever exist as to a loss that "will be incurred" at some time in the future.[21]

This means that the reasonable person discovers a loss at the point when, knowing certain facts and not knowing others, he deems it reasonable to provide notice to the insurer because he has more than a "mere suspicion" that a loss has been or will be incurred. This key element of the discovery test should be analyzed in every fidelity bond case.

The third and final subpart of the Keeton discovery test is that the loss being assumed by the hypothetical "reasonable person" is "a loss of the type covered by this bond [which] has been or will be incurred, regardless of when the acts causing or contributing to such loss occurred, even though the exact amount or details of a loss may not then be known." Judge Keeton related this requirement to the loan loss before him, which involved two bank employees. One of those employees was married to a man who had managed to obtain 100% financing for a condominium purchase from the very bank which employed his wife. In the process, he received a $7,700 financial benefit in the form of a free down payment on his condominium. In actuality, this was the tip of the iceberg of the loss, because the loss involved hundreds of loans. Judge Keeton, however, held that this was enough to trigger discovery of the entire loss under the bond, holding as follows:

21. *Id*. 928 F. Supp. at 61 (citations omitted).

> The language of the Bond defining 'discovery' makes clear that 'discovery' occurs 'even though the exact amount or details of loss may not then be known.' I conclude, therefore, that representatives of the Bank did not have to know the actual state of mind of the employees or the exact amount of benefit those employees received in order for the Bank officials' level of awareness to constitute 'discovery' of the loss. It would be sufficient to constitute 'discovery' that Bank officials had information regarding the nature of the fraud involved, the identity of at least some of the employees who were involved, and the benefit allegedly received by those employees in return for their fraud.[22]

This tells us that the basic elements of a loan loss under Insuring Agreement (A) must be known by the insured before discovery takes place. But serious questions remain. For example, the insured must have information concerning the "fraud involved," but is that the same as the "loss involved?" Apparently not, if "loss" means "the particular facts constituting dishonesty in each transaction." Indeed, the insured's knowledge of only some transactions appears to have convinced Judge Keeton that the entire 500-loan loss was discovered well before the particular details of each loan were uncovered. Without saying it, Judge Keeton is at least partly agreeing with the "pattern or scheme" formulation of *Federal Deposit Insurance Corp. v. Fidelity & Deposit Co. of Maryland*, which was discussed above.

Judge Keeton also held that the insured must also have information of "allegations" of financial benefit. But what if these allegations prove later to be untrue in that different financial benefits actually had been obtained? Has discovery still taken place at the earlier date? After all, many rumors could be floated by the insured concerning nefarious bribes of an employee, and often those rumors might not prove to be true later on. Much of this depends on the positions the parties are taking with regard to the discovery date.

After doing his best to unscramble the concepts embedded in this three-part test, Judge Keeton went on to hold that, under the undisputed facts, the bank-insured had discovered the loss more than thirty days before providing notice. His following comments are noteworthy:

> The series of events and documents upon which INA relies primarily involve disputes and litigation between the Bank and purchasers of condominiums from the Rostoff Group. Often, this information came to the Bank through lawsuits against the Bank, or counterclaims against the Bank when the Bank initiated foreclosure proceedings against defaulting borrowers.
>
> INA calls attention to the verified complaints and verified counterclaims of two sets of borrowers: Herbert and Deanna Bello and Edward and Dorothy

22. *Id.* at 61.

> Giamette. Both of these complaints and the counterclaims were received by the Bank in September of 1989. Moreover, it is significant that when the Bank finally sent INA a Notice of Loss on January 16, 1990, it included, as the only documentation of the loss, the Giamette verified complaint and verified counterclaim.
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> ….
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> Another source of evidence of discovery to which INA calls attention is DiCologero herself. Phillip Gillette, a Vice President of the Bank, has testified that DiCologero told him in October that her husband had purchased a condominium from the Rostoff Group without making any down payment. Gillette testified that this admission caused the Bank to conduct an internal investigation. A special meeting of the Bank's Audit Committee was called on November 6, 1989, and the Bank decided to hire the law firm of Gaston & Snow to investigate the situation.
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> Gaston & Snow then prepared a "proposed Scope of Investigation" dated November 15, 1989. This document indisputably shows that by at least November 15, the Bank had decided to take action. In these circumstances it is beyond genuine dispute that at this time, if not before, Bank officials "assumed" that the Bank had suffered a loss under the Bond. The conclusion that no contrary inference could reasonably be drawn by a finder of fact is reinforced by the fact that the proposal by Gaston & Snow reveals that, at the very least, the Bank had information regarding:
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> 1. Possible violations of federal or state banking laws through the 100% financing of condominium purchases.
>
> 2. The possibility that the above violations were the intentional acts of Bank employees who may have received compensation in return.
>
> 3. Specifically, that DiCologero, her son and her husband had received compensation from outside sources.
>
> 4. The possibility that the Bank's counsel in the loan closings was involved or had information about the events. Gaston & Snow also proposed to hire a private investigator to investigate DiCologero, her husband, and her son. The Bank agreed to the full proposal, which estimated the cost of Gaston & Snow's investigation at $25,000.[23]

This language tells us that the following factors are involved in "close" discovery cases:

(1) The nature of the evidence of dishonesty contained in the notice letter;

23. *Id.* at 62.

(2) The date the insured obtained that information;

(3) The date outside counsel was hired by the insured, if counsel was indeed hired by the insured;

(4) The existence of third-party actions against the insured relating to the subject loans, and the allegations contained in the pleadings therein.

These two recent discovery cases involving the FDIC are both maddening and interesting. No one can determine with precision how far these cases go in calculating an insured's discovery date. In a close case, they can be surprisingly important tools.

C. Termination of Coverage

It has been firmly established that, in an employee dishonesty case, the insured is barred from recovery if the insurer establishes that the "insured, or any director or officer not in collusion" with the allegedly dishonest employee, learned of any dishonest or fraudulent act of that employee prior to the acts for which coverage is sought. The Fifth Circuit, in *First National Bank of Louisville v. Lustig*,[24] held that the prior "dishonest or fraudulent acts" need not rise to the level of the type of manifest intent dishonesty covered by Insuring Agreement (A). No case holds otherwise, and rightly so: Section 12 of the bond very clearly so provides.

Two important cautionary points are germane regarding this defense. First, it is not going to be easy to flush out such prior dishonesty. The best evidence available might be that found in the insured's personnel records regarding the particular employee. It is crucial to ask for such records "by category," and not "by file." In other words, you don't ask for a "personnel file" or "employee file," but rather for "all documents relating to the employee's ability or honesty in the performance of his work." Equally crucial are any written rules or handbooks relating to an employee's duties toward her employer. These will set the baseline for the employee's honesty.

Beyond this, a trickier kind of evidence of prior dishonesty is the employee's verbal tales of how his earlier behavior, bordering on the dishonest and sometimes beyond, was happily tolerated by his employer, the insured. This type of evidence is often inflated, or wrong. However, because of the potential reach of section 12, and *Lustig's* approval of section 12, the employee should be thoroughly interviewed on this issue.

Sureties must further realize that they are justified in applying to the 1986 version of Section 12 all of the cases under Insuring Agreement (A) that were decided prior to the addition in 1976 of the manifest intent dis-

24. 961 F.2d 1162 (5th Cir. 1992).

honesty requirements. Some of these cases imposed a relatively weak threshold of dishonesty, thus expanding Insuring Agreement (A) coverage dramatically.[25] All of those earlier cases should now be utilized by sureties in contending that acts of "non-manifest intent dishonesty" of an employee terminated coverage for that employee.

Finally, please further note that coverage terminates under Section 12 when the "insured, or any director or officer not in collusion with the offending employee, learns of that employee's dishonest acts. It seems clear that courts will interpret "insured" here to mean any agent of the insured, not just an officer or director.[26] However, as noted above, agency principles must apply to this determination. The relevant agent, for example, must be in such a position to bind the insured to the legal consequences of his or her possession of that knowledge.[27]

Section 12 is a potent weapon, and, as shown above, it is very wide in scope. It can plan an important role in otherwise disparate claim situations.

D. Notice and Proof of Loss Requirements

As noted above, there are several states that strictly construe the notice requirement under first party insurance contracts, and many others that do not. The best argument in a reported case for strictly construing this requirement is found in *Federal Deposit Insurance Corp. v. Insurance Co. of North America*.[28] Judge Keeton applying Massachusetts law, provided an extended rationale for this rule. Other courts, of course, are unimpressed by such arguments, holding that such a strict construction of this provision would work a forfeiture for no good reason, unless prejudice were shown.

One jurisdiction, however, is unique in adopting a "notice prejudice" rule on notice while strictly construing the proof of loss requirement. In *National Union v. RTC*,[29] a Kansas federal judge applied three cases from the 1930's and 1950's to defeat the RTC's fidelity claim. Interestingly, the court never stated why there should be disparate interpretive rules for these very similar requirements. However, until this case is overturned, if ever, it stands as a warning to check older authority in the relevant jurisdiction for arguably anomalous decisions that a federal court must honor.

25. *See, e.g*., *Maryland Casualty Co. v. American Trust Co*., 71 F.2d 137, 138 (5th Cir. 1934) *cert. denied* 293 U.S. 582 (1934).

26. *First National Bank of Louisville v. Lustig*, 150 F.R.D. 548 (E.D. La. 1993).

27. *Restatement (Second) of Agency*, § 275.

28. 45 F.3d 969.

29. 923 F.Supp. 1402 (D. Kan. 1996)

IV. MITIGATION

An important issue that occasionally arises when an insurer has determined that a claim is otherwise covered is the doctrine of "mitigation of damages" or, as it has become known in recent years, the doctrine of "avoidable consequences." However, this doctrine is often misunderstood and is only rarely applied successfully in the fidelity bond context.[30]

Sureties also have argued that, under the law of subrogation, the insured cannot recover on the claim if it releases possible subrogation targets at any time without the consent of the insurer. This theory has occasionally been accepted.[31]

However, a much more potent tool is Section 7(e) of the Financial Institution Bond, which states that, as to the insurer's rights of recovery, the "insured shall do nothing after discovery of loss to prejudice such rights or causes of action." Thus, if you are going to pay a loss, make sure that the insured indeed has first complied with Section 7(e).

Section 7(e) was first added to the Bankers Blanket Bond in 1980. No case on this section has yet been reported. However, Section 7(e) obviously imposes an affirmative duty to protect the insurer's recovery rights, a duty that begins on the date of discovery. And because the discovery date may be earlier than the insured contends, an insurer may argue that after the discovery date (a) the insured disposed of collateral in a costly or inefficient manner; (b) the insured failed to sue a possible recovery target before the applicable statute of limitations expired; or (c) the insured released such a target from liability without receiving adequate consideration.

Basing a insurer's mitigation arguments on Section 7(e), therefore, turns the otherwise mushy doctrine of "avoidable consequences" into a stronger duty to preserve assets and causes of action. This section deserves more attention than it has yet been given.

30. A good discussion is found in E. ALLEN FARNSWORTH, CONTRACTS 12.12 (2d ed. 1990).

31. *See, e.g.*, *Security National Bank v. Continental Insurance Co*., 586 F. Supp. 139, 146-48 (D. Kan. 1982); *St. Louis Federal Savings & Loan Assoc. v. Fidelity & Deposit Co. of Maryland*, 654 F. Supp. 314 (E.D. Mo. 1987). It is doubtful that this argument will be accepted in every case. Moreover, there is authority holding that an improper claim denial wipes out this defense. *First National Bank of Louisville v. Lustig*, 1990 U.S. Dist. LEXIS 7457 (E.D. La. 1990). And other cases show (at the very least) strong hostility to sureties who wrongfully deny coverage and then, in the view of the courts in question, attempt to second-guess the way in which recoveries were made or applied. *FSLIC v. Transamerica*, 661 F. Supp. 246 (C.D. Cal. 1987); *FDIC v. Reliance*, 20 F.3d 1070 (10th Cir. 1994).

V. THE RELATIONSHIP BETWEEN SECTION 7(e) AND THE POTENTIAL INCOME EXCLUSION

It is crucial in some cases where coverage is clear to establish that any recoveries made by the insured, including those made prior to payment by the insurer, are applied pursuant to Section 7(c) of the bond. This subsection, which was revised in 1986, states that recoveries are to be applied in the following order, net of the expense of such recoveries:

> (1) To the insured to the extent that the loss would be covered but for the fact that it exceeds either the Single Loss or Aggregate Limits of Liability;
>
> (2) To the Underwriter to the extent of its loss payment;
>
> (3) To the insured in satisfaction of the Deductible.

Note that this substation does not, as do subsections 7(a) and 7(b), apply only "in the event of payment" by the Underwriter. It is quite arguable, therefore, that Section 7(c) applies to all recoveries made after loss is first discovered, regardless of whether payment has yet been made by the Underwriter.

One case has held otherwise. In *First National Bank of Louisville v. Lustig*,[32] the Court held that recoveries made by the insured, prior to payment by the insurer, could be applied by the insured first to past due interest on the loans which were the subjects of the claimed loss. Interest losses are, of course, excluded from recovery under the FIB.

The court allowed this application of recovery monies for two reasons. First, the court stated that recoveries made by the insured before being paid by the insurer are not within Section 7(c). The court's only authority for this was the 1969 edition of the Annotated Bankers Blanket Bond, which stated that the then-current "salvage" provision of the bond "[did] not apply to recoveries made before payment of loss." This holding is obviously wrong, because the 1969 salvage provision specifically stated that it did not apply until after payment by the underwriter.

The court went on to hold that even if Section 7(c) did apply, the version of Section 7(c) being construed in that case allowed recovery moneys to be applied first to "loss" in excess of the amount paid under the bond. And because "loss" could mean both covered and uncovered loss relating to the fraudulent loans in question, the insured was allowed to rake off -- right off the bat -- past due interest on those loans.

32. 847 F. Supp. 1322 (E.D. La. 1994).

But that reasoning is no longer valid under the 1986 version of the FIB. The pecking order of recovery has been radically changed. The Lustig case comes into play only where the loss of the insured is shown to have exceeded either the Single Loss Limit of Liability or the Aggregate Limit of Liability. And in the relatively rare cases where that happens, *Lustig* can be countered by citing another Louisiana case holding directly the opposite regarding the "first application source" of recoveries: *Federal Deposit Insurance Corp. v. Fidelity & Deposit Co. of Maryland*.[33]

There are two additional aspects of Section 7(c) that require respectful attention. First, Section 7(c) does not specifically state that the Underwriter is permitted to benefit from recoveries made by the insured prior to a payment by the Underwriter. A liberal court might rule that Section 7(c), placed as it is after two subsections that apply only after payment is made, may apply only after a payment by the insurer. This depends on how a court would view the absence of any reference to a payment by the Underwriter at the beginning of Section 7(c). The better rule is that the absence of such language, combined with the removal of the prepayment condition in 1980, allows the Underwriter to benefit from Section 7(c) prior to paying the claim.

Yet the word "settlement" in Section 7(c) might cause problems in some cases. An insured might argue that 7(c) does not benefit the Underwriter unless a settlement agreement is entered into between the insured and the Underwriter. Note the difference between the word "payment" in 7(a) and 7(b), and the word "settlement" in 7(c). If a "settlement" is not reached, and recoveries are then made by an insured, the insured will argue that 7(c) is inapplicable unless a consensual settlement has been agreed to by the parties. No case has discussed this argument, and *Federal Deposit Insurance Corp. v. Fidelity & Deposit Co. of Maryland*[34] holds that 7(c) applies even if the Underwriter pays the claim after judgment in a lawsuit between the Underwriter and the insured.

Section 7 of the FIB, in short, is in a state of flux. In a close case, much may depend on interpreting it correctly.

VI. APPLICATION OF EXCLUSIONS

A final topic of interest here is the art of applying exclusions to agreed facts. There is a tendency for both insureds and sureties to over argue their positions on exclusions. For a good example of an overzealous insurer, review *In re Prime Commercial Corp.*[35] For a good example of an overzealous

33. 827 F.Supp. 385 (M.D. La. 1993).

34. 827 F.Supp. 385 (M.D. La. 1993).

35. 187 B.R. 785 (N.D. Ga. 1995).

insured, review *Lyons Federal Savings & Loan v. St. Paul Fire & Marine Ins. Co.*[36] In both instances, questionable arguments were advanced that went absolutely nowhere. This does not help one's standing with a trial judge or a jury. Moreover, your credibility with your adversary may suffer if such arguments are made.

Sureties considering application of an exclusion must recognize out front that exclusions are narrowly interpreted. Yet this means nothing if the insurer can convincingly demonstrate that there is no logical explanation for an otherwise covered loss after the exclusionary facts are taken into consideration.

How is that accomplished? It is best to avoid a scatter gun approach to citing bond exclusions. No one will be fooled by this, least of all one's opposition. Only the most potent exclusions — under the facts presented — should even be mentioned.

Secondly, the exclusion must be explained to the insured in narrative form. An obvious example of this is the potential income exclusion. If a loan loss claim involves past due interest, the denial letter to the insured should state that the exclusion applies because: (a) the loss claimed includes x-dollars in past due interest; (b) past due interest obviously is interest not realized by the insured; and (c) there is no other logical way to characterize this part of the loss.

Just about anyone can do that much. But other cases require subtle argumentation. Two examples are of particular interest. In *Insurance Company of North America v. Gibralco*,[37] a sales representative of a stock brokerage persuaded some customers to exchange their bonds for higher-yielding securities. He then opened two unauthorized trading accounts. After obtaining the bonds, he sold them and kept the proceeds, some of which he later used to purchase different securities that were kept by him. The district court applied the trading loss exclusion to this loss, but the Ninth Circuit properly reversed.

Why? After all, the bond in question excluded "loss resulting directly or indirectly from trading," unless covered under Insuring Agreements (D) or (E). The Ninth Circuit held that the bond was ambiguous "with respect to losses involving both trading and employee dishonesty,"[38] but this really was not necessary. What the Court was truly concerned about was that this exclusion "would eviscerate the employee dishonesty coverage provisions of the bond in every case where a trade might occur in the course of an

36. 863 F. Supp. 1441 (D. Kan. 1994).

37. 847 F.2d 530 (9th Cir. 1988).

38. *Id.* at 534.

employee's dishonest scheme."[39] In other words, the Court was convinced that the trading by the dishonest employee was merely the means by which he carried out the theft of his customers' assets. To put it yet another way, the loss did not "result directly or indirectly from trading" because it resulted very directly from devious employee dishonesty. The driving thrust of the dishonest transactions was conceived to be dishonesty, not trading, and from that point the Court used an ambiguity argument as a convenient rhetorical device.

Continental Corp. v. Aetna Casualty & Surety Co.,[40] unlike Gibralco, applied a "transactional exclusion" to an employee dishonesty claim so as to defeat coverage. Continental involved an Insurance Company Blanket Bond, which contained an exclusion for liability of the insured "under contracts of insurance." The undisputed facts were that a Continental employee fraudulently caused bogus insurance policies to be issued to innocent insureds. Some claims were made on those policies; Continental had no choice but to pay those claims. Its ensuing bond claim, alleging an employee dishonesty loss, was rejected by the Seventh Circuit.

This was the correct result. But again one must understand why this is so. In *Gibralco*, as in *Continental*, the exclusion specifically was written into the bond to apply even if all the elements of an Insuring Agreement (A) claim had been met. Why did *Continental*, but not *Gibralco*, result in a insurer victory?

The answer can't be found in the opinions themselves, but rather in the characterizations of the two losses being compared. The *Gibralco* loss obviously "resulted directly" from employee dishonesty, as did the *Continental* loss. But the *Gibralco* Court in effect held that the *Gibralco* loss did not even indirectly result from trading, because the trading in that case, under the facts presented, was not a cause of the loss but rather an instrumentality through which the dishonest employee caused the loss.

The *Continental* exclusion, however, did not lend itself to being characterized in this fashion. It simply stated that the subject bond did not cover the liability of the insured "under contracts of insurance." The Seventh Circuit, therefore, had no room to set up a "comparative causation test" between employee theft (covered) and certain activities of the employee in achieving his dishonest ends, such as trading (not covered). Indeed, no comparison of any kind could be set up between Insuring Agreement (A) and an excluded "transaction category," the insured's liability under contracts of insurance. So the exclusion was properly applied.

39. *Id.* at 533.

40. 892 F.2d 540 (7th Cir. 1992).

Had the dishonest employee done something to cause the loss independent of the issuance of bogus policies, a different result would have been reached. For example, had the employee also canceled a reinsurance treaty that would have reinsured the insured for claim payments on the bogus policies, this would qualify as a covered loss because there would then be two independent reasons for the loss: (a) loss of reinsurance rights, which could not be characterized as liability of the insured under contracts of insurance (covered); and (b) loss sustained because of claim payments "under contracts of insurance." (not covered).

Gibralco and *Continental* show how detailed and logical any exclusion analysis must be if it is to succeed. An insurer must make fine distinctions between exclusions if its arguments are to be accepted.

VII. CONCLUSION.

The party prevailing in each of the above cases is the one who paid attention to the rules of contract interpretation extant in all fifty states. If this is done in every case — even tough ones — sureties will have a much better chance of having the bond interpreted as intended, and in avoiding payment of uncovered claims.