Why Aren’t Insurers Getting Their Day in Federal Court in Legal Malpractice Coverage Cases?

By David A. Grossbaum, Esq.

Federal courts are reluctant to decide LPL coverage cases where lawyers have failed to preserve coverage for the benefit of injured clients.

Many insurance companies like to have their cases heard in federal court. There are many reasons for this. Federal judges have strong academic credentials and lots of judicial experience. Because federal courts have jurisdiction over cases between citizens of different states, federal judges are very familiar with insurance coverage cases (insurers are often citizens of a state different than their insureds or claimants). In addition, an out-of-state insurer may be concerned about judicial bias when it is sued by a local insured or claimant, who may be familiar to, or sympathetic to, the state judiciary (or its lawyer may be). Still further, the procedural rules and practice in many federal courts mean that the case will be heard and decided quickly, and one judge will hear all of the motions and trial in the case, rather than a series of rotating state court judges. Also, federal courts will follow state court precedent, and will not create new law, and the insurer may like the existing state law. Finally, an insurer might like its chances on appeal before one of the federal circuit courts of appeal, rather than a state supreme court, which may be perceived as likely to protect its own citizens at the expense of a foreign insurer.

Whatever the reasons, insurers frequently file their coverage cases in federal court or transfer their cases there if they are sued in state court. But a few recent cases show that an insurer may not always be able to stay in federal court, particularly in cases interpreting legal malpractice policies. Notwithstanding that these recent cases involved straight-forward principles of insurance law (and appeared to be easy winners for the insurers), the federal courts refused to decide them, in significant part, because the conduct of lawyers is regulated by state authorities and the state court should decide whether an injured client should have access to the proceeds of the lawyer’s insurance policy.

For example, in Reifer v. Westport Ins. Co., 751 F.3d 129 (3rd Cir. 2014), the appellate court upheld the trial court’s decision to decline jurisdiction over a declaratory judgment action involving coverage under a legal malpractice policy. The federal court invited the state court to issue a new rule nullifying the clear language of the insurance policy so a client could access the policy proceeds, even though the insured violated the claims made and reported provisions of the policy.

The client, Reifer, instituted a legal malpractice action against the lawyer in March of 2008, at which time he was covered by an insurance policy issued by Westport. The lawyer did not promptly report the claim to Westport, which had issued a claims made and reported policy to him. When the complaint was filed against him, his malpractice policy lapsed and he did not secure replacement coverage. He attempted to give Westport notice after Reifer filed a second complaint, but Westport denied coverage because the claim was not first made and...
For many PLUS members, their local Chapter is their first contact and the face of PLUS, offering the best opportunity to connect with their industry peers, stay on top of current issues and practices, and earn essential continuing education credit. Last year almost 3,500 insurance professionals engaged with PLUS through their local Chapters. For many, Chapter involvement is the primary benefit of their PLUS membership.

Thirteen Chapters spread across the U.S. and Canada each host between 3-8 events each year that impact the local communities and meet the needs of the members in their region. This year PLUS Chapters will host 88 events, from workshops, receptions, and golf tournaments, to service projects and Women’s Leadership Network lectures. Top industry experts explore topics from D&O, Cyber, MedPL, and other markets, focusing on the unique perspective and interests of the local region.

The PLUS Foundation utilizes the Chapters to disseminate $79,000 in Foundation grants to local charities selected by the Chapters. Most also offer opportunities to provide service to those in need through partnered activities with the local Chapter Charity.

The people who participate in Chapter events are likely to be younger professionals, and a significant number are non-members (46%), making Chapter involvement a key gateway into the PLUS organization. Proximity and reasonable prices offer a cost effective way to attend a PLUS event. For many, that first Chapter event is the launching point of their career and the beginning of a long relationship with PLUS.

The 13 PLUS Chapters are active and growing because of the passion and commitment of almost 200 volunteers. 70% of PLUS volunteers are doing so through their Chapter. These gender, age and ethnically diverse leaders are expanding the vision and reach of PLUS among their peers. Involvement on a Chapter committee fosters relationships that can advance careers, lead to higher level positions within PLUS, and result in lasting friendships. As a group, Chapter committee members have a powerful voice that help formulate the strategic goals of PLUS and affect the professional liability industry as a whole. We encourage every PLUS member to check out the offerings and consider getting involved with their local Chapter.
Congratulations to 2015 PLUS Award Recipients!

Founders Award

The Founders Award recognizes a member of PLUS who has made lasting and outstanding contributions to the Society. The Award is presented in honor of PLUS Founder Angelo J. Gioia. Criteria used when selecting the Founders Award recipient include membership in PLUS, participation in PLUS activities, creativity and innovation when needed to address PLUS tasks, amount of time and effort dedicated to the organization, promotion of PLUS in the industry and to the public in general, or other contributions to the image of PLUS, and involvement in developing, implementing, improving and/or continuing PLUS programs.

The recipient of the 2015 Founders Award is...

Jeffrey R. Lattmann, Executive Managing Director, BEECHER CARLSON

Jeff Lattmann is widely known in the industry for his knowledge and expertise with Executive Liability products. He has more than 28 years of experience in both underwriting and brokerage in these lines of insurance, and his intimate knowledge of the marketplace and executive liability exposures helps to identify how a company’s risks should be treated. As Executive Managing Director for Beecher Carlson in New York, he is responsible for leading a group of professionals in designing and negotiating coverage to cover the full gamut of executive liability risks. Jeff previously led the U.S. operations for Marsh FINPRO placement. Prior to Marsh, Jeff was a regional manager for National Union Fire Insurance Company, a member company of AIG. As a former PLUS president, trustee, and co-chair of the D&O Symposium, as well as a frequent speaker at PLUS events, Jeff defines what PLUS looks for in its volunteer leaders; knowledge, dedication, and passion.

PLUS1 Award

The PLUS1 Award is presented to a person whose efforts have contributed substantially to the advancement and image of the professional liability industry. Criteria include reputation and success in the professional liability industry, history of lectures and service on panels addressing topics in the industry, current activity in professional liability, activity and involvement in PLUS, longevity in the insurance industry, and measure of impact on the professional liability industry.

The recipient of the 2015 PLUS1 Award is...

Michael C. Sapnar, President & Chief Executive Officer, Transatlantic Holdings

Michael Sapnar is President and Chief Executive of the Transatlantic Holding Group. He joined in 1995 as a specialty casualty underwriter, writing D&O, E&O and Medical Malpractice. From 1998 to 2002 he was the Underwriting Manager of the London branch office, before returning to the U.S. as Chief Underwriting Officer for Domestic Operations. He assumed his current role in January 2012. Prior to joining TransRe, Mike spent eight years as a professional liability underwriter at Continental Insurance. Mike holds a bachelor’s degree in Economics from the College of William and Mary, and an MBA in Finance from New York University.

See pg.15 for a list of past Founders Award and PLUS1 Award winners.
In data breach cases, identifying the basis for standing can be a tricky business. At the motion to dismiss stage, plaintiffs must clear a high hurdle in proving that they have suffered a cognizable injury under Article III of the United States Constitution. The likelihood of clearing that hurdle hinges on a number of factors, including the jurisdiction where the case was filed and, of course, the underlying facts. According to the Supreme Court, allegations of future harm can establish Article III standing when the harm is “certainly impending.” However, many lower courts have determined that an increased risk of identity theft—the principal argument in many class actions—doesn’t fit the bill. This article will analyze four of the most recent cases to evaluate how courts have treated the standing issue and discuss what insurers should expect going forward.

**Article III Requirements**

Article III limits a federal court’s jurisdiction to actual “cases or controversies.” One element of the “case or controversy” requirement is standing. The doctrine of standing guarantees that only parties with a real interest in the outcome of the case can file suit. Without standing, there is no subject matter jurisdiction, and federal courts must dismiss the case. To have standing, a plaintiff must establish an injury-in-fact that is: (1) concrete, particularized, and actual or imminent; (2) fairly traceable to the defendant’s actions; and (3) redressable by a favorable judicial decision.

In the data breach context, lower courts have routinely granted motions to dismiss based on the first prong—whether the plaintiff has established an actual or imminent injury. Although the Supreme Court acknowledged that “imminence is . . . a somewhat elastic concept,” the plaintiff must proffer more than “allegations of possible future injury.” However, allegations of future harm can establish Article III standing “if the threatened injury is ‘certainly impending,’ or there is a ‘substantial risk’ that the harm will occur.”

**The Clapper Decision and its Aftermath**

The Supreme Court analyzed this injury-in-fact requirement in Clapper v. Amnesty International, which involved a challenge to a provision of the Foreign Intelligence Surveillance Act of 1978 (“FISA”) that permitted government surveillance of certain activities. Human rights organizations feared that the challenged provision would hinder their ability to “communicate confidential information to their clients.” There was no evidence, however, that the government had intercepted their communications or was likely to do so. Rather, the plaintiffs asserted that “there was an objectively reasonable likelihood that their communication with their foreign contacts [would] be intercepted under [FISA] at some point in the future.”

The Court held that the plaintiffs lacked Article III standing because their fear of government surveillance was “highly speculative” and contingent upon a “highly attenuated chain of possibilities.” The Court rejected the “objectively reasonable likelihood” standard, explaining that it was “inconsistent” with the bedrock requirement that an injury-in-fact must be “certainly impending.” Notably, the Court also stated that “[i]ts cases do not uniformly require plaintiffs to demonstrate that it is literally certain that the harms they identify will come about. In some instances, [the Court has] found standing based on a ‘substantial risk’ that the harm will occur[].”

Following the Clapper decision, lower courts have applied the “certainly impending” and “substantial risk” standards to data breach cases. Under the majority view, an increased risk of identity theft—without actual harm—does not establish Article III standing. A minority of courts, however, have held otherwise. The Ninth Circuit, for example, remains a hotbed of activity. Notably, the Adobe court argued that “Clapper did not change the law governing Article III standing” nor did it overrule precedent requiring an “immediate and very real” risk of harm. Moreover, a district court in Minnesota has even applied a looser standard than Clapper’s “certainly impending” or “substantial risk” language.

**Trends in Data Breach Cases**

Despite the different outcomes, definite patterns emerge. Courts generally examine how susceptible plaintiffs are to an attack, how plausible a threat is, and the consequences of potential attacks. As detailed below, courts have focused on the following factors: (1) threats of physical harm, (2) immediacy of fraudulent charges, (3) an increased risk of identity theft, and (4) mitigation expenses and emotional distress.

**Threats of Physical Harm**

When personal information is readily accessible on file-sharing websites and also used to threaten physical harm, plaintiffs can establish an injury-in-fact that is “certainly impending.” That was the case in Corona v. Sony Pictures Entertainment, Inc. where hackers stole the sensitive and personal information of at least 15,000 former and current Sony Pictures Entertainment, Inc. (“Sony”) employees. As a result, plaintiffs filed suit against Sony alleging claims for negligence, among other allegations. The plaintiffs alleged that their personal information was posted on file-sharing websites and traded on torrent networks. Moreover, the plaintiffs asserted that their personal information had been used to send e-mails threatening physical harm to the plaintiffs and their families.

Sony filed a motion to dismiss, but the U.S. District Court for the Central District of California denied the motion, in part. The court found that the allegations regarding the file-sharing websites and the threatening e-mails were enough to establish a “credible threat of real and immediate harm, or certainly impending injury.”
Immediacy of Fraudulent Charges

Moreover, the U.S. Court of Appeals for the Seventh Circuit is the first post-Clapper appellate court to confer standing to class action plaintiffs. In the Neiman Marcus case, hackers targeted Neiman Marcus and stole the credit card information of roughly 350,000 customers. For approximately four months, the credit card information was exposed to the hackers’ malware. Following the cyber attack, Neiman Marcus notified potentially affected members and offered free credit monitoring services to affected customers for one year.

A number of consumers filed a class action against Neiman Marcus in the U.S. District Court for the Northern District of Illinois alleging that Neiman Marcus put the class at risk for identity theft and fraud. The plaintiffs alleged, among other things, that they faced “an increased risk of future fraudulent charges and greater susceptibility to identity theft.” Specifically, 9,200 credit cards had already experienced fraudulent charges.

The district court dismissed the case, but the Seventh Circuit reversed, holding that the plaintiffs demonstrated a “substantial risk of harm from the Neiman Marcus data breach” and thus had standing to pursue their claim. The Seventh Circuit reasoned that the hackers deliberately targeted Neiman Marcus and stole the credit card information of its customers. The court asked, “Why else would hackers break into a store’s database and steal consumers’ private information?” Presumably, the purpose of the hack is, sooner or later, to make fraudulent charges or assume those consumers’ identities.

According to the court, the plaintiffs “should not have to wait until hackers commit identity theft or credit card fraud in order to give the class standing, because there is an ‘objectively reasonably likelihood’ that such an injury will occur.” Further, the Court drew an adverse inference from Neiman Marcus’s offer for one year of free credit monitoring.

Increased Risk of Identity Theft

As discussed above, an increased risk of identity theft is insufficient to establish standing. For example, in Maglio v. Advocate Health and Hospitals Corporation, an unknown burglar or burglars stole four computers containing patient information from Advocate Health’s offices. In response, plaintiffs filed a class action alleging claims of negligence, among other allegations. Notably, the plaintiffs did not allege that their personal information was used in any unauthorized manner. Rather, they claimed that they faced an increased risk of identity theft or identity fraud. What’s more, the patient information related to roughly 4 million patients, but at that time, only two plaintiffs had received notification of fraudulent activity.

The trial court dismissed the action, and the Illinois Appellate Court affirmed, determining that the plaintiffs were unable to establish standing under Article III because an increased risk of identity theft or fraud is “purely speculative and conclusory.” Despite the plaintiffs’ concerns, the fact that only two plaintiffs of roughly 4 million experienced fraudulent activity does not show that the plaintiffs face “imminent, certainly impending, or a substantial risk of harm as a result of the burglary, where no such activity has occurred with respect to their personal data.”

Similarly, the U.S. District Court for the District of New Jersey affirmed that without evidence of post-breach misuse of compromised data, plaintiffs do not have standing. Essentially, a court must examine whether a laptop, for instance, was stolen for its street value or for the personal information to assume those individuals’ identities. In the Horizon case, an unknown thief stole two password-protected laptop computers from Horizon Healthcare Services, Inc.’s (“Horizon”) headquarters. The laptops contained the personal information of at least 839,000 members. After the theft was discovered, Horizon notified its potentially affected members and “offered free credit monitoring and identity theft protection.” Following this announcement, plaintiffs filed a class action asserting claims under the Fair Credit Reporting Act and several state law causes of action.

Of particular relevance is that the plaintiffs did not allege any post-breach misuse of compromised data. Horizon filed a motion to dismiss, which the New Jersey district court granted. The court emphasized that there is not a shred of evidence that the laptops were taken for the information they contained or that the information had been accessed or misused. Although Horizon had notified the potentially affected members and offered credit monitoring just like Neiman Marcus, there was no evidence that any Horizon members were affected. Thus, the court determined that the plaintiffs rested on generalized allegations of harm.

Mitigation Expenses and Emotional Distress

In addition to future injuries, these cases stand for the proposition that mitigation expenses (e.g., credit card monitoring and other preventative measures) do not establish an injury-in-fact when the harm is not imminent. If the law were otherwise, an enterprising plaintiff would be able to secure a lower standard for Article III standing by making an expenditure based on a nonparanoid fear. In that same regard, plaintiffs cannot rely on an emotional distress argument when they cannot demonstrate that their information is being used in a malicious way.

Conclusion

Although Clapper ostensibly resolved a circuit split between the appellate courts, the Clapper decision has created an intra-circuit split between the district courts in the Seventh and Ninth Circuit. Pre-Clapper, the Seventh and Ninth Circuits held that an increased risk of future harm was sufficient to confer standing. Subsequently, some courts have ruled that Clapper has overruled these decisions, but others have disagreed. And there is little doubt that more cases will spring up in the Seventh and Ninth Circuits, among other jurisdictions. The Supreme Court may need to intervene and issue a clear statement on the standing issue.

But even if plaintiffs can clear the hurdle for standing, the next challenge is class certification. Under Federal Rule of Civil Procedure 23(b) (3), plaintiffs must show that “questions of law or fact common to class members predominate over any questions affecting only individual members.” However, the calculation of damages will likely vary between class members and undercut the predominance of common questions. To illustrate: one plaintiff may have suffered fraudulent charges, but another may not. One plaintiff may accept free credit monitoring like the ones offered in Horizon and Neiman Marcus, but another may refuse. If courts are reluctant to approve class certification, data breach cases—even with standing—may be dead on arrival.

Endnotes To view the full article endnotes, please see the online version of the article at: http://stage.plusweb.org/Journal.aspx
This article identifies emerging trends in civil litigation, errors and omissions (E&O) claims against insurance agents and brokers, with a quick look at some recent national cases which address the expanding "duty to advise," and a focus on the current state of Pennsylvania E&O law. While recognizing areas ripe for claims, I conclude with practice thoughts for E&O defense counsel, and "best practices" for insurance professionals to mitigate their E&O exposure in 2016.¹

**Duties Owed**

With respect to a retail broker's tort duties owed, the general rule is that "An insurance broker is under a duty to exercise [reasonable] care that a ... businessman in the brokerage field would . . . and if the broker fails to exercise such care and if such care is the direct cause of loss to his customer, then he is liable for such loss." *Industrial Valley Bank and Trust Co. v. The Dillks Agency, et. al., 751 F.2d 637 (3rd Cir., 1985)*; see also *Al's Cafe v. Sanders Ins. Agency, 820 A.2d 745, 751 (Pa. Super. Ct. 2003)*. In other words, the agent has a duty to use that degree of care as would be expected of a reasonably competent agent under the same or similar circumstances. Keep in mind the distinction between claims for breach of tort duties owed (negligence) v. contract or statutory causes of action.

**Duty to Procure v. Duty to Advise / “Special Relationship”**

A key inquiry courts continue to tackle is the issue of a broker's "duty to procure" v. "duty to advise." Duty to procure means the broker is simply an "Order Taker", i.e., a duty to obtain coverage requested by the customer which they are willing to pay for, or to notify them of inability to do so. This duty is largely limited after binding of a policy absent affirmative misrepresentation.

On the other hand, a "special relationship" between a broker and customer may trigger a heightened "duty to advise", and this is an emerging trend which suggests expanding the duty of brokers under certain circumstances. Courts have identified the following factors which may give rise to a "special relationship" and duty to advise:

- Client pays "broker fee" for services beyond standard commission (10-15% of total premium);
- Advertisements of brokers as experts in a certain field / reliance by client; (e.g., restaurants/bars, aviation risks, condo buildings, etc.)
- Broker provides advice on specific coverage issue;
- Long-standing or exclusive relationship between broker and client;
- Who makes final decision on coverage selections?
- Engagement Letter / Contract Language.

I recently handled a case where a mid-sized insurance brokerage always required their customers to sign a "Management Fee Agreement" which read in part:

> We often charge fees to cover various expenses such as inspections, credit reports, customer service, risk management . . . appraisals or valuations. Additionally we charge a management fee as part of our overall compensation, in addition to receiving commission. This is not intended to increase your overall cost of placing insurance through our company. The fee is separate and apart from all premiums and installment fees charged by insurance companies.

In accordance with State Insurance Laws, we must ask that you sign this memorandum prior to coverage going into effect, acknowledging your acceptance of the above as part of procuring the … insurance coverage through our facilities.

Needless to say, plaintiff’s counsel viewed this document as a 'smoking gun' which triggered a "special relationship" and heightened duty of our broker to advise, appraise and valuate their customer's insurance needs, as well as recommend and instruct the client as to the type and amount of commercial coverage needed to adequately insure their commercial building, business personal property and business income interruption. Brokers should be wary of using documents like this, including additional fees charged for services which go beyond mere "procurement" functions.

Unfortunately for defendants, courts are tending to deem the "special relationship" issue a question of fact for a jury, rather than a question of law to be adjudicated at the summary judgment level before trial. Here are some recent decisions:

- Florida recognizes "special relationship" exception to the general rule of no duty to advise and considers it a question of fact. *Tiara Condo. Ass'n v. Marsh, USA, Inc., 2014 U.S. Dist. LEXIS 3677 (S.D. Fla. Jan 13, 2014)*. The broker's MSJ was denied. USDC for Southern District of Florida noted the contract with the client stated broker would act as "risk manager" for client, and therefore a factual question existed whether there was a "special relationship" and if broker had a "duty to advise." The jury found no "special relationship" existed. Plaintiff condo association was a sophisticated insurance purchaser.
• In a 2015 opinion, the Supreme Court of Indiana, on summary judgment review, held that SJ was proper on implied contract theory (good for defense because no comparative negligence on contract theory), but that it was a question of fact as to whether the parties enjoyed a special relationship that created a duty to advise. Ind. Restorative Dentistry, P.C. v. Laven Ins. Agency, Inc., 27 N.E.3d 260 (Ind. 2015). After a fire, a dentist’s office discovered that the contents coverage of its insurance policy—a policy it had maintained for over thirty years—was inadequate to cover the loss. The insurance agent and the insured disputed whether their long-term relationship was a special relationship that obligated the agent to advise the insured about its coverage. The parties also disputed whether their past dealings show a “meeting of the minds” on an implied contract, requiring the agent to procure a policy that would cover all losses to office contents. The Court reasoned:

All special relationships are long-term, but not all long-term relationships are special. “[I]t is the nature of the relationship, not [merely] its length, that invokes the duty to advise.” Over the past four decades, our Court of Appeals has consistently relied on four factors beyond mere duration to identify a special relationship: whether the agent(1) exercise[es] broad discretion to service the insured’s needs; (2) counsel[s] the insured concerning specialized insurance coverage; (3) hold[s] oneself out as a highly-skilled insurance expert, coupled with the insured’s reliance upon the expertise; and (4) receive[es] compensation, above the customary premium paid, for the expert advice provided.. (citing Parker, 630 N.E.2d 567 (Ind. Ct. App. 1994)).

However, these factors are not exhaustive, nor is any particular factor dispositive. The Court went on to identify these special relationship factors:

• Annual questionnaires sent to customer
• Marketing material touting industry expertise in dentistry
• Underscores industry trade association ties
• Long term relationship, 10+ years with current agency
• No extra fees above commission

In Voss v. Netherlands the NY Court of Appeals (Feb. 2014) found an issue of fact for trial existed re: whether a special relationship existed and if broker owed a duty to advise on business interruption coverage.

A special duty or relationship may be created when an agent assumes additional duties by holding herself out as having specific expertise. Williams v. Hill, Rogal & Hobbs Ins. Servs. of Cal., Inc., 98 Cal. Rptr. 3d 910, 919 (Ct. App. 2009).

Insurance agents or brokers are not personal financial counselors and risk managers, approaching guarantor status. Insureds are in a better position to know their personal assets and abilities to protect themselves . . . unless the [agents or brokers] are informed and asked to advise and act. W. Joseph McPhillips, Inc. v. Ellis, 778 N.Y.S.2d 541, 543 (App. Div. 2004).

Note that some states recognize a duty to advise even without special relationship test as this is engulfed by breach of fiduciary duty or even negligence standards.

**Breach of Fiduciary Duty / Restatement 552**

Claims for breach of fiduciary duty and Restatement (Second) of Torts § 552 are creating another mechanism for imposing liability. Some courts hold that insurance agents and clients have a fiduciary relationship akin to a lawyer, accountant or other professional. As such, a fiduciary will be required to exercise utmost good faith and mere silence could be actionable. See Randolph v Mitchell, 677 So.2d 976 (Fla. 5th DCA 1996); Triarsi v BSC Group Services, LLC, 422 N.J. Super 104 (2011):

It is unclear whether a fiduciary relationship exists between an insurance broker and an insured. An insurance broker does act in a fiduciary capacity when he receives and holds premiums or premium funds. Mark Tanner Constr. v. Hub Int’l Ins. Servs., 169 Cal. Rptr. 3d 39, 48 (Ct. App. 2014).

Some states including Pennsylvania have adopted 552 which provides for liability of one who supplies information for the guidance of others in the course of his profession, who rely upon it. This applies where a broker negligently conveys information to an insured about the coverage available under a policy. See Rempel v Nationwide Ins. 370 A.2d 366 (Pa. 1977). Most states already use 552 to create liability for other professions (accountants, appraisers, bank officers).

**Declaratory Judgment Actions**

Turning away from the special relationship analysis, other litigation trends include insurance carriers as plaintiff pursuing the broker on E&O claims. I am actively defending one such suit where Carrier Plaintiff sues co-defendant Policyholder seeking policy rescission (equitable relief on dec. action claim) for the alleged material misrepresentations in the policy application. Carrier claims it would never have issued the policy or charged higher premium had application questions been answered accurately. The carrier also sued my client broker for money damages in same suit under separate counts for fraud / negligent misrepresentations in the application (failure to investigate truthfulness of answers and negligent oversight). Carrier claims that, if coverage is owed on the policy for underlying catastrophic loss, then defendants owe underlying defense costs and indemnity payments incurred by carrier (policy limits) to defend and indemnify the underlying claims.

We raised a series of broker defenses, including: 1) Plaintiff’s dec. action against policyholder is an equitable claim seeking policy rescission and should be adjudicated separately as a threshold issue; if Carrier prevails on rescission and Court rules Carrier owes no coverage under the policy, then Plaintiff’s tort claims against Broker are extinguished and moot because Plaintiff owes no damages (No cross claims from policyholder against broker); 2) Carrier’s tort claims against Broker should fail because Broker owed no tort duties to Carrier, and there is no contract between Carrier and Broker; 3) Carrier and its Managing General Agent (MGA w/ binding authority) were comparatively / contributorily negligent for failing to perform their due diligence in writing and binding the policy by adequately inspecting the property and reviewing information/documents provided by...
Breach of Contract
Insurance brokers have no legal duty to inspect a business. Tort duties owed to Policyholder, Not Carrier.
Gist of the Action doctrine / Economic Loss doctrine
Expert report is required to establish the duty owed by an expert rather than on the contents of the insurance policy itself, or to “pass” when the time comes to read the policy.

Fraud / Intentional Misrepresentation

Breach of Fiduciary Duty
Contributory Negligence; 1% bars recovery. Gorski; Ind. Court held that, when pure monetary losses are sought, “malpractice actions are outside the scope of the comparative negligence act, and hence the doctrine of contributory negligence should apply.”

Deceptive or Unfair Trade Practices Statutes, (e.g., PA UTPCPL,73 P. S. §201-1 et. seq )

Common Legal Causes of Action Alleged Against Retail Brokers

- Breach of Contract
- Negligence / Negligent Misrepresentation
- Fraud / Intentional Misrepresentation
- Breach of Fiduciary Duty
- Deceptive or Unfair Trade Practices Statutes, (e.g., PA UTPCPL,73 P. S. §201-1 et. seq )

Contributory Negligence Defense in Pennsylvania

When defending brokers against negligence claims in PA, we raise the contributory negligence defense for fault of the policyholder / plaintiff, e.g., failure to read the policy or determine the value of his own property. Unlike many other states, in Pennsylvania, the doctrine of contributory negligence still exists with respect to actions seeking purely economic loss against professionals, and should bar recovery where Plaintiff is at least 1% responsible for the damages claimed.

Under Gorski v. Smith, 812 A.2d. 683 (Pa. Super. 2002), when pure monetary losses are sought, and one is not seeking damages for death, injury to person or property, the Comparative Negligence statute (42 Pa. C.S.A. §7102) does not apply. In Gorski, the Pennsylvania Superior Court held that, when pure monetary losses are sought, “malpractice actions are outside the scope of the comparative negligence act, and hence the doctrine of contributory negligence should apply.”

Applying contributory negligence principles in a professional negligence action against insurance brokers, the Third Circuit stated that, “Although an insurance broker owes a duty of care to its customer, that duty is not unaffected by the conduct of the customer itself.” (emphasis added). Industrial Valley Bank and Trust Co. v. The Dilks Agency, et. al., 751 F.2d 637 (3rd Cir., 1985). The Third Circuit in Dilks went on to confirm the duty of insurance brokers in Pennsylvania as follows:

An insurance broker is under a duty to exercise the care that a reasonably prudent businessman in the brokerage field would exercise under similar circumstances and if the broker fails to exercise such care and if such care is the direct cause of loss to his customer, then he is liable for such loss; unless the customer is also guilty of failure to exercise care of a reasonably prudent businessman for the protection of his own property and business which contributes to the happening of such loss. Dilks at 639; see also Al’s Cafe v. Sanders Ins. Agency, 820 A.2d 745, 751 (Pa.Super. Ct. 2003) (emphasis added).

Yet, other Pennsylvania cases demonstrate a theoretical conflict we see across other states. In Drelles (Pa. Super. 2005), the Court found an insured has the right to rely on the representations made by an insurance agent because of the agent’s expertise in a “complicated subject.” Considering the trust placed in insurance agents, the Court found it is “not unreasonable” for consumers “to rely upon the representations of the expert rather than on the contents of the insurance policy itself,” or to “pass” when the time comes to read the policy.

Last year, in Sherman v. John Brown, (W.D. Pa. 2014), the Court rejected the economic loss doctrine defense (not contrib.) to negligence claims seeking purely economic damages -- and found that brokers fall within professional liability exception to the rule.

Common Legal Defenses of Brokers in Pennsylvania (And Elsewhere)

- Contributory Negligence; 1% bars recovery. Gorski; Ind. Valley Bank; (limited protection to negligence claims only); Most states recognize comparative negligence rather than contrib. as complete bar.
- Insured has both the capacity and a duty to inquire about the scope of insurance coverage, rather than rely on “hand holding and substituted judgment.” Kilmore v. Erie Ins. Co., (Pa. Super 1991).
- Brokers have no duty to speak about other policy options before policyholders purchase their insurance policy. Weisblatt, (E.D.Pa., 1998).
- Insurance brokers have no legal duty to inspect a business property for purposes of offering insurance. Wisinski (Pa. Super. 2006).
- Tort duties owed to Policyholder, Not Carrier.
- MGA /Wholesaler liability.
- Insured has a non-delegable duty to review and read an insurance Application before signing it. Rony; Young (E.D. Pa. 1997).
- An applicant for insurance “may not avoid the responsibility imposed by the application by signing a blank form and leaving it to another to fill in the appropriate responses.” American Franklin Life Ins. Co.,(E.D. Pa. 1991).
- Insured cannot avoid the consequences of an insurance policy by alleging failure to read or understand the policy. Standard Venetian Blind., (Pa. 1983).
- Gist of the Action doctrine / Economic Loss doctrine
Some plaintiffs attempt to plead bad faith against broker under statute (42 Pa.C.S.A. 8371), but broker does not meet statutory definition of “insurer”.

**Broker Best Practices to Reduce E&O Exposures**

Lastly, a non-exhaustive list of best practices for retail brokers to reduce E&O exposure in 2016:

- Service Engagement Letters to define / limit scope of services;
- Provide Customer with Options for their Selection / Decision;
- Document Everything – Especially Poor Decisions by Customer:
  - Annual mailings with enclosures, dec. sheets, policies, notices of renewal / termination
  - When client declines coverage or higher limits
- When client is informed of reduced, changed or deleted coverage
- Quote/proposal with sign-offs if appropriate
- Phone conversations / all communications reduced to writing
- Do not assume duties beyond scope of knowledge (e.g., business valuations, appraisals, inspections, “risk management”);
- Read and communicate all terms, quotes and binders from MGAs;
- Review existing coverage of new client before placing the risk;
- Application Process -- Insured Must See and Sign the Application;
- Educate broker's support staff.

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**Endnotes**

1. The definitions of insurance “agent” v. insurance “broker” are jurisdictionally specific and readily interchangeable within the insurance industry. This article refers primarily to retail insurance brokers/agents, who deal directly with the customer / insured policy holder. A retail broker is an individual licensed by the state to secure insurance for the policyholder. Unless an insurance professional is affiliated with a particular company, that party is an agent of the insured not the insurer for the purpose of procuring coverage. *Regis Ins. Co. v. Rathskellar*, (Pa. Super. 2009). Most states follow this rule.

2. Gorski was a legal malpractice action but the rationale we argue still applies for brokers.

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reported during the policy period. The lawyer then admitted liability to Reifer, but reserved the right to contest damages. The jury awarded Reifer $4.2 million plus "delay damages." The lawyer assigned his rights against Westport to Reifer, who then filed the action against Westport. Reifer's argument was that Westport was required to prove prejudice in order to disclaim coverage.

The coverage case was removed to federal court, and neither party argued that the court should decline jurisdiction. Westport filed a Motion to Dismiss under well-established law enforcing claims made and reported provisions without a showing of prejudice, and the magistrate recommended that the motion be granted. Nonetheless, the District Court, on its own initiative, declined to exercise jurisdiction, remanding the case to state court.

The Third Circuit Court of Appeals acknowledged that the exercise of jurisdiction in a declaratory judgment action is discretionary, rather than compulsory. The standard of review of the District Court's decision was for an "abuse of discretion."

Westport argued that the District Court did not have the discretion to decline jurisdiction because, although couched as a declaratory judgment action, it was actually a claim by Reifer for money damages in the amount of the judgment awarded to her. The Third Circuit rejected the distinction, finding that what was really at stake was Westport's coverage for the underlying judgment. The fact that money damages would flow from a declaration in the case did not change the nature of the case or remove it from the declaratory judgment act.

Federal law requires courts to consider a number of general factors in determining whether to exercise jurisdiction in a declaratory judgment action. First, federal courts may decline to decide a case if there is already a case pending in state court addressing the same issues. If not, then it must consider: (1) the likelihood that the federal court's decision in the declaratory judgment case will actually resolve the issue in dispute (or whether there will still be a dispute between the parties on some other issue); (2) the convenience of the parties; (3) the public interest in having the issue resolved; and (4) the availability of remedies other than a declaratory judgment to resolve the issue. Moreover, in the insurance context, federal courts have been advised to consider additional specific factors: (1) a general policy of restraint when the same issues are pending in state court (such as where facts relevant to the coverage dispute will be decided in the underlying state case against the insured); (2) the inherent conflict of interest between an insurer's duty to defend the underlying action and its desire to characterize that action as uncovered in the coverage case; (3) the avoidance of duplicative litigation; and (4) the reluctance of federal courts to decide a coverage issue that has not yet been addressed by a state court.

Westport contended that there was no pending action against the insured in state court (it had already resulted in a judgment against the insured) and Pennsylvania law was clearly in its favor (as was already decided by the magistrate). Thus, there was no good reason to send the case to state court.

The federal court disagreed: "[w]here state law is uncertain or undetermined, the proper relationship between federal and state courts requires district courts to 'step back' and be 'particularly reluctant' to exercise DJA [declaratory judgment act] jurisdiction" (citation omitted). Reifer argued that state law was uncertain, and that she was entitled to coverage even if the insured lawyer had breached the terms of the policy. She pointed out that the practice of law is regulated by the Pennsylvania Supreme Court, and lawyers are required to disclose whether they maintain insurance coverage and to notify clients if their coverage lapses. These disclosures create reasonable reliance by the public on the existence of insurance. Because claims made policies are the only type available to lawyers in Pennsylvania, and do not require a showing of prejudice before an insurer can disclaim, the requirement to disclose the existence of insurance and the terms of claims made insurance creates illusory security for clients if lawyers do not promptly report claims made against them. Westport, on the other hand, argued that the lack of coverage was well-settled in Pennsylvania where an insured failed to report a claim during the policy period, without regard to prejudice.

While not expressing an opinion on the merits of Reifer's claims, the Third Circuit said:

At a minimum, she makes a non-frivolous argument for possibly carving an exception to governing Pennsylvania law in the context of legal malpractice insurance contracts. ... Reifer's argument unmasks a potentially unintended and unforeseen consequence arising out of the nexus of those rules [of professional conduct] and Pennsylvania insurance law, which places in the hands of negligent attorneys the responsibility of ensuring their clients receive a remedy. Reifer raises a legitimate concern that current Pennsylvania insurance law permits the fox to guard the henhouse and hinders realization of the Pennsylvania Supreme Court's intent. Thus, we believe her argument – whatever its merits – is best decided in the Pennsylvania court system because it directly raises a matter particularly within the purview of that state's highest court. [footnote omitted].

Thus, the upshot of this decision was, not only that the state court should decide the coverage issue, it was asked to consider whether long-standing law in Pennsylvania enforcing claims made and reported policies should be reconsidered and overturned when it comes to lawyers. Had the federal court maintained jurisdiction, it would have been required to affirm the magistrate's decision in Westport's favor, based on that same well-settled state law.

Another recent case involving abstention in a lawyer's professional liability coverage case was Minnesota Lawyers Mutual v. John P. Hildebrand, LPA, 2014 WL 1050911 (N.D. Ohio March 17, 2014), which also relied, in part, on the state regulation of lawyers when sending the case back to state court. In that case, the insurer, MLM, issued one year professional liability policies to the Hildebrand firm starting in 2004 and ending in 2010. For each policy, the Hildebrand law firm affirmed that it was "not aware of any claim or circumstances that could reasonably result in claims or disciplinary actions that had not been reported to MLM." The policy contained an intentional acts exclusion, with innocent insured protection for any insured who did not participate in or have knowledge of another insured's intentional conduct, if that notice was given to MLM as soon as the innocent insured learned of it.

The firm was comprised of a father and son, Hildebrand, Sr. and Hildebrand, Jr. Hildebrand, Sr. affirmed each year that there were no potential claims of which any insured was aware. During the same period of time, however, Hildebrand, Jr. was engaged in conduct that ultimately resulted in his being disbarred. Between August 2008 and February 2009, the Cleveland Bar Association received grievances against Hildebrand, Jr. In July

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continued on page 14
2009, the Bar filed a complaint of misconduct against him. In November 2009, his law license was suspended and he was ultimately disbarred in 2010.

In March 2010, after Hildebrand, Jr.’s suspension, but prior to his disbarment, Hildebrand, Sr. asked to remove Hildebrand, Jr. from the policy and to change the firm name to the Hildebrand Sr. firm. This was done and a policy was issued just to Hildebrand, Sr. for the period April 1, 2010 to April 1, 2011. When applying for this new policy, Hildebrand, Sr. stated that he was unaware of any potential malpractice claims that might be made against him or the firm.

In December 2010, after Hildebrand, Jr.’s disbarment, Hildebrand, Sr. notified MLM of a potential claim, which then ripened into a lawsuit, based on Hildebrand Jr.’s dishonest conduct. MLM agreed to defend the Hildebrands under a reservation of rights. MLM named the Hildebrands and the legal malpractice plaintiff as parties.

One factor the court evaluated was whether there might be contradictory rulings on the same issue by the federal court (hearing the coverage action) and the state court (hearing the legal malpractice case). One issue in the declaratory judgment action was whether the claims arose out of excluded criminal dishonest, malicious and deliberately fraudulent conduct, and the culpability of the insureds was also an issue in the underlying state court case. Nonetheless, rescission of the policy based on the insured’s failure to disclose in 2010 the prior bar grievances and disciplinary petition against Hildebrand, Jr. was separate from that issue. Presumably, this defense was strong and could have resulted in a final and dispositive decision in favor of the insurer regardless of whether the Hildebrands acted negligently or intentionally.

As in Reifer, the court ruled that state courts are better able to resolve novel questions of state law and other factual issues controlled by state law, and federal courts should abstain when there are important state public policy goals involved. The court referred to the policies underlying the interpretation of insurance contracts and the regulation of attorneys as a basis for abstaining.

Conclusion

These cases point out that federal courts are not always available to insurers for the resolution of coverage disputes, even simple ones based on well-established principles of insurance law. Federal courts are showing a reluctance to deny coverage for a claimant injured both by a lawyer’s negligence in the first instance, and then by the failure of the lawyer to preserve insurance coverage for that negligence. Because federal courts cannot make new law on these issues, they are shipping these cases to state courts, which can create new rules that somehow find coverage.
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