Supreme Court of Kentucky

Case No. 2010-SC-000827-D
Court of Appeals Case No. 2008-CA-1248

AIG DOMESTIC CLAIMS, INC.
and NATIONAL UNION FIRE INS. CO. — APPELLANTS

v.

On Appeal From The Pike Circuit Court
Action No. 06-CI-00231

TAMMY TUSSEY, PIKE COUNTY
BOARD OF EDUCATION and
EDDIE MCCOY — APPELLEES

REPLY BRIEF FOR APPELLANTS

This shall certify that the record on appeal was not withdrawn by the undersigned in preparation of this brief and that this brief was served by depositing true copies in the United States Mail, first class, postage prepaid, addressed to Hon. Sam Givens, Clerk of the Court of Appeals, 360 Democrat Drive, Frankfort, KY 40601; Hon. Eddy Coleman, 435 Hall of Justice, 172 Division Street, Pikeville, KY 41501; W. David Deskins, Pike Circuit Court Clerk, 336 Hall of Justice, 172 Division Street, P.O. Box 1002, Pikeville, KY 41502-1002; Lawrence R. Webster, Webster Law Offices, P.O. Drawer 712, Pikeville, KY 41502; Neal Smith, Smith, Atkins & Thompson, PLLC, 140 Scott Avenue, P.O. Box 1079, Pikeville, KY 41502; and Robert L. Chenoweth, Chenoweth Law Office, 121 Bridge Street, Frankfort, KY 40601, on this the 27 day of January, 2012.

Respectfully submitted,

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STATEMENT OF POINTS AND AUTHORITIES

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INTRODUCTION

"Where the terms of an insurance policy are clear and unambiguous, the policy will be enforced as written." *Kemper Nat. Ins. Companies v. Heaven Hill Distilleries, Inc.*, 82 S.W.3d 869, 873 (Ky. 2002). "[C]ourts should not rewrite an insurance contract to enlarge the risk to the insurer." *St. Paul Fire & Marine Ins. Co. v. Powell–Walton–Milward, Inc.*, 870 S.W.2d 223, 226–27 (Ky. 1994).

The first page of the Board's claims-based insurance policy provided:

> **NOTICE: THIS IS A CLAIMS-MADE FORM: EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED HEREIN, THE COVERAGE OF THIS POLICY IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE COMPANY WHILE THE POLICY IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.**
>
> In consideration of the premium charged . . . the Company and the Insured agree as follows:
>
> INSURING AGREEMENTS
>
> 1. ERRORS AND OMISSIONS
>
> To pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as Damages resulting from any Claim first made against the Insured and reported to the Company during the Policy Period for any Wrongful Act of the Insured in the performance of duties for the School Entity.

[Policy at 1 (underlying added), copy attached as Appendix A]

The insurance policy in effect when Tussey filed suit against the Board on February 20, 2006, covered a policy period from July 1, 2005 through July 1, 2006. At the end of that time, the Board purchased a second policy covering a policy period from

July 1, 2006 through July 1, 2007. [Appendix A, Declarations Page (identifying the effective dates of the second policy and describing Policy No. 672-64-37 as a "replacement" of Policy No. 492-29-21)] The Board first reported Tussey's claim to National Union in late April 2007, ten months after the first policy expired. [See Notice of Occurrence/Claim Form, copy attached as Appendix B] Because Tussey's claim was not first made against the Board and reported to National Union during the same policy period, there is no coverage for her claim under either insurance policy.

ARGUMENT

I. There Is No Coverage For Tussey's Claim Because It Was Not Made Against The Board And Reported To National Union During The Same Policy Period.

There are two separate claims-based insurance policies at issue here. Each policy is identified by a different policy number, and each policy covers a distinct 12-month policy period running from July 1 to July 1. [*See, e.g,* Appendix A, Policy Declarations Page] The Board's Brief begins by acknowledging that "[a]t the time the Complaint was filed the Board was insured under an Errors and Omissions policy provided by National Union . . . This policy was a claims-made policy which ran from 12:01 a.m. on July 1, 2005 through 12:01 a.m. on July 1, 2006." [Board's Brief at 1] Yet, the Board later asserts that "[t]he policy was in force . . . from July 1, 2005 through July 1, 2007," that "the same policy of insurance was in place at all relevant times," and that "there was no break in the policy during those years." [Board's Brief at 6, 7] In attempt to create a single overarching policy covering the two separate policy periods, the Board refers to the second policy as a "renewal" of the first, and contends that it timely notified National Union of Tussey's claim during the "renewal period." [*See, e.g.,* Board's Brief at 1-2]

Characterizing the second policy as a "renewal" is of no consequence, as by its terms, each policy provided coverage only for those claims "***first made against the Insured and reported to the Company during the Policy Period***." [Appendix A, Policy at p.1, ¶1 (emphasis added)] The "policy period" is defined as "the period from the effective date of *this* policy to the expiration date or earlier cancellation of *this* policy." [*Id.* at p. 2 (emphasis added)] The Declarations page specifically identified both the beginning and ending dates of the second policy period as July 1, 2006 to July 1, 2007, and covering only those 12 months in between. [*Id.* at Declarations Page[1]] Nowhere does the second policy say that it is a "renewal policy." Instead the Declarations page identifies it as a "replacement" of the prior policy. [*Id.*] Moreover, nothing in the policy language suggests that the purchase of a "renewal" or "replacement" policy serves to negate each individual policy's reporting requirements or result in a merger of the otherwise separate policies or policy periods.

Kentucky's Highest Court considered whether an annual renewal of a city tax collector's bond resulted in one continuous bond contract or separate contracts in *City of Middlesboro v. American Sur. Co. of N.Y.*, 307 Ky. 769, 211 S.W.2d 670, 673 (1947). The Court concluded that each "bond is a distinct contract, the renewals are separate and distinct contracts, and the liability of the Company for an act committed during a given period must be determined by the terms of the contract in force at the time of its commission." *Id.* Similarly in this case, there is no basis for finding that a single insurance policy or, more importantly, a single policy period, covered the date when

[1] Similarly, the "Employment Practices Violation Endorsement," which would apply to wrongful discharge claims such as Tussey's, states on its face that it was "effective at 12:01 am, July 1, 2006" – four months after Tussey filed suit against the Board. [*See* Appendix A, Policy at Endorsement # 11]

Tussey's claim was first made in February 2006 and when it was first reported to National Union in April 2007.[2] Because there was not one continuous policy (or one continuous policy period) covering the 14 months at issue here, there is no coverage under the Board's claims-based insurance policies.

Finally, the Board maintains that it "expected" to have "continuous coverage" with National Union during the relevant period, and suggests that a denial of coverage would mean there were "breaks" or "gaps" in the insurance. [*See, e.g.,* Board's Brief at 6, 8] Yet having "continuous coverage" under a string of successive, but separate claims-based policies does not create one policy of insurance or otherwise allow the insured to ignore the specific terms of the individual policies, any more than having successive purchase contracts or successive employment contracts would negate the individual provisions set out in those contracts. Still, there were no unexpected "gaps" or "breaks" in the Board's insurance coverage. To the contrary, all claims made against the Board at any time throughout the successive policy periods would have been covered, either by the first policy or by a subsequent policy, ***if the Board had notified National Union of the claim within the policy period in which it was first made against the Board***, as was required by the plain language of each of the policies. Because the Board failed to comply with the policies' terms, there is no coverage. *See, e.g., Pantropic Power*

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[2] A number of courts have specifically rejected arguments concerning the "renewal" of claims-based insurance policies such as those advanced by the Board in this case. *See, e.g., Pantropic Power Products v. Fireman's Fund Ins. Co.*, 141 F.Supp.2d 1366, 1370 (S.D. Fla. 2001), *aff'd* 34 Fed. Appx. 968 (11th Cir. 2001)(noting "Plaintiff's characterization of the second policy as a renewal is of no legal import" as there remained two separate policy periods); *Boerman v. American Empire Surplus Lines Ins. Co.*, 2001 U.S. Dist. LEXIS 16270, *7 (W.D. Mich. 2001), *aff'd* 50 Fed.Appx. 248 (6th Cir. 2002)(rejecting a claim that annual renewal of claims-made policies create one "seamless policy" reporting period); *National Union Fire Ins. Co. v. Bauman*, 1992 WL 1738, *10 (N.D. Ill. 1992), *aff'd* 997 F.2d 305 (7th Cir. 1993)(rejecting a claim that renewal creates a single policy period for reporting purposes); *World Health and Education Foundation v. Carolina Cas. Ins. Co.*, 612 F.Supp.2d 1089, 1096 (N.D. Ca. 2009)(same).

Products, 141 F.Supp.2d at 1369 (rejecting an argument similar to the Boards, and noting that the claim "did not fall into cracks between the two policies, nor was the coverage illusory. Had [the insured] reported the claim during the policy period in which it was asserted against [it], [the insurer] would have been obligated to defend the claim."); *World Health and Educ. Foundation*, 612 F.Supp.2d at 1096 (similarly concluding that "if a claim is not timely reported during a policy period, the insured is not covered simply because it has a subsequent policy").

II. The Overwhelming Majority Of Courts Have Found That The Act Of Purchasing Successive Claims-Based Policies From A Single Insurer Does Not Alter The Reporting Requirements Set Out In The Separate Policies.

As it has throughout this litigation, the Board relies nearly exclusively on two cases to support its claim that purchasing successive claims-based insurance policies permits it to ignore the language of the individual policies and notify National Union of Tussey's claim at any time during the parties' relationship. For the reasons explained in National Union's opening brief at 23-24, 28-29 the Board's reliance on *Helberg v. National Union Fire Ins. Co.*, 657 N.E.2d 832 (Ohio App. 1995) and *Cast Steel Products v. Admiral Ins. Co.*, 348 F.3d 1298 (11th Cir. 2003), is misplaced, and those opinions should not be followed by this Court.

Moreover, while Board has found only ***two*** cases nationwide to support its claim that successive claims-based policies create one continuous reporting period, National Union has identified ***over a dozen*** opinions from ***11*** different jurisdictions in which courts have refused to find coverage under successive claims-based policies for claims made and reported in different policy periods, including:

- *National Union Fire Ins. Co. v. Talcott*, 931 F.2d 166, 168 (1st Cir. (Mass) 1991), explaining the inherent nature of claims-made insurance "requires strict adherence to the notice requirement regardless of whether the same company continued to provide coverage (through a different policy) at the date the notice was received."

- *National Union Fire Ins. Co. v. Bauman*, 1992 WL 1738, *31 (N.D. Ill. 1992), *aff'd* 997 F.2d 305 (7th Cir. 1993), finding "[t]he language of the policy, the case law and the well-established rationale behind claims made coverage demonstrates that renewal of the policy did not create a single policy period for reporting purposes."

- *National Union Fire Ins. Co. v. Baker & McKenzie*, 997 F.2d 305, 307 (7th Cir. (Ill.) 1993), finding "no question that a claim was reported . . . during the second policy period; but if that claim was 'first made' during the first policy period yet not reported then, it is not covered by the policy."

- *Insite-Properties v. Jay Phillips, Inc.*, 638 A.2d 909, 912 (N.J. Super. 1994), "reject[ing the plaintiff's] claim that it was entitled to prevail because it had coverage [under a successive policy] on the date notice was actually given to the carrier. The policy required notice of the claim within the same policy period in which it was received."

- *Ehrgood v. Coregis Ins. Co.*, 59 F.Supp.2d 438, 445-7 (M.D. Pa. 1998), refusing to find coverage for a claim made and reported during different policy periods and noting that three successive claims-based policies with different policy numbers and different policy periods "clearly evinces an intent to create three separate policies, as opposed to one continuous policy."

- *CheckRite Limited v. Illinois National Insurance Co.*, 95 F.Supp.2d 180, 194 (S.D.N.Y. 2000), concluding "[t]here was no continuous coverage and reporting period spanning the two policy period[s], and no coverage under the [second] Policy."

- *Van G. Miller & Assocs. v. Gulf Ins. Co.*, 2001 WL 1165135 (N.D. Iowa 2001), similarly recognizing that the renewal of a claims-based policy does not create an extended policy period for reporting purposes.

- *Pantropic Power Products v. Fireman's Fund Ins. Co.*, 141 F.Supp.2d 1366, 1370 (S.D. Fla. 2001), *aff'd* 34 Fed.Appx. 968 (11th Cir. 2002), finding that, regardless of whether the policy was "renewed" from the same insurer or not, the insured and the insurer must both receive notice of the claim during the same individual policy period for coverage to arise.

- *Boerman v. American Empire Surplus Lines Ins. Co.*, 2001 U.S. Dist. LEXIS 16270, *12-13 (W.D. Mich. 2001), *aff'd* 50 Fed.Appx. 248 (6th Cir. 2002),

concluding "[i]n order to be covered, a claim must be made and reported during [the same policy] period. Nowhere does the contract indicate that renewal creates a seamless policy period or that a policy period would include previous periods. A commonsense understanding of 'renewal' does not alter this conclusion based on the nature and purpose of claims-made insurance policies."

- *Westport Ins. Corp. v. Mirsky*, 2002 WL 31018554, *11 (E.D. Pa. 2002), *aff'd* 84 Fed.Appx. 199 (3rd Cir. 2003)(unpublished), finding "[a] conclusion that the renewal of 'claims made' policies creates one continuous policy period for reporting would frustrate the purpose of claims made coverage by creating a long 'tail' of liability exposure, the avoidance of which forms the conceptual framework for claims made coverage in the first instance." (internal quotation marks and citation omitted).

- *Executive Risk Indem., Inc. v. Chtd. Benefit Servs.*, 2005 WL 1838433, *8 (N.D. Ill. 2005)(unpublished), disagreeing with the insured's claim that there was "seamless coverage" between the initial policy and the renewal policy that would allow a claim made during the first policy period to be reported during the second policy period.

- *World Health and Education Foundation v. Carolina Cas. Ins. Co.*, 612 F.Supp.2d 1089, 1096 (N.D. Ca. 2009), rejecting a claim that a renewal of a claims-based policy created a continuing reporting period and finding that "if a claim is not timely reported during a policy period, the insured is not covered simply because it has a subsequent policy."

- *Westport Ins. Corp. v. Markham Group Inc. PS*, 403 Fed.Appx. 264, 266 (9th Cir. (Wash.) 2010), noting that a finding of coverage for a claim made during one policy period and reported during a later policy period "would provide coverage the insurer did not intend to provide and the insured did not contract to receive. In fact, it would negate the inherent difference between occurrence and claims made policies, and would rewrite the insurance contract." (internal citations, quotation marks and brackets omitted).

- *Comena v. City of Baton Rouge/Parish of East Baton Rouge ex rel. Baton Rouge Metropolitan Airport*, 2011 WL 2268960, *5 (M.D. La. 2011), adopted at 2011 WL 2292290 (M.D. La. Jun 08, 2011)(unpublished), rejecting an argument that the renewal of a claims-based policy extended the reporting period and noting that "if this argument was accepted it would contradict the plain terms of the policy."

These authorities, copies of which are attached in Appendix C for the Court's convenience, show that "***most courts that have confronted [this issue] have concluded that a renewal does not extend the reporting period for claims made during the earlier***

policy period. It has been concluded that such a rule is consistent with the rationale underlying claims made insurance and the reasonable expectations of the parties to such policies." *CheckRite Limited,* 95 F.Supp.2d at 194 (citations omitted).

The Board's arguments in favor of coverage largely ignore the inherent nature of claims-based insurance, the critical distinction between claims-based and occurrence-based policies, and the fact that the lower court's rulings will result in the Board getting "more coverage than [it] bargained for and paid for, and require [National Union] to provide coverage for risks not assumed." *United States v. Strip*, 868 F.2d 181, 187 (6th Cir. 1989).[3] Recognizing the distinction between claims-based and occurrence-based insurance, Judge Wine correctly predicted that a finding of coverage in this case will create "occurrence-based coverage for all claims-based policy holders in the Commonwealth. . . [and] surely have ramifications in insurance premium costs to professionals and professional organizations all over this great Commonwealth." [Opinion, J. Wine dissenting at 12] National Union asks the Court to enforce the Board's insurance policies as written, thereby aligning Kentucky with the vast majority

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[3] Again, there is a critical distinction between claims-based and occurrence-based insurance. As described by the United States Supreme Court:

> An "occurrence" policy protects the policyholder from liability for any act done while the policy is in effect, whereas a "claims made" policy protects the holder only against claims made during the life of the policy. . . . 'a doctor who practiced for only one year, say 1972, would need only one 1972 'occurrence' policy to be fully covered, but he would need several years of 'claims made' policies to protect himself from claims arising out of his acts in 1972.'"

St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 535, n.3 (1978). "Claims-made or discovery policies are essentially reporting policies. If the claim is reported to the insurer during the policy period, then the carrier is legally obligated to pay; if the claim is not reported during the policy period, no liability attaches. If a court were to allow an extension of reporting time after the end of the policy period, such is tantamount to an extension of coverage to the insured gratis, something for which the insurer has not bargained." *Trek Bicycle Corp. v. Mitsui Sumitomo Ins. Co., Ltd.*, 2006 WL 1642298, *3 (W.D. Ky. 2006). Accord, 22-139 *Appleman on Insurance*, Matthew Bender & Company, 2008 §139.8 ("Claims-made policies are based upon a bargained-for exchange that typically provides insurance coverage at a reduced cost to the insured, only for claims made during the policy period and for which notice is provided during

of jurisdictions that have held that the failure to notify an insurer of a claim within the same policy period in which it is first made against the insured defeats coverage under a claims-based policy.

III. There Is No Ambiguity In The Insurance Policy, As It Clearly Covered Only Claims That Were First Made Against The Insured And Reported To The Insurer During The Same Policy Period.

In an effort to avoid the plain language and purpose of the policy as set out on page 1, the Board takes portions of unrelated and irrelevant policy provisions out of context and maintains that its personal interpretation of these terms creates such ambiguity in contract as a whole that the plain language of the policy must be ignored in favor of a finding of coverage. "The mere fact that [a party] attempt[s] to muddy the water and create some question of interpretation does not necessarily create an ambiguity,' Only actual ambiguities, not fanciful ones, will trigger application of the [reasonable expectation] doctrine.'" *True v. Raines*, 99 S.W.3d 439, 443 (Ky. 2003)(citations omitted); *accord*, *St. Paul Fire & Marine Ins. Co.*, 870 S.W.2d at 226 (finding "a non-existent ambiguity" should not be utilized to resolve a policy against an insurance company and "courts should not rewrite an insurance contract to enlarge the risk to the insurer."). Moreover, "[a]n ambiguous contract is one capable of more than one different, ***reasonable*** interpretation." *Frear v. P.T.A. Industries, Inc.*, 103 S.W.3d 99, 106 n. 12 (Ky. 2003)(emphasis added, citation omitted). There is no ambiguity in the Board's insurance policies because the Board's suggested interpretations are not reasonable.

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the policy period. Each claims-made policy stands alone and is considered as a separate entity requiring compliance with its provisions regarding notice.").

For example, the Board argues that the policy provision offering the insured an option to purchase an extended period in which new claims could be discovered and reported after the policy is canceled or not renewed creates an ambiguity concerning whether such an extension automatically applies when a replacement policy is purchased. [Board's Brief at 10] The same argument was rejected in *CheckRite Limited*, 95 F.Supp.2d at 193, and in *Ehrgood,* 59 F.Supp.2d at 447, where the courts found that optional extended reporting periods are just that -- an option available at a cost to an insured in certain limited circumstances, which do not include upon renewal or replacement of the underlying policy. The optional extended discovery provision in the Board's policy has no relation to the current dispute because the Board did not purchase an extended discovery period and does not claim that Tussey's claim would be covered by such an extension, if one had been purchased.[4]

The Board also argues that certain policy ***exclusions*** support a finding of coverage. [Board's Brief at 8] However, as this Court has noted, "***exclusion clauses do not grant coverage; rather, they subtract from it.***" *Kemper*, 82 S.W.3d at 872 (citation omitted, emphasis added); accord *Cincinnati Ins. Co. v. Motorists Mut. Ins. Co.*, 306 S.W.3d 69, 78, n.35 (Ky. 2010) (noting "a court need not consider the applicability of an exclusion if there is no initial grant of coverage under the policy")(citations omitted). For this reason, the Board's reliance on bits and pieces of various policy ***exclusions*** in an

[4] Any contention that the optional extended discovery period could cover Tussey's claim ignores the plain language of the provision, which offers an additional 12 months for the insured to provide "written notice to the Company of any claim ***made against the insured during said twelve (12) month period.***" [Appendix A, Policy at 4 (emphasis added)] Because Tussey's claim was made four months prior to the expiration of the initial policy, it was not made during the 12 months following the expiration of that policy, and would not have been covered by the extended discovery provision in any case.

effort to create a greater sphere of coverage than that actually provided by the affirmative coverage provisions is of no avail and cannot support a finding of coverage in this case.

The Board's arguments concerning ambiguity in the policy exclusions are also without merit on their face. Specifically, the Board relies on 2 of the 16 policy exclusions as fodder for its claim that the two separate policies provide one continuous policy period and negate the specific coverage and notice provisions contained therein. The two exclusions relied on by the Board (exclusion 14 and 16) exclude coverage for **claims filed as a result of**:

- 14 - litigation that was pending or filed prior to the effective date of the first policy issued by National Union; and
- 16 - wrongful acts committed prior to the effective date of the first policy issued and continuously renewed by National Union, if at that time the Board knew or could reasonably have foreseen that such acts could lead to a claim.

[Appendix A, Policy at 3, ¶14, ¶16][5] Although the Board points out that exclusions 14 and 16 do not exclude coverage for claims resulting from wrongful acts known or litigation pending prior to each individual policy period, but only those in existence prior to the first policy period (Brief at 8), Tussey's claim does not arise out of prior litigation involving the Board, nor was coverage denied because of the date of the wrongful acts alleged in Tussey's Complaint. Moreover, nothing in these policy exclusions act to override the affirmative coverage provisions or create coverage where none existed as a result of the Board's failure to comply the affirmative coverage requirements.

[5] The Board overlooks the intervening Exclusion 15, which excludes claims based on wrongful acts alleged in a claim reported "under any policy of which this policy is a renewal or replacement or which it may succeed in time." [*Id.* at ¶ 15] Exclusion 15 specifically recognizes the separate nature of successive claims-based insurance policies as well as the difference between a "renewal" policy and a "replacement" policy (as we have in this case). It also excludes coverage for claims reported under separate, but successive policies.

Finally, even when if the Board were able to identify some actual ambiguity in relevant language of the insurance policy, the question would then be what coverage the Board could have reasonably expected in light of the insurance it actually purchased, not what it now claims that it expected in hindsight. *See*, *Estate of Swartz v. Metropolitan Property and Casualty Co.*, 949 S.W.2d 72, 76 (Ky. App. 1997). In light of the clear policy language and the general nature and stated purpose of the Board's claims-based policies, the Board could not have reasonably anticipated that it would have coverage for a claim that it failed to report to National Union for fourteen months – at least ten of which fell outside the policy period in which the claim was first made against the Board.

IV. In The Alternative, There Is No Coverage Because The Board Failed To Notify National Union Of Tussey's Claim As Soon As Practicable.

The "Notice/Claim Reporting Provisions" in the Board's insurance policy also provided that "***the [Board] shall, as a condition precedent to the obligations of the Company under this policy, give written notice as soon as practicable to the Company of any Claim made against the [Board]***." [Appendix A, Policy at p. 4 (emphasis added)] Although the Board made no effort to show that it had notified National Union "as soon as practicable" after its receipt of the Tussey's Complaint, the majority of the Court of Appeals declined to consider the Board's failure in this regard, concluding that the issue was not raised before the trial court. [Opinion at 9] As pointed out in National Union's opening brief (at 30-31), that finding was incorrect, as National Union did indeed raise this issue as an alternative basis for a denial of coverage below. While the Board contends that National Union did not "fully develop" this argument and that it was not the basis of the trial court's decision (Brief at 12), it is impossible to identify the basis of

the decision from the trial court's one-sentence rulings. While it's true that National Union did not dwell on this aspect of the Board's untimely notice—because it believed (and still believes) that there is no coverage for claims that are was not first made and reported during the same policy period—the record shows that National Union did raise and argue this issue below. [*See, e.g.,* R. v.1 at 107, 108, 109, 112, Summary Judgment Memorandum pp. 4, 5, 6, 9]

The Board also asserts that its failure to notify National Union of Tussey's claim "as soon as practicable" is not a basis for denying coverage unless National Union can prove it was prejudiced by the fact that it was unaware of Tussey's lawsuit until 14 months after it was filed. However, National Union should not have to show prejudice from late notice when the only notice that was ever provided was insufficient to trigger coverage under the policy as a matter of law. As the Sixth Circuit Court of Appeals has explained provisions requiring notice "as soon as practicable" in claims-based policies are "intended to preclude an insured who has knowledge of a claim near the beginning of the policy period, from waiting many months until near the end of the policy period to notify the insurer of the existence of the claim, when such delay would cause prejudice to the insurer. ***It does not excuse, modify, or render ambiguous the claim reporting requirement [requiring notice during the policy period] as a condition of coverage.***" *Strip*, 868 F.2d at 186-87 (emphasis added).[6]

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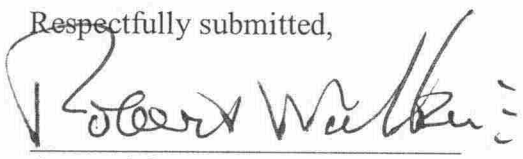
[6] Other courts have rejected similar attempts to impose the notice-prejudice rule onto claims-based insurance policies. *See, e.g., Salt Lake Toyota Dealers Ass'n v. St. Paul Mercury Ins. Co.*, 2006 WL 1547996 *4, n.39 (D. Utah 2006)(unpublished, copy attached in Appendix C)(compiling cases finding the notice-prejudice rule inapplicable to claims-made policies); *Trek Bicycle,* 2006 WL 1642298, *3 (recognizing this majority rule and predicting that Kentucky state courts will follow that rule because "to allow coverage under these circumstances simply rewrites the policy [and] allows the insured to avoid the reasoning behind a claims made policy.").

Finally, while generally adopting the legal arguments advanced by the Board, Tussey's Brief also cites an Opinion of the Tennessee Supreme Court that she contends shows a public policy of compensating tort victims. This appeal does not address and will not determine Tussey's compensation in relation to her pending discrimination claim against the Board. And there is certainly no public policy in Kentucky requiring National Union to provide coverage for Tussey's claim when none exists under the terms of the Board's insurance policies. In the end, this Court should enforce the Board's claims-based insurance policies as written and find no coverage for Tussey's claim.

CONCLUSION

For any or all of the reasons set out above, as well as in National Union's opening brief, National Union respectfully requests the Court to reverse the Opinion of the Kentucky Court of Appeals and remand this action to the Pike Circuit Court with instructions to enter a summary judgment of no coverage in favor of National Union.

Respectfully submitted,



Counsel for Appellants