Agents E&O Standard of Care Project

Kentucky Survey

To gain a deeper understanding of the differing agent duties and standard of care by state, the Big "I" Professional Liability Program and Swiss Re Corporate Solutions surveyed their panel counsel attorneys. Each attorney was asked to draft a brief synopsis outlining the agents' standard of care in their state. They were also asked to identify and include a short summary of the landmark cases. In addition, many of the summaries include sample case studies emphasizing how legal duties and issues with standard of care effected the outcome. Finally, recent trends in errors in the state may also be included.

This risk management information is a value-added service of the Big "I" Professional Liability Program and Swiss Re Corporate Solutions. For more risk management information and tools visit www.iiaba.net/EOHappens. On the specific topic of agents' standard of care check out this article from the Hassett Law firm, our E&O seminar module, and this risk management webinar.

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PROFESSIONAL LIABILITY:

INSURANCE AGENT E & O CLAIMS IN KENTUCKY (2014)

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1) **Case Study 1—*Insured "X" v. Agency***

a. **Line of coverage involved.**

Building $650,000.00/Business personal property $50,000.00

b. **Position of person in the agency involved.**

Agent.

c. **Personal or commercial lines.**

Commercial.

d. **Type of coverage involved.**

Business Building and Property Insurance.

e. **Procedural or knowledge-based error.**

Procedural/clerical error.

f. **Claimant allegation.**

Insured "X" alleges misappropriation against Agency, specifically claiming that the agency misappropriated the insurance proceeds from the fire claim by wrongfully issuing the insurance proceeds to parties not authorized by the insurance documents, and by failing to negotiate the fire loss claim with Insured "X".

g. **Settlement or trial.**

Trial – Judge directed a verdict that the agency breached its duty by failing to procure a policy of insurance with "X" as a named insured, which caused damages in the amount of $47,000.00. The Jury found no further damages as a result of the negligence.

h. **Description of alleged error.**

Previous application for insurance was submitted under one entity, when in fact a new entity was applying for insurance. The proceeds therefore were distributed according to the application which was erroneous.

i. Tip to avoid claim.

j. Summary of case.

On November 30, 2004, Insured "X" and "Y", individually and as an agent of the corporation, (collectively Insured "X") entered into a contract for deed with "Z" for the purchase of a hotel. Insured "X" took possession of the property and held equitable title. Legal title remained with "Z". The contract specified the property would remain under mortgage held by the bank.

Insured "X" contacted the agency to obtain commercial property insurance for property, which it had renamed. On behalf of Insured "X", the agency procured a policy to insure the hotel. In the following years, Insured "X" renewed the coverage. In October 2007, however, the hotel ceased operating. A month later, in November 2007, Insured "X" failed to renew its insurance policy and coverage lapsed. The property went uninsured until April 2008.

During the period the property was uninsured, Insured "X" and "X" each contacted the agency at different times concerning coverage for the hotel. "Z" advised it intended on reopening the hotel. Later, Insured "X" contacted the agency and advised it intended on reopening the hotel. This back and forth occurred a number of times.

In February 2008, an application for insurance was completed by the agency at the request of "Z". The application contained "Z's" information and claims history. On behalf of "Z", the application was submitted to a wholesale insurance broker. The wholesale broker

responded with a quote for the coverage, which was underwritten by a surplus lines carrier. The agency forwarded the quote to "Z", but "Z" never purchased the coverage.

Subsequently, in April 2008, Insured "Z" contacted the agency to obtain insurance on the hotel. The agency contacted the wholesale broker to determine if the previous quote would still apply. However, the agency did not advise the broker that it was Insured "X", not "Z", who was seeking coverage. The wholesale broker advised the quote would still apply and, ultimately, coverage was bound based upon the "Z" application.

The agent testified its intent was to secure coverage for the hotel on behalf of Insured "X". He explained the agency made a clerical error in the application process. Due to the clerical error, the agency procured coverage based upon the "Z" application. Thus, the commercial insurance policy issued by the carrier was in the name of the hotel/"Z", not the Insured "X". The bank was listed as the mortgagee and loss payee on the policy. When the agency received the policy and compared it to the application on file, the named insured on the policy was consistent with the name listed on the application. The clerical error was not discovered at that time.

During the policy period, Insured "X" made two claims on the policy: a wind loss and a fire loss. The wind loss claim remains unresolved. The fire loss claim was adjusted by an adjusting service, who was retained by the wholesale broker. Following the adjustment of the claim, the broker issued a settlement draft in the amount of $47,422.34 made payable to "the hotel and the bank." A representative of the adjusting service delivered the settlement draft to "Z". The exchange took place at the agency's office. The agent may have been present. "Z" then negotiated the draft and delivered to the bank to be applied to the principle of the mortgage.

The commercial loan officer for the bank was deposed regarding the application of the loan proceeds to the outstanding balance on the mortgage. He was identified by the bank, pursuant to a CR 30.02 deposition notice and subpoena, as the person with the most knowledge concerning the transaction.

The loan officer confirmed "Z" had encumbered the property with a mortgage held by the bank. As with any mortgage, the bank required the borrower to maintain insurance on the real estate in an amount at least equal to the outstanding balance on the note. The bank demanded it be listed as a loss payee/mortgagee on the policy. In instances where the policy premium is financed, the bank will receive notification if the borrower fails to pay the premium installments. When there is a loss payee or mortgagee on a policy, then insurance settlement drafts are made payable to the named insured and any loss payee/mortgagees.

The loan officer acknowledged he received the settlement proceeds in the amount of $47,422.34. The check was delivered by two representatives of "Z" and the agent. The funds were not deposited, but instead were applied to the principle balance of the note. In addition, the bank received a letter from counsel for "Z", instructing that the insurance proceeds be applied to the note.

Ultimately, it is the bank's decision on whether to apply the insurance proceeds to the loan or to release the funds to the borrower. In this case, the loan officer testified there was never an issue as to whether or not the settlement proceeds were going to be applied to the balance of the loan.

Even accepting Insured "X's" claim that the agent facilitated the delivery of the settlement proceeds to the bank, that does not establish misappropriation. At the most basic

level, the agency did not benefit or make personal use of the settlement proceeds. The most fundamental element of misappropriation does not exist in this case. Additionally, the proceeds were delivered to the named insured on the policy, and then to the mortgagee listed on the policy. After the clerical error had been made, there was nothing for the agent to do than to facilitate payment to the named insured. The evidence reveals that the insurance proceeds were issued to and received by the named insured. The proceeds were then transmitted to the bank, an entity that had a legal and contractual right to the funds.

2) **Case Study 2—*Insured Dealership v. Agent***

a. **Line of coverage involved.**

$250,000.00

b. **Position of person in the agency involved.**

Agent.

c. **Personal or commercial lines.**

Commercial.

d. **Type of coverage involved.**

Commercial real estate insurance/Garage liability policy.

e. **Procedural or knowledge-based error.**

Knowledge-based error.

f. **Claimant allegation.**

Agent failed to "provide adequate commercial insurance coverage which would protect [it] from a total loss to its building, contents, and automobiles, and the loss of the ability to continue the business in the event of a fire.

g. **Settlement or trial.**

Trial – Jury found in favor of the agent.

h. Description of alleged error.

Agent was negligent in its "failure to obtain and effectuate adequate insurance limits which would cover a total loss."

i. Tip to avoid claim.

Agent should always inquire and investigate the value and nature of the property they are insuring and have some documentation regarding said valuation. Further, as most disputes with amounts of coverage procured are a swearing contest between agent and client, best practice would suggest the agent should have written documentation of the amount suggested and written documentation the insured required less.

j. Summary of case.

Agent sold insurance to insured on a number of occasions, and insured contends that he used agent exclusively for his insurance needs. In the past, agent had obtained insurance for insured's businesses including a convenience store and scrap yard.

In 2006, insured contacted agent to purchase insurance for a commercial property. The building was vacant and in need of some renovations. Insured had recently purchased the property for $190,000. Insured did not tell agent how much he paid for the property and did not advise agent with an opinion on the fair market value of the property. Insured denied he instructed agent to secure a certain amount of insurance to cover the property. It is undisputed that agent secured a policy for the insured business with a coverage limit of $250,000.

In 2007, agent assisted insured in renewing the insurance for the property. Insured advised agent he had made renovations to the property and that he intended to operate a used car dealership on the premises. Agent shopped the property coverage and was able to secure another

$250,000 policy to cover the property for a lower premium. In addition to the property coverage, agent also obtained a garage liability policy for the insured business. Garage liability is required by law and agent obtained the statutory minimum coverage limits.

On March 21, 2008, the insured business suffered a fire loss. Insured reported the claim to agent, who notified the insurance carrier. The carrier adjusted the claim within a month and paid policy limits to insured in the amount of $250,000 plus another $10,000 for debris removal.

Three years later, the insured business submitted a supplemental claim to the insurance company. The supplemental claim sought payment for damage to the contents of the building and for business interruption. The supplemental claim was adjusted: portions of the claim were denied with portions remaining unresolved to date due to inadequate documentation of the loss.

The insured business then filed this lawsuit against agent for negligence and breach of fiduciary duty. Specifically, insured business alleges agent failed to "provide adequate commercial insurance coverage which would protect [it] from a total loss to its building, contents, and automobiles, and the loss of the ability to continue the business in the event of a fire . . ." Insured business complains agent was negligent in its "failure to obtain and effectuate adequate insurance limits which would cover a total loss." In sum, insured business claimed $378,000 in damage to the buildings contents and $977,000 in lost profits.

3) Case Study 3—Insurer v. Insured Dealership and Agency

a. Line of coverage involved.

$1,030,000.00 business property and garage liability policy.

b. Position of person in the agency involved.

Agent and Principle.

c. Personal or commercial lines.

Commercial.

d. Type of coverage involved.

Business property/Garage liability policy.

e. Procedural or knowledge-based error.

Knowledge based error.

f. Claimant allegation.

Carrier intervened in the wrongful death lawsuit against insured alleging it would not have issued the insurance policy had it known insured's employee was a driver of dealership vehicles and sought monetary damages from insured under the theories of fraud and negligent misrepresentation. Carrier also brought claims against agent under the theories of fraud (voluntarily dismissed), negligent misrepresentation, and general negligence in the procurement of the insurance policy.

g. Settlement or trial.

Trial.

h. Description of alleged error.

Carrier alleged agent misrepresented information it knew or should have known about insured employee and/or failed to make carrier aware of pertinent information it had. Carrier alleged the close relationship between the insured and agent changed the agency relationship.

i. Tip to avoid claim.

Insureds, who are covering potential employee liability, should ensure that a written request is made for employee/driver list and all written response maintained in client file.

Part of the issue here was two (2) different agents completing applications and poor communication between agents. The list from the insured should go with the application and a signed copy of the application should be maintained in the agent's file. Policies should also have expressed language stating those scenarios that are not covered and explicitly warning employers of the consequences if they fail to fully disclose employee information.

j. Summary of case.

Insured is a car dealership. Agent and insured share common ownership. Agent assisted insured in procuring insurance with carrier.

During the application process, Agent gathered information about the dealership in order to complete the carrier application. The application required insured to provide a list of all drivers of dealership vehicles. An employee of Agent asked the dealerships general manger, to provide a list of drivers. The dealership generated a list of drivers. However, insured did not identify Employee "X", a salesperson at the dealership, as a driver of dealership vehicles. Employee "X" had a suspended license. Based upon the information provided by insured, Agent prepared a carrier application, which did not list Employee "X" as a driver. The application was signed by an insured's representative, who was also an owner of agency. The application was then submitted to carrier and coverage was bound.

After insurance coverage was placed with carrier, Employee "X" was involved in a catastrophic accident while operating an insured's vehicle. The accident resulted in the death of one person and injuries to two others. A wrongful death and personal injury lawsuit was filed against insured and its employee, Employee "X".

Carrier intervened in the lawsuit against insured Agency alleging it would not have issued the insurance policy had it known Employee "X" was a driver of dealership vehicles. Carrier also brought claims against Agent. Carrier settled the personal injury claims for a total amount of $1,030,000.00, and then sought the following relief: 1) to void the insurance policy with Dealership pursuant to KRS 304.14-110; 2) monetary damages from Dealership under the theories of fraudulent and negligent misrepresentation; and 3) monetary damages from Agent under the theories of fraudulent misrepresentation (voluntarily dismissed), negligent misrepresentation, and general negligence in the procurement of the insurance policy. Carrier also believed it filed a breach of the agency agreement claim against Agent. The Court held carrier failed to plead such a claim.

Following a lengthy trial, the jury found the information contained in the insurance application was incorrect, and that carrier in good faith would not have issued the policies had it know Employee "X" was a driver of dealership vehicles. On the tort claims, the jury held Dealership negligent, but absolved Agent of any liability finding that Dealership had falsely told both Agent and carrier that Employee "X" was not a driver of dealership vehicles. The jury apportioned 100% of the fault to Dealership and awarded carrier $1,030,000.00 in damages. In its judgment, the trial court concluded insured made a material misrepresentation in the application and declared the policies void ab initio. The judgment also included the $1,030,000.00 in monetary damages against Dealership in favor of carrier.

Dealership filed a motion for judgment notwithstanding the verdict. The issues raised were: 1) whether Agent was the agent of carrier or Dealership; and, 2) if agent was an agent of carrier, could the carrier void the policy. Dealership relied heavily upon citations from an insurance treatise, Appleman on Insurance 2d. The trial court overruled Dealership's JNOV

motion on the grounds that Agent was the agent of the Dealership (or possibly a dual agent) and, regardless, carrier could not be held responsible for the material misrepresentation in the insurance application. Importantly, the trial court explained its finding was consistent with the jury's factual determination that Agent was not negligent. The jury determined Agent had not failed to exercise the degree of care of reasonably competent insurance agency acting under similar circumstances.

Dealership appealed and the Court of Appeals affirmed the judgment and the denial of the motion for JNOV. In its for discretionary review, Dealership raised the following issues:

1) Should an insurer be estopped from rescinding a policy because of a material omission by an insurance agency "solely because the insured was owned by persons who also owned the insurance agency?"

2) Which insurance treatise trial courts are to rely upon: Appelman or Couch?

3) Should insurance statutes control determinations of agency and imputed knowledge and should jury instructions conform to the statutory language?

4) Whether jury instructions on the issue of material misrepresentation should use an objective or subjective standard?

The Supreme Court denied discretionary review. Carrier attempted to appeal the verdict against Agent, but failed to include the Dealership as a party to the appeal. Carrier hoped to keep the verdict against its insured/Dealership while seeking a new trial against the Agent. The Agent moved to dismiss the appeal for failure to name an indispensable party. The Court of Appeals agreed and dismissed the appeal.

4) **Case Study—*Insurer v. Insured Homeowner and Agent***

a. Line of coverage involved.

b. Position of person in the agency involved.

Agent.

c. Personal or commercial lines.

Personal.

d. Type of coverage involved.

Homeowner's policy.

e. Procedural or knowledge-based error.

Procedure and knowledge-based error.

f. Claimant allegation.

Carrier alleged both agent and insured misrepresented information contained in the application in relation to an alleged wood-burning stove.

g. Settlement or trial.

Summary Judgment for agent. Trial for homeowner resulting in verdict in favor of homeowner.

h. Description of alleged error.

Homeowner's application stated the home did not have a wood-burning stove. Coverage was bound. Subsequently the home suffered fire damage. The cause was found to be excess heat from a vent near a curtain. The vent extended from a system within the fireplace. Carrier claimed the system to be a wood-burning stove and alleged it would not have issued the policy had it known the home had a wood-burning store. Homeowner claimed the system was simply a fireplace.

i. Tip to avoid claim.

Make sure all applications are reviewed and signed by insured even if you are going to submit electronically. If electronic submissions are required, still print a hard copy for insured's signature and maintain its agent's file. This makes all representations on the application to be those of the insured and insulated agents.

j. Summary of case.

Homeowner sought a homeowner's policy from agent. Agent asked homeowner all questions on the application. Carrier required agent to visit the home and obtain a photo of the exterior only. The application inquired about supplemental heat sources, and in particular, about wood-burning stoves. The potential insured told Agent he did not have a wood-burning stove and Agent marked as "no" on the application. The homeowner signed the application.

After coverage was bound and issued, a fire ensued with heavy property damage. The fire marshal blamed a vent hooked up to an insert within the fireplace. The unit was unusual and consisted of a metal box sitting within the fireplace opening. The unit burned wood, had a door and was hooked to vents throughout the house. Carrier alleged this unit was a wood-burning stove and that it would not insure such homes. The owner insisted it was merely a fireplace.

Both agent and homeowner were sued for negligent misrepresentation. As the application was signed by the owner, agent successfully argued all representations, false or otherwise, are the representations of the owner and not the agent. The court agreed and summarily dismissed the agent leaving the question of misrepresentation of the owner for a jury to decide.

E & O Claims in Kentucky

Claims against insurance agents arising from the procurement of property and liability insurance are a relatively recent development in Kentucky. Historically, most claims brought against an agent dealt with errors or omissions by the agent during the application process for health or life insurance. Insureds that have been denied coverage or are dissatisfied with the adjustment of a claim have now begun to bring negligence claims against their agent. While Kentucky has addressed the fundamental principles of these claims, such as the duty owed by the agent and the statute of limitations governing the actions, there is a lack of guidance from the courts on the application of these principles. The uncertainty created by the limited precedent is many times compounded by the fact that plaintiff's counsel, the judge, or both may have never have practiced an agency negligence claim before. This creates significant challenges for the claims specialist and defense counsel in analyzing the liability exposure and developing the most effective litigation strategy.

The following article provides a cursory overview of the duties owed by an agent, when those duties may be heightened, bad faith exposure, the governing statute of limitations, as well as some practical considerations in defending E & O claims.

Generally, claims against insurance agencies by their clients are brought as negligence claims. Grigsby v. Mountain Valley Ins. Agency, Inc., 795 S.W.2d 372 (Ky. 1990). Although the relationship between an agent and its client has elements of a contract, the claim for breach of an agent's duty must be prosecuted as a tort. Id. In contrast, carriers may file both a negligence claim and a breach of contract claim if there is an agency agreement.

Insurance agents owe a duty of reasonable care. Associated Ins. Service, Inc. v. Garcia, 307 S.W.3d 58, 63 (Ky. 2010). An insurance agent fulfills this duty to the insured by providing the requested coverage, but has no duty to advise a client to obtain different or

additional coverage. Mullins v. Commonwealth Life Ins. Co., 839 S.W.2d 245, 248 (Ky. 1992). In practice, this means an agent MUST do the following:

1) carry out specific instructions of the client;

2) advise the client if the agent is unable carry out the specific instructions;

3) procure any statutorily required minimums or "non-optional" coverages for the type of insurance sought by client;

Furthermore, an insurance agent is not a fiduciary. Accordingly, their clients have no reasonable basis to "repose special confidence and trust" in the agent. See Associated Ins. Service, Inc. v. Garcia, 307 S.W.3d 58, 63 (Ky. 2010) (contrasting attorneys who are fiduciaries and owe the utmost duty of undivided loyalty). The relationship between the agent and the client is simply an ordinary business transaction. This is important because Kentucky does not recognize an affirmative duty to advise of optional coverages. See Mullins v. Commonwealth Life Ins. Co., 839 S.W.2d 245, 248 (Ky. 1992). Technically, an agent has no duty to tell the client what types of coverage he should purchase; how much insurance to purchase; or to value the insurable interests of the client.

Kentucky courts have not explained the reasoning for not recognizing a duty to advise. However, other jurisdictions, which have also rejected the duty to advise, explained it would elevate an insurance agent to the status of a personal financial counselor or risk manager. Since the agent must rely upon the information provided by the customer to have any insight into the nature of the business, the financial risks associated with an interruption of the business, or the contents of a building, to place a duty on the agent to advise the customer of what types of insurance or the limits of insurance needed essentially places the agent in a position approaching

a guarantor for any loss. See Dubreuil v. Allstate Ins. Co., 511 A.2d 300, 302 (R.I.1986) (citation omitted).

Creating heightened duties for agents can create significant exposure. The actions of either the client or the agent can heighten the duty owed by the agent to include advising the client. If the customer specifically requests advice then the agent has a duty to respond. See Mullins v. Commonwealth Life Ins. Co., 839 S.W.2d 245, 248 (Ky. 1992). However, asking for a "good policy," "adequate policy" or the "best coverage" does NOT create a duty to advise. These types of requests are too speculative to create a heightened duty for the agent. Courts have noted that the question of adequacy of coverage is necessarily a matter of opinion. As with all insurance, the amount of property coverage, contents coverage, and business interruption coverage is a trade-off between cost and risk.

An agent may also expressly or impliedly assume the duty to advise. Mullins v. Commonwealth Life Ins. Co., 839 S.W.2d 245, 248 (Ky. 1992). This heightened duty may be created by:

1) The client paying the agent above a commission on the premium;

2) The agent holds himself out as a risk manager; or

3) There is a long-time course of dealing that should put the agent on notice that the client is seeking and relying on the agent's advice.

Even if there is a duty to advise the client, this duty would probably be limited to advice on assessing the RISK, not evaluating the EXPOSURE. An agent is capable of assisting the client in identifying the various risks or insurable interests the client may face. This means the agent has a duty to advise the customer about what types of insurance and coverages are available. However, the client is in the best position to evaluate the exposure created by those

risks since the client knows the extent of personal assets, ability to pay, and personal and business considerations. So, the decision on how much insurance to purchase should always remain the obligation of the client. With that being said, if the amount of insurance the client requests are conspicuously low, it is best practice for the agent to challenge the client's assessment of his insurance needs.

There is one possible exception where an agent has a duty to advise the client on how much insurance to purchase. Where a client requests a homeowner's or commercial property policy and claims are valued on a replacement cost basis, the agent should look closely to ensure the amount of coverage is adequate. The ultimate decision is obviously still with the client, but since the agent may have at his disposal various tools to calculate the replacement cost it is best practice to assist the client in evaluating the amount of coverage to purchase. Furthermore, agents should always explain coinsurance – or at least the fact that there may be a penalty for underinsuring your property. When the client does not accept the agent's suggestions for types or amounts of insurance, the agent may want to procure written documentation of same for his file.

In Kentucky, agents are NOT subject to Common Law Bad Faith or the Unfair Claims Settlement Practices Act ("UCSPA"). If an E&O claim has been filed against an insurance agent, it is likely the product of Plaintiff's attorney's inexperience coupled with a lack of due diligence on what the law permits. Typically, Plaintiff's counsel will file a breach of fiduciary duty claim and a bad faith claim. The common law tort of bad faith and all UCSPA claims apply only to those entities that are "engaged in the business of entering into contracts of insurance." Davidson v. American Freightways, Inc., 25 S.W.3d 94 (Ky. 2000). The UCSPA was clearly intended to regulate the conduct of insurance companies." Id. at 96.

In Davidson, the Supreme Court elaborated that absent a contractual obligation to pay a claim; there can be no statutory or common law basis for bad faith against a party. Id. at 100. So, the claims cannot be maintained against an agent since they are not a party to the contract and have no obligation to pay the claim. See also Kentucky National Ins. Co. v. Shaffer, 155 S.W.3d 738 (Ky. App. 2005). These claims should be dismissed by a motion for summary judgment, along with the claims for breach of fiduciary duty.

Kentucky law provides that the sale of insurance policies falls within the authority of the Consumer Protection Act ("CPA"). The CPA does not apply in the commercial context. CPA claims are typically not very effective since the Plaintiff must prove the agent provided misinformation in order to induce the client to purchase the policy.

Currently, the statute of limitations for an insurance agency negligence claim is five (5) years. Kentucky has a professional negligence statute which provides that "a civil action, whether brought in tort or contract, arising out of any act or omission in rendering, or failing to render, professional services for others shall be brought within one (1) year from the date of the occurrence or from the date when the cause of action was, or reasonably should have been, discovered by the party injured." KRS 413.245. The statutory definition of "professional services" found in KRS 413.243 is "any service rendered in a profession required to be licensed, administered and regulated as professions in the Commonwealth of Kentucky. . ."

When asked to apply this definition to insurance agents, the Court of Appeals rejected the argument that an agent is professional despite fitting the definition. In Plaza Bottle Shop, Inc. v. Al Torstrick Ins. Agency, Inc., 712 S.W.2d 349 (Ky.App. 1986), the court compared agents to hair dressers and others who are licensed and regulated by the state but not under the umbrella of

professionals. The Court reasoned that "the mere fact that one is licensed or regulated by the state does not make his services 'professional' within the purview of this statute. The appellee's assertion that a broad interpretation be given this statute to include all who are licensed would result in the inclusion of embalmers, realtors and beauticians, a result we believe unreasonable, absurd and clearly not reflective of the intent of our legislators." What is interesting, though, in that case the court applied the 5 year statute of limitations governing actions upon contracts not in writing express or implied. Id. (applying KRS 413.120(1)). As noted above, the courts have concluded these are negligence claim so why is the Court applying a contract statute of limitations? As agents are licensed, regulated and administered, including continuing education credits, this is an issue that should be challenged at some point.

When applying these principles to practice, there are some practical considerations. First and foremost, the signed application is the MOST compelling evidence. Insurance applicants have the duty to read, or at least know, the contents of the application before signing it. Miles v. National Union Fire Ins. Co. of Pittsburg, Pa., 256 S.W.2d 7, 8 (Ky. 1923). Applicants, consequently, are charged with knowledge of the contents regardless of whether they read the application. Id. Even if the customer alleges he gave the correct information to the agent but that the agent erred in completing the application, summary judgment is still possible under the legal doctrines of equitable estoppel and ratification IF the client signed the application.

Despite the importance of the signed application, the trend of agencies to go paperless has led to situations where the agent does not have a signed application or, more commonly, a signed renewal. Paperless or not, the agent should still get a signed application to protect himself. There have been situations where a carrier has alleged violations of the agent's duty to the carrier for failing to have a signed application.

However, an agent may not defend a negligence action by arguing the client should have read the policy. See Grigsby v. Mountain Valley Ins. Agency, Inc., 795 S.W.2d 372 (Ky. 1990). The agent may only defend the action by applying the policy itself. In Grigsby, a client brought a negligence claim against its insurance agent for failure to provide a certain type of coverage under a fire policy. The agency defended by arguing the client was negligent in failing to read and understand the policy it received. The Supreme Court held that the insurance agent cannot avoid liability for failing to secure the requested coverage simply "by reason of any contributory negligence on the part of the insured in not having read and familiarized himself with the contents of the policy." Id. Important to the Grigsby holding is the fact that "policies of fire insurance are rarely examined by the insured, and even where examined are not always enlightening to him, due to the technical and complicated language in which the contract is usually couched." Id. at 374. The open question, though, is whether there is a duty to review the declarations sheet particularly when addressing a claim of inadequate insurance limits.

As another practical matter, insurance agents act with dual agency. Agents owe duties to both the client and the broker/insurer. The agent acts on behalf of the client in filling out the application, carrying out the client's instructions, providing advice if requested, and procuring the policy. The agent acts on behalf of the broker/insurer in transmitting relevant information to the carrier, preparing binders if authorized to do so, and issuing Certificates of Insurance. This "dual agency" means that when there is a coverage issue, based upon an error in the application, that the agent has exposure regardless of how the coverage issue is resolved. So, if a court determines there is coverage the carrier may have a negligent misrepresentation claim or breach of contract claim (if there is an agency agreement) against the agent.

To reiterate, these claims are a relatively recent development in Kentucky and while Kentucky has addressed the fundamental principles there is a lack of guidance by the courts on application and therefore, creates difficulty in analyzing the liability exposure and developing the most effective litigation strategy. See case studies listed above for application of these principles to some of the most significant E&O case studies handled by our firm.