# Agents E&O Standard of Care Project

## Washington, DC 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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## I. SUMMARY OF STANDARD OF CARE OWED BY INSURANCE AGENTS AND BROKERS IN THE DISTRICT OF COLUMBIA

In the District of Columbia, "an insurance broker who undertakes to procure insurance for another and through fault or neglect fails to do so is liable for damages thereby resulting." *Adkins & Ainley, Inc. v. Busada*, 270 A.2d 135, 136 (D.C. 1970) (quoting *Shea v. Jackson*, 245 A.2d 120, 121 (D.C. 1968). Liability may exist even in the absence of consideration to the broker for the services in question. *See Remeikis v. Boss & Phelps, Inc.*, 419 A.2d 986, 991 (D.C. 1980) (one who undertakes to act, even though gratuitously, may be subject to the duty to act with reasonable care); 4 J.A. APPLEMAN & J. APPLEMAN, INSURANCE LAW & PRACTICE, § 2261 at 181 (Rev. Ed. 1969) ("[I]f any person undertakes, even wholly without consideration, to procure insurance and actually takes steps in the matter, he is responsible for misfeasance.").

"It is settled that a plaintiff may bring either a contract claim or a tort claim against an insurance broker for failure to obtain requested insurance, at her election." *Zitelman v. Metro. Ins. Agency*, 482 A.2d 426, 427 FN1 (D.C. 1984); *Hayes v. Chtd. Health Plan*, 2006 U.S. Dist. LEXIS 75378 (D.D.C. 2006) (same); *see also* 43 Am. Jur. 2d Insurance § 163 (2006) (collecting cases). However, an insurance agent acting on behalf of a disclosed carrier principal in procuring insurance policies for a client does not become a party to the insurance contract; thus,

he will not be liable for damages caused by breach of the contract by the insurance company. *Emersons, Ltd. v. Max Wolman Co.*, 388 F. Supp. 729, 735 (D.C. 1975).

Regarding the nature of the duty of care, District of Columbia courts have imposed a heightened duty on those who work in the insurance industry. *See Morrison v. MacNamara*, 407 A.2d 555, 560 (D.C. 1979) (noting that an insurance agent is a "professional" who possesses "specialized knowledge and skill"); *Saylab v. Don Juan Rest., Inc.*, 332 F. Supp. 2d 134, 146-147 (D.D.C. 2004) (noting that "an insurance broker in the District of Columbia is held to a higher standard than the average salesman and may be required in some instances to be proactive in assisting a client"). Stated somewhat differently, an insurance agent who undertakes to obtain insurance on behalf of a client has a duty to perform those services "with the reasonable skill and ordinary diligence which can be expected from a person in his profession." *Adkins*, 270 A.2d at 137. Additionally, "[w]here an agent also holds himself out as a consultant and a counselor, he does have a duty to advise the insured as to his insurance needs, particularly where such needs have been brought to the agent's attention." *Stevenson v. Severs*, 158 F.3d 1332, 1333-1334 (D.C. Cir. 1998) (quoting 16A J.A. APPLEMAN & J. APPLEMAN, INSURANCE LAW & PRACTICE 65-66 (1981); *Aetna Casualty & Surety Co. v. Walter Ogus, Inc.*, 396 F.2d 667, 669 (D.C. Cir. 1967) ("[t]here can be no doubt that an insurance agent may have affirmative duties to his clients.").

Whether an insurance agency has an affirmative duty to advise a client as to the *nature* of available coverage is an open question in the District of Columbia. In *Saylab*, the United States District Court for the District of Columbia noted that in Maryland, "an agent, employed to effect insurance, must exercise such reasonable skill and ordinary diligence as may fairly be expected from a person in his profession or situation, in doing what is necessary to effect a policy, *in*

*seeing that it effectively covers the property to be insured,* in selecting the insurer, and so on." *Saylab*, 332 F. Supp. 2d at 146 (emphasis in original).[1] The *Saylab* court went on to note that that "it is unlikely that the D.C. Court of Appeals would adopt a bright-line rule that an insurance agency cannot, as a matter of law, be held liable in tort for failing to advise an insured about types of coverage" given the heightened standard of care set forth above. *Id.* at 146. (As predicted by the *Saylab* court in 2004, the D.C. Court of Appeals has not addressed the issue since the time of that decision.)

Similarly, while the D.C. Court of Appeals has not squarely addressed whether an insurance agent has an affirmative duty to advise as to the available *limits* of coverage, Maryland's courts have indicated that absent "special circumstances," an insurance agent has no affirmative duty to inform a client of or to recommend policy limits higher than those requested by the insured. *Saylab*, 332 F. Supp. 2d at 145 (citing *Sadler v. Loomis Co.*, 776 A.2d 25, 38 (Md. Ct. Spec. App. 2001).

## II. LANDMARK CASES

***Shea v. Jackson*, 245 A.2d 120 (D.C. 1968).**

In *Shea*, Mr. Shea was enrolled in a group life insurance program through his employer. Prior to Mr. Shea's death, an insurance broker approached the employer and induced the employer to change the group life insurance policy to a different insurance company, representing that all employees covered by the former policy would be covered by the new policy, regardless of whether such employees were at work on the commencement date of the

1 The common law of Maryland is the source of the District of Columbia's common law "and an especially persuasive authority when the District's common law is silent." *Napoleon v. Heard*, 455 A.2d 901, 903 (D.C. 1983).

new policy. Shea enrolled in the new group life insurance plan, but died several months later. The insurance company refused to pay benefits on the grounds that Shea was specifically excluded from coverage, as he had not been at work on the commencement date of the policy. Shea's widow filed suit against the broker, alleging misrepresentation.

The trial court granted the broker's motion to dismiss the account, but gave no reason for the dismissal. The broker asserted two grounds for dismissal: first, that the action was premature, as the plaintiff should have sued the insurance company to determine her rights under the policy; and second, that the plaintiff failed to state a claim upon which relief could be granted. The Court of Appeals rejected both arguments, noting that rejection by the insurance company was a valid proof of loss, and finding that the plaintiff could establish a breach of the brokerage contract, as "[a]n insurance broker who undertakes to procure insurance for another and through fault or neglect fails to do so is liable for damages thereby resulting." As the plaintiff was a third-party beneficiary of the insurance policy, she had the right to sue.

***Adkins & Ainley v. Busada*, 270 A.2d 135 (D.C. 1970).**

The plaintiff contacted his son, an insurance broker, and requested that the son obtain insurance policies on real property. The son contacted the defendant, an insurance agent, which issued two appropriate policies. For reasons not set forth in the opinion, the insurance company elected not to cover the property involved, and directed that the policies be canceled. The plaintiff, upset at the cancellation, called the insurance agent who told him the insurance agent would look into the matter, and that the plaintiff should "forget about the matter" unless he heard otherwise from the agent. Shortly thereafter, the insured property was destroyed by fire, and the plaintiff filed suit against the insurance agent for not following up on the canceled insurance

policy. As the insurance agent had a duty to perform with the reasonable skill and ordinary diligence expected from a person in his profession, the trial court found that the standard of care was not met.

The court noted that while there was a divergence of opinion among jurisdictions as to whether tort or contract theory applies to a cause of action against an insurance broker for breach, noted that the "better rule" would be to allow recovery under either theory. As the insurance agent, through his affirmative assurances, lulled the plaintiff into believing the plaintiff was insured, and as this reasonable reliance led to a loss, the agent was responsible for the loss.

***Zitelman v. Metro. Ins. Agency*, 482 A.2d 426 (D.C. 1984).**

In *Zitelman*, the plaintiffs contacted an insurance agent to arrange to be added to an existing insurance policy as additional named insureds. The insurance agent transmitted the request to the insurance company, but the plaintiffs were designated as loss payees rather than additional named insureds. Pursuant to the policy, a loss payee could only recover if a named insured was entitled to recover (whereas an additional named insured could recover regardless). After a fire damaged the insured property, and their claim was denied, the plaintiffs sued both the insurance company and the agency.

The agency argued that it did not have an agency agreement with the plaintiffs, as there was no consideration. The Court found that consideration was unnecessary (as quoted above), as the agency undertook to procure insurance and took steps to do so, and as such would be responsible for any neglect in so doing.

***Saylab v. Don Juan Rest., Inc.*, 332 F. Supp. 2d 134 (D.D.C. 2004).**

In *Saylab*, the plaintiffs were four family members who lost two relatives in an automobile accident, which was caused by a patron who was driving while intoxicated after eating at a Mexican restaurant in Washington, D.C. The restaurant sought a judicial declaration that its insurance agent owed a legal duty to advise the restaurant of the availability of liquor liability insurance. After summarizing the state of the law in Maryland—that an insurance broker has a duty of reasonable care to ensure that the type of coverage is appropriate—the Court held that it was a question of fact as to whether the insurance agent should have informed the restaurant about the availability of liquor liability coverage. Stated somewhat differently, it was an issue for the jury to determine "what a reasonable insurance agency in the District of Columbia would have done under the circumstances here – *i.e.*, would a prudent agent or broker have informed Don Juan about the availability of liquor liability coverage?" *Saylab*, 332 F. Supp. 2d at 147.

## III. CASE STUDIES

Case Study - 1

A. Line of coverage involved: Financial

B. Position of person in the agency involved: Sales agent

C. Personal or Commercial Lines: Personal

D. Type of coverage involved: Life

E. Procedural or knowledge-based error: Procedural

F. Claimant allegation: failure to notify Plaintiff directly concerning expiration of high value term life insurance policy or concerning 62 day grace period for reinstatement without evidence

of insurability, where agent allegedly knew that claimant's health problems would prevent claimant from obtaining comparable replacement policy.

G. Settlement or Trial: Settlement

H. Description of the alleged error: Claimant alleged that the agent was aware of his health problems and aware that he would be unable to obtain a comparable life insurance policy should his existing policy lapse. Claimant alleged that agent breached his duties when failing to make Claimant aware that the policy had lapsed and of the urgency of the policy's renewal. Life insurer had sent notices to a third party responsible for handling the renewal, and sales agent sent reminders to same third party but did not send copies of overdue notices to the insured's personal contact addresses.

I. Tip to avoid claim: Copy insured with overdue notices, even if a third party has been engaged to manage the insured's insurance.

J. Summary of case: Plaintiff filed suit in D.C. Superior Court against insurer and sales agent raising claims of breach of contract, breach of fiduciary duty, bad faith, fraud, negligence, and violations of the D.C. Consumer Protection Act, claiming damages of more than a million dollars and attorney's fees, based on lapse of high value term insurance policy when the Plaintiff sent in the premium about four months late, and the required additional forms for evidence of insurability were not sent in with the premium. The insurer initially accepted and deposited the check, but about a month later, refunded the money. Because the Plaintiff was still alive, he claimed damages for the premium increases he had to pay for a replacement policy, and emotional distress for being uninsured for a period of time. The case was removed to the federal court in the District of Columbia. After initial document discovery, it was determined that case should be settled after sales agent indicated that he had attempted to persuade the insurer to accept the client's late premium, by trying to take responsibility for the delay. By subpoenaing the replacement policy directly from the Plaintiff's new insurer, we were soon able to establish that Plaintiff's maximum out of pocket damages were less than a third of what he had claimed. The case settled for a fraction of the original projected litigation costs. Prior to the settlement, the sales agent was dismissed from the suit with prejudice.

Case Study 2

A. Line of coverage involved. Automobile

B. Position of person in the agency involved. Principal

C. Personal or Commercial Lines. Commercial

D. Type of coverage involved. Automobile insurance for a private sector company that provided non-emergency transportation in the District of Columbia.

E. Procedural or knowledge-based error. Procedural.

F. Claimant Allegation. The claimant obtained a new automobile policy that had a start date one day later than the termination date of the prior policy. The claimant operated under a certificate of authorization issued by the Washington Metropolitan Transportation Commission [WMATC]. WMATC suspended the claimant's certificate for three weeks because of the one day gap in coverage, during which time claimant was unable to operate and allegedly lost customers.

G. Settlement or Trial. Settlement.

H. Description of alleged error. There was a dispute as to whether the agent timely submitted the application for coverage. The dispute turned on the interpretation of a "15 day rule." Ultimately the insurer agreed with the agent and reissued the policy with a new policy inception date that was one day earlier.

I. Tip to avoid claim. Obviously, the agent believed that application had been timely submitted, and insurance company appeared to agree. By that time, however, the suspension had been imposed and it took some time to convince WMATC to lift it. In this case, action well in advance of the deadline would have prevented the insurer from assigning the wrong date to the policy.

J. Summary of case. There were many moving parts to this case. Did the insurer incorrectly interpret the 15 day rule? If so, was that foreseeable? Was the breach obvious (the plaintiff had no standard of care expert)? Was WMATC's delay in lifting the suspension an independent intervening cause? A major issue in the case involved the plaintiff's damages. Plaintiff asserted lost revenues as damages rather than lost profits. It is likely the Court would not have allowed lost revenues as damages. Moreover, there were substantial causation questions relating to the real reasons for the claimants' loss in business.

Case Study 3

A. Line of coverage involved. D&O

B. Position of person in the agency involved. Principal.

C. Personal or Commercial Lines. Commercial.

D. Type of coverage involved. Defense of derivative suits against the insured company.

E. Procedural or knowledge-based error. Procedural.

F. Claimant Allegation. Claimant corporation was sued in a derivative suit by some of its shareholders. The insurer denied coverage for two reasons. One reason involved the percentage ownership exclusion. According to that exclusion, derivative claims by shareholders holding more than 10% of the company's stock were excluded. Claimant alleged that the broker was negligent in securing a policy with such an exclusion.

G. Settlement or Trial. Settlement.

H. Description of alleged error. Claimant alleged that it had instructed the broker to provide full, adequate and comprehensive business liability coverage to afford maximum liability insurance protection to the company. In light of the fact that the company had a limited number of shareholders, it was foreseeable that this exclusion would come into play if a derivative suit were filed.

I. Tip to avoid claim. With 20-20 hindsight, it would have been better to bring this exclusion to the attention of the insured and ask whether the insured wanted the broker to try to have it removed or seek coverage from another source. The problem is that this "defect" in the policy only became important when the derivative suit was filed. This case highlights the importance of documenting the broker's interaction with the insured, to include documentation that could prevent future unsubstantiated claims that certain specific requests were made. Examples are, "Insured requested plain vanilla policy" or "insured wants minimum liability and nothing more." The plaintiff's allegation in this case that it specifically requested "full, adequate and comprehensive business liability coverage to afford maximum liability insurance protection" highlights this problem. Whether or not this statement was actually made will ordinarily be a question for the jury to decide. Any contemporaneous documentation that is inconsistent with that allegation can help considerably. If the insured specifically requests certain types of coverage or notes unusual features about its business, those should be noted in writing. The more difficult problem is noting requests that were not made.

J. Summary of case. The insurer denied coverage for two reasons, one of which was not the basis of a claim against the broker. Claimant took that position that it could not lose; either there was coverage and the insurer would pay or there was not and it was the broker's fault. In cases such as this, the claimant can drive a wedge between the insurer and the broker. Fortunately, that did not happen in this case.