BUSINESS CONTINUITY PLANNING FOR THE COVID-19 PANDEMIC

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INTRODUCTION

Government ordered COVID-19 closures of restaurants, hotels, entertainment venues, country clubs, and other businesses have created panicked claims for financial help to insurance agencies to cover business losses and expenses. The very nature of how customers interact with businesses have changed across the board. Many claims , arising out of the COVID-19 pandemic, have already been filed for a broad spectrum of businesses, both large and small, and of varying types.

Nearly all insurers' responses though to-date have been the same — denial of coverage. Insureds are finding out that their insurance policies, for which they have been paying insurance premiums, are according to their insurance carriers inapplicable to the COVID-19 situation.

What are you to do? What can you do? Should you try and get coverage like so many others are doing? What types of losses are covered? Is there any reason not to file a claim? What is the best way to go about it? Does filing a claim mean litigation? How can and should you file an insurance claim in this pandemic? Whom should you consult? What does this cost? What are the chances of success?

These are the questions this paper strives to answer.

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FILING THE CLAIM

Three Important Points

In order to better understand the answers provided in this paper, the following three very important matters must be understood.

First, you (the business) are called the "insured" – you own the policy of insurance and paid premiums for whatever insurance coverage is provided. The insurance carrier is called the "insurer" – for a premium payment it takes the risk that a bad event will not happen and cause you losses and expenses the insurer must bear. The word "coverage" has all kinds of meanings depending on who is speaking, but generally, it describes the situation where because the terms of the insurance contract are satisfied, the insurer pays the insured compensation for its losses and reimbursement for its expenses.

Second, "filing a claim" with your insurance carrier does **not** mean filing a lawsuit. Instead, it means writing to your insurance broker or insurance carrier to let them know that you are suffering losses and expenses that you understand and expect are "covered" under one or more of your insurance policies. This writing is referred to as a "tender" and by sending it to your insurer you are "tendering" a claim. In this paper, we try to make clear that you should not self –tender your claim– your tendering should be done by a professional who knows how to maximize the recovery potential and to protect your rights in the event the insurance carrier denies your claim and you have to file a lawsuit to enforce your rights. Because COVID–19 circumstances are novel to both you and the insurance industry, the wording in the tender takes on more importance and can be crucial to the processing of your claim.

Third, there are time limits in which you can tender a claim. They are set forth in the insurance policy, but they tend to be very short so that the insurer can right away investigate whatever you are claiming. If you don't give the carrier timely notice of a claim, the carrier is well within its rights to deny your claim because you waited too long. To drive home this point, here is a MAXIM of insurance law:

> ***When an insured timely tenders a claim, the insurer has a duty to try and find coverage under the policy; if the insured does not tender a claim, the insurer has no duty to tell the insured it is covered even if it is and the insurer knows it.***

In other words, if you don't timely tender a claim, you are denying any potential for coverage.

Tenders Are Being Denied

Nearly all insurers are denying tenders seeking coverage for losses and expenses arising from the COVID–19 circumstances. Insureds are finding out that their insurance policies, even those including specific coverage provisions for property damage and loss of use of property, are according to the insurers inapplicable to the COVID–19 situation.

Insurers are in a very difficult predicament. If they cover one insured, then they must cover all who have the same claim situation or they risk that they are arbitrarily discriminating against the insured, unless they can make distinctions between them. And, insurers are limited to making those distinctions only from the language they used in their insurance policies. Because they drafted the insurance policy language, any ambiguity is construed against them and in favor of the insured. This is another way of saying that if there is a tie in the argument between coverage or not, the tie is decided in favor of the insured who paid the premiums.

In most insured events, the insurers collect premiums from the many and pay out to the few. For instance, automobile insurers collect premiums from and insure virtually every car on the road, but not every car on the road gets in an accident. Similarly, property insurers collect premiums from and insure virtually every property, but not every property suffers from a fire or a tree falling on the roof or some other casualty. Even in large calamities like earthquakes, fires, and hurricanes, the area of damage and loss is limited to less than the whole because the problem is geographically restricted.

This is not so for the COVID–19 situation. While the insurers have collected premiums from across the board, the suffering from COVID–19 is not limited to a certain category of property (cars in accidents) or to a geographic area (a hurricane in the southeast). Instead, the losses and expenses from COVID–19 are everywhere. That doesn't make the losses and expenses any less covered under the insurance contract, but it makes it that much more difficult to convince the insurer that you should get paid because it knows that if it pays your claim, it might have to pay, and pay again, and keep paying throughout the whole of the country.

As mentioned, if an insured tenders a claim, the insurer is duty bound to try and find the coverage under the policy, but in doing so it will also look to see if its coverage is limited by definition, scope, or time, or excepted under certain circumstances, or excluded all together. In the following sections, this paper describes these issues of coverage, exception and exclusion. And, so if the first thing you have already learned is to make sure you tender a claim, the second thing to learn is to have a professional tender it for you.

Insurance Contract Language

Like most insureds, you probably bought your insurance through an insurance broker and not directly from an insurer. Insurance contracts or policies start with the premise that the insured is covered for a risk that is stated in the policy. But not all risks stated in the policy may be covered because the nature, scope or timing of the risk can be circumscribed by definition or can be "excepted" or "excluded" from coverage as set forth in the policy.

It has been said, and it is true, that the best insurance policy is stated in one page – it says that you are covered for all risks and will be paid the sum stated on the policy if the risk events occur and the insured suffers a loss or expense up to the stated amount of the policy. But most insurance policies are *not* just one page and that is because all the pages beyond the first page define what is considered the insured risk, and provide for when and how the claim is to be made, what is the limit of any amount to be paid, under which circumstances the coverage may be excepted, and also what is excluded all together.

For example, let's use a life insurance policy that provides coverage (or a payout of money at a stated sum) in the event of an accidental death. The policy may define exactly what is an "accidental" death, set forth how to make a claim and within so many days after the date of death, it might make exceptions for coverage such as when the accident is caused by another family member, and it might have an exclusion such as an accidental death arising from scuba diving or sky-diving. In other words, the language of the policy must be read in its entirety and as a whole in order to determine whether the insurer must make the payment it promised to make in the insurance contract.

It is for this reason, that insurers will scrutinize the language of your policy looking for whether coverage applies because whether coverage applies means what do the definitions, exceptions and exclusions provide. Of course, if an insured doesn't tender a claim, the insurer doesn't have to do anything and the time period for tendering a claim will expire.

Injury to the Insured

Every insurance policy requires some form of injury to the insured. The injury typically is defined as some form of loss. For this paper, we are discussing injury in the context of loss of use of property, expenses for protecting people (employees, customers, and vendors) from physical (health) injury, property damage, and restoration.

When tendering a claim, identifying and describing the injury is an important part of triggering the coverage under the insurance policy. Proving the loss of use of property, equipment, inventory, and other assets, requires more than just stating it. For instance, insurance policies often contain language that the insurer will pay for actual expenses caused by direct physical loss of or damage to the property at the premises. Therefore, just stating that you have lost the use of your business property, for example your inside dining area, is likely insufficient to require the carrier to make a payment to you for your loss.

In tendering a claim, the insured needs to be careful to characterize and delineate the injury so that it falls within the coverage definition without being excepted or excluded. The tender should focus on triggering potential coverages under the policy and not to add statements or documents which might allow the insurer a basis for denying the claim.

Businesses should disregard statements from their brokers and insurers that coverage is unavailable or its futile to tender a claim. Should that ultimately be the case, then let the insurer put that in writing after you have made a timely tender and the insurer is under the duty to find coverage within your policy. Remember, if you do not tender a claim, the insurer does not have a duty to tell you if you are covered.

Businesses should likewise ignore anecdotal stories about others that tendered and were denied any coverage. While it is true that claims for injury from the COVID–19 crisis are regularly being denied right now forcing insureds to file lawsuits to enforce their rights, different insureds have different insurers and not all the policies read the same way or have the same coverage provisions, the same definitions, exceptions, or exclusions. Common misconceptions about coverage are being perpetrated even when the insurers themselves are not sure how a court may interpret their policy language against the current COVID–19 circumstances. Some may take the position that because others filed a claim and it was denied it is useless for you to file a claim. However you don't know what their tender looked like, you don't know the language of their policy, and you don't know if they understood the matters set forth above.

Similarly, proving loss of use requires more than just stating it in a claim. Insurance companies rigorously enforce the language in their policies and their policies contain language like the following: "the insurer will pay for actual loss of business income or expenses . . . caused by direct physical loss of or damage to property at premises." At the time you bought the policy, you thought the language made perfect sense, that you would receive reimbursement for extraordinary expenses, for damages to, and for loss of use of your premises due to an event that was happenstance and that you didn't cause. You thought you were paying premiums for the insurance carrier to take that risk off your hands. Instead, insurance carriers are throwing back at claimants that they can't show "physical loss" or "property damage" and, if they can, then they can't show that their loss of business income or expenses are "directly" caused by such physical loss or property damage.

In order to make the most persuasive claim for coverage, a detailed proof of loss properly characterizing the businesses' damages tailored to fit the language of the specific insurance policy is needed. And, that can and should only be done by someone who knows how the insurance carriers use the coverage words on the insurance coverage chessboard to prevent you from getting to their queen.

What should be readily understood is that every insurance policy has a stated duration for filing a claim and so every business is "on the clock right now" and depending on the language of their policy, their claim period could be expiring as they wait to see what happens to others who file. However, those parties who file nothing immediately and wait, risk that their claim will be considered filed too late or beyond the cut –off period that might get set for compensating claims. It is a fundamental axiom that those who sit on their rights lose them and those that exercise their rights earn the additional right to have their claim judiciously adjudicated.

Advice of an attorney is highly recommended for tendering your claim. Tendering should only be done after a thorough review of the language in the businesses' policy(ies). This review should be done by a skilled attorney knowledgeable not only with the policy language, but also knowledgeable as to what is happening with these claims at the adjustment level in the insurance industry, in the courts, and before legislative bodies.

EVERY POLICY IS DIFFERENT

Business Interruption Coverage

"Business Interruption" coverage, also known as "Loss of Business Income" coverage, usually covers loss of earnings caused by damage to or destruction of the insured property from a "covered cause of loss." What is not necessarily clear is what constitutes loss of earning or loss of business income? Depending on the policy, it could mean revenue, though it could also mean profit, and even then, it isn't clear whether it is net profit and whether it is before or after depreciation and taxes.

While some policies will require a complete "cessation" or "suspension" of business operations, as opposed to a partial slow down, that isn't true for every policy and it isn't clear what that means. For example, a restaurant that was forced to close its dining area but remains partially open for "take -out" orders — did that restaurant cease or suspend its business operations? It certainly did with respect to the "operation" of its dining area. Does the "whole" business have to shut down? At the time the policy was issued, the restaurant did not "operate" from the curbside — the insurer insured the operation running a dining area and not a take-out business, but the insurers now want to use the partial "Sloan exclusion" to obviate a payment as if the insured's dining hall was partially blocked off, but that is a different circumstance from having the entire dining area closed of operations and operating at curbside.

That isn't to say that the insurer's perspective may not hold the day, but it isn't black and white and without making a claim you will never know. And, nevertheless, not all business interruption coverage forms contain a "suspension" or "cessation" requirement and some actually cover partial operations.

For most "business interruption" claims, the insurance policy will likely require the following: (1) direct physical loss or physical damage; (2) to a covered property; (3) caused by a "covered cause of loss" during the policy period; (4) resulting in an actual loss of income; (5) due to "necessary suspension [or cessation] of operations"; and (6) during the "period of restoration." As mentioned before, the most controversial of these factors in recent litigation, is whether or not a business can prove there was "physical loss" or "physical damage" that caused them a loss of income. Most businesses will have a better chance arguing there was a "physical loss" as opposed to "physical damage." This is because California courts have interpreted "loss" to cover property that cannot be used even though it was not actually physically damaged. In trying to determine whether you have coverage, you must analyze the exact language of your policy to see how your carrier defines "physical loss."

What Constitutes a "Physical Loss" For Coverage?

Whether a claim is analyzed by a carrier under a Property Coverage Form, or whether it is analyzed under a Business Interruption Form, the policy will likely require you to prove "physical loss" or "physical damage" to the property. However, not every policy will define and interpret a "physical loss" in the same manner. Therefore, analyzing the precise language in the policy is extremely important.

For example, some policies will have language stating that a business is covered only if the property suffers "direct physical loss or damage to" it that results from a "Covered Cause of Loss." While other policies will say a business is covered if the property suffers "direct physical loss of or damage to" it that results from a "Covered Cause of Loss." Notice that the difference between the two is very subtle. Yet, the latter language, which includes the word "of," will more likely provide for coverage in the absence of actual physical damage to a property because of prior case law interpreting how the proposition "of" affects the interpretation of the coverage to be provided.

While insurance companies are making the argument that the insured must show it suffered actual physical damage to the property in order to get coverage, the courts in California have said that isn't the case. In a case captioned *Total Intermodal Services, Inc. v. Travelers Prop. & Cas. Co. of Am.*[1], the court held that the plain meaning of the policy language "loss of" was construed to mean a permanent dispossession of something. This allowed the business to be able to prove a "direct physical loss of" the property by being dispossessed of it even though the property suffered no actual physical damage. In a 2002 decision arising out of an E. coli outbreak, a California court held that a finding of "physical loss" does not require structural damage or physical alteration to the covered property.

To this point, businesses have arguably currently suffered a "direct physical loss of" their property because by the COVID–19 orders they have been dispossessed of their premises. But that is not all, they have been dispossessed of their customers, employees, expired inventory, equipment, and of their goodwill. *This is a physical loss.* These businesses are unable to access, open, or conduct business or use their business property, employees, inventory, equipment, or goodwill, as they did when they bought their policies and because of it, they are not able to generate revenue or income or profit, however defined.

Of course, the likelihood of coverage stems from the particular language of the policy. If the policy does not contain certain language such as "loss of," an insured might not be able to obtain coverage because it will have to show the alternative requirement that it suffered actual physical damage to its property. But physical damage need not mean the equivalent of cracking, dry rot, crumbling, or breakage. Physical damage can be from the aerial deposit of the virus on doorknobs, rails, countertops, restaurant and bar equipment, stools, tables, and even hand towels, glasses, plates, money, and other fixed and unattached fixtures and assets in the premises. The fact that the virus is invisible to the naked eye does not mean that it doesn't exist or that it hasn't caused damage. It could with a human being cause serious physical damage to one's lungs and kidneys; moreover, its presence is a microscopic change to what it comes to rest on and restricts the full use and enjoyment of such asset. No one would reasonably argue that ashes from a fire that came to rest on a piece of toast didn't cause the toast to be damaged, but insurers want to make the distinction that because you can't see the virus then it doesn't cause damage in the same manner. Moreover, because coronavirus attaches to surfaces and can cause potentially fatal infections, it prevents business owners from using and enjoying their property which is "physical damage."

Of course, insurers who wrote these policies could have easily written that "visible" damage was a requirement of defining property damage, but they didn't. Instead, now, after they have collected the premiums leaving you to the understanding the property damage is akin to fire ash settling on toast, they want to retrospectively say that there is no such thing as damage except for what you can see.

The bottom line is that coverage will depend precisely on the policy language, even if the policies appear to be the same. Because businesses do not write their own policies and courts interpret policies broadly looking for coverage, the advantage rests with the claimant whom timely acts. There is nothing to lose by making a claim. The worst it can get you is that you get what they are giving you now — nothing.

Speaking of "Actual Property Damage"

Insurers have been quick to adopt the defense that the virus does not cause any "property damage". As set forth above, that is one of the requirements for coverage — that there be a "physical loss or damage" or "physical loss of or damage".

It might be true that there is no property damage when the policy defines "property damage" to be akin with damage which a fire or weather event may cause. However, not all policies define property damage in the same manner and many define "property damage" to mean either "physical damage" to tangible property or "loss of use" of property. As a result, attention needs to be given to each policy, so that any claim can be specifically weighed against and tailored to the verbiage and definitions in the insurance policy.

The science regarding the virus is evolving with more and more study, but it is clear that it can take an aerosol form, that it moves where those infected with it move, and it can be spread through the air at long distances; additionally, when it lands, it can remain in existence and harmful for up to 72 hours. Though the virus is invisible to human sight, it doesn't make it any less of a real thing. There is a reason everyone is washing their hands, sanitizing regularly, and disinfecting surfaces wherever possible.

California law defines "damage" to mean that a detriment has been caused. Thus, property damage would be a detriment caused to property. The word detriment is defined in the Civil Code as a "loss or harm suffered in person or property." Detriment is defined in common parlance as a drawback, disadvantage, impediment, or something that is harmful. In this respect, exposure of your property to the virus is a detriment;, there is an impediment and drawback to use, and such use could be harmful.

In that very regard, several of the California state and county orders specifically include language that the order was necessary because COVID–19 is "physically causing property loss or damage due to its proclivity to attach to surfaces for prolonged periods of time." Such orders support the argument for policy coverage.

What About Civil Authority Coverage?

Some insurance policies also include what is known as Civil Authority Coverage. These provisions describe coverage for the "actual loss" sustained and "extra expense" incurred by the insured during a "period of liability" if an order of civil or military authority limits, restricts, or prohibits partial or total access to the insured's property, provided such order is the direct result of physical damage of the type insured.

Insurers have adopted the defense that the government orders do not create separate coverage because the orders have not created property damage. The denial letters from insurers often state that the issuing of the orders from the state or federal government was neither due to physical loss or damage nor did they prohibit access to the demised premise.

However, even though these civil authority provisions typically use language like "as a result of physical damage," courts have held that a showing of actual property damage is not necessarily required to trigger Civil Authority Coverage. This was exemplified in a 1973 Michigan case captioned *Sloan v Phoenix of Hartford Ins Co.*[2], in which the Court held that regardless of any physical damage to the insured property, coverage should be provided and benefits payable "when, as a result of one of the perils insured against access to the insured premises was prohibited by order of civil authority [...]" Another case, decided in Texas in 2006, captioned *Houston Cas. Co. v Lexington Ins. Co.*[3], found coverage for the insured under Civil Authority Coverage when the insured closed its amusement park due to a mandatory evacuation order from the Governor for an approaching hurricane even though the hurricane never made landfall. That decision seems pertinent to businesses dealing with the COVID–19 pandemic. Businesses were forced to close due to the mandatory shelter-in-place orders because of looming consequences of catching the virus even if the virus never made its way to the business itself.

The "actual loss" or "extra expense" being incurred by the business may include what the insured is doing to handle the pandemic as required by government orders. This could be something as simple as having no customers to buying extra cleaning supplies and hiring extra cleaning staff to ensure the property is being maintained (disinfected) pursuant to a government order when your business is permitted to reopen. This is just one of many examples, and these expenses add up. If a policy includes Civil Authority Coverage, there is an additional chance the business can be covered for these types of losses or "extra expenses."

Notably, however, most Civil Authority Coverage comes with two exceptions/limitations. The first is a requirement that a claim is made as soon as possible after the government order is issued. The second is that the losses and expenses incurred within the first 72 hours after the order are not compensable and that there is usually some limitation on the number of days (14 or 28 days by way of example) for which losses and expenses will be paid. Left undefined is whether each new order constitutes the running of a new time frame and whether an insured must tender based on each or every order for which it seeks compensation.

VIRUS EXCLUSIONS MAY NOT BAR COVERAGE

Notwithstanding that there may be property loss, property damage, or losses arising from government orders which set the basis for coverage, in order to secure compensation or reimbursement there must also not be an exclusion precluding coverage.

In many policies there is language excluding loss due to bacteria, microorganisms, pollutants, and more recently to "virus" concerns. Insurers added the virus exclusion as a result of the SARS virus outbreak in the early 2000s. Older policies may not have the "virus" exclusion. And, because exclusions are narrowly construed, it is not clear that those with the exclusionary language should be precluded from coverage because the exclusionary language used is subject to different interpretations and may not apply to all losses and expenses being incurred.

For instance, some insurers are saying that COVID–19 related claims are excluded because of a *bacteria* exclusion, but a virus is scientifically different from a bacteria. Similarly, while insurers like to also say that a virus is also a pollutant or a microorganism, because exclusions are narrowly construed, the insurer has a greater than usual burden to prove that a virus is one in the same as a bacteria, microorganism, and/or pollutant. Because they have been mostly unsuccessful at making that showing, that is why some insurers specifically added a "virus" exclusion to their policy.

On a much more technical level, when a virus exclusion is provided by what is called a "stand-alone endorsement" (a fancy way of saying an added sheet to the policy), meaning it is an add-on to the original policy, such a stand-alone endorsement will usually apply to "all coverage" and typically only excludes loss "caused by or resulting from any virus" "that induces or is capable of inducing physical distress, illness, or disease."

The uniqueness of this form is that it usually applies to the coverage under the policy and it is not benefited by any "lead-in" exclusion language in the policy. In other words, when there is a virus "lead-in" exclusion within the exclusion language of a policy, for example, "we will not pay for loss or damage caused directly or indirectly by any of the following […]" such loss or damage is excluded regardless of any other cause or event that contributes concurrently or in any sequence to the loss. This "lead-in" language allows the carrier to invoke an exclusion because of the conditional nature of the language. It allows a carrier to argue that the virus exclusion applies because the covered loss is caused "indirectly" by the virus and "regardless of any other cause or event that contributes concurrently or in any sequence to the loss" it must be excluded.

However, if instead of a "lead-in" exclusion, there is a stand-alone endorsement virus exclusion, the insured may be able to avoid application of the virus exclusion. If the standard stand-alone endorsement language is used, the insured would be able to argue that it does not apply because the covered loss (say, for example, "direct physical loss of" the property due to government orders and the dangerous risk of further use of the property) is not a loss "caused by or resulting from any virus" at the property "that induces or is capable of inducing physical distress, illness, or disease." To state it another way, the loss is caused by the shelter-in-place orders themselves not the virus.

Civil Authority Coverage

When it comes to arguing for Civil Authority Coverage, insurance carriers are prone to saying that the exclusion for reimbursing losses and expenses applies because these losses are *caused* by the virus. In actuality, though, the virus did not force businesses to close down their facilities — customers would still be using them today if not for the orders and the enforcement of those orders. It was the orders that precluded the use — had the virus closed off these areas there would not have been a need for the orders. (The orders were a means to avoid mass use of limited hospital resources and to reduce the rate at which the virus spread through the populace; these orders did nothing to treat, cure, remedy, or ward off the virus itself.)

While the language can be quite confusing, the takeaway here is that just because there is a "virus exclusion," it does not necessarily mean coverage is not available. Although many insurance carriers have drafted their policies in a way to minimize coverage by excluding losses from a virus, such as using lead-in language, not all carriers have followed suit. And, carriers that do not have that lead –in language do not have the same argument. This distinction is a fine one, but it is also part of the takeaway for you to know that while some losses may be excluded, others may not. And, when they are not excluded, the insurer should be required to uphold its coverage obligation.

WHAT IS AT STAKE?

Your losses may include such things as loss of use of your property, loss of customers, extraordinary management expenses, cleaning, additional utility payments for water and electricity, and other COVID–19 related expenses. When purchasing insurance coverage from their insurance agent or broker, almost all insureds believed that "property damage" and "loss of use" of the insured premises not caused by the insured would be covered events. Insurance brokers usually sold the insurance as necessary to the operation of a business alleging the policy would cover "unexpected" property damage, loss of use of the premises, and extraordinary expenses that are currently being incurred.

With their backs up against the wall, the insurers are now lobbying legislators, stating that the insurance industry will be destroyed by having to reimburse COVID–19 losses and expenses. And, they are denying claims where they can find the language to do so because to pay on some while denying others is a slippery slope and could expose them to bad faith claims.

The insurance industry will fight all COVID–19 claims and they will fight on the grounds stated herein — by raising that claims were untimely tendered, not appropriately tendered, do not state a claim for coverage, or the coverage is excluded. Nevertheless, if no tender is made, then insurers need not act. And, if they wrongfully deny claims, they still will not be required to pay until claimants stand up for their rights and courts start forcing insurers to pay. Nobody knows what these same insurers will say when businesses are sued for not mitigating their damages or properly cleaning and disinfecting their property; thus, filing a claim is imperative.

YOUR TENDER SHOULD BE TAILORED TO THE POLICY LANGUAGE

This may seem obvious but making sure a proof of loss is tailored precisely to the policy language can be quite difficult. A detailed and precise proof of loss, as well as general responses to an insurance company's investigation of a claim, must be crafted in a way so as to prevent an opportunity for the insurance company to deny coverage based on vague, ambiguous, or misapplied information. In other words, every response provided to the insurance company bears a risk that the information in the response can be used against you.

Another issue is that losses may be ongoing. Seeing as government orders have been continuous, and with no foreseeable end to the pandemic in the near future, an insured's (your) losses may continue to accrue even after a claim is filed. This is another reason why vigorous documentation is important for a proof of loss. In the event that losses continue after coverage has been accepted or denied, the insured will need to prove the continuous accrual of losses with adequate documentation.

As stated before, hiring an attorney can be vital during this process in order to correctly interpret the policy language, and guide the insured to submit precise responses in accordance with that specific policy's language. This can prevent a denial of coverage that could have been easily avoided if only a proof of loss was done correctly. Furthermore, a well –documented claim is likely to receive coverage more quickly than one that is not.

Four Key Things to Remember When Tendering a Claim:

- Every Policy is Different/Have Your Policy Read by A Legal Professional
- Damage can either be "Physical Property Damage" or "Loss of Use" of the property
- Virus Exclusions May Not Bar Coverage
- Your Tender Should be Tailored to the Policy Language

Notice of Change in Circumstances

Businesses may also want to consider filing a Notice of Circumstances claim. If certain claims are not made by the date when the policy period ends, the business owner will not be able to assert those claims for that policy period. However, the policyholder may choose to submit a notice of circumstances before the policy period ends, describing the "circumstances" that might give rise to a currently covered claim in the future.

If a notice of circumstance is submitted during the policy period and a claim is later asserted after the policy period has ended, but arising out of the noticed circumstances, then the insurance carrier must treat the claim as if it were made when the notice of circumstances was submitted. The purpose behind this is to allow a business to file an anticipated claim that may not come to fruition until the policy period is over and the insurance carrier adjusts the policy to exclude what may have been covered in the previous policy.

Although this may seem like an easy and catch all way to cover your grounds, there are some caveats to filing a Notice of Circumstances. First, a policy will usually require that the Notice "be specific and contain full particulars as to the facts and circumstances potentially giving rise to the Claim, including a narrative setting forth dates, names of the potential plaintiffs and affected Directors or Officers, names of other parties involved, the nature and scope of anticipated Claim, and all reasons why such a Claim is reasonably anticipated." However, it may be difficult to provide such detail since the facts and circumstances may only be anticipated as opposed to currently available. Courts will allow some leeway to the policyholder in this situation, but the policyholder should nevertheless strategically draft the Notice using sufficient particularity and detail.

If the policyholder does not have sufficient detail to file the Notice, it may consider holding off until there is enough evidence to support the claim, but before the policy period ends. The key takeaway to consider before filing a Notice of Circumstances is that your business may lose the opportunity to file a claim that is currently covered after the policy period ends because your renewed policies will likely include new exclusions for pandemics, COVID–19, viruses in general, and/or government orders. In other words, it's better to be safe than sorry. With this in mind — Gather your facts, documents, and any other evidence for an anticipated claim and be prepared to file a Notice of Circumstances if/when the time comes.

CONCLUSION

It is important to remember you are not in this alone. Many businesses are experiencing the same or similar situations and are in desperate need of insurance coverage. However, all such businesses, profit and non-profit, are continuously being denied coverage. That is why the way you approach your claim should set you apart from the rest and put you in the best position for coverage. You will be one step closer to obtaining coverage if you utilize these key takeaways.

Key Takeaways

- Remember That Every Policy Is Different — Policies have subtle differences in the language that can make or break coverage for the insured.
- Don't Assume That You Will Be Denied Coverage — physical damage can be both property damage and loss of use of property, even without property damage. If you are going to be denied coverage, put the onus on the insurer to first look for coverage for you and let your insurer tell you in writing there is no coverage.
- Certain Exclusions May Not Bar Coverage — Don't jump to the conclusion that you will be denied coverage simply because your policy contains a virus exclusion.
- Finally, Tender a Timely Claim Tailored to the Policy Language By Experienced Counsel — It is important to tender because without it you can't even be considered for coverage, but tender using an attorney who understands how to interpret policy language and who can maximize your chance at recovering some money.

By acting now, you not only give yourself a chance to gain reimbursement for your losses and budgeted expenses, but you also protect your business from denial of coverage from your liability carrier or D&O carrier when the business was either negligent and caused harm to its clients or failed to act — allowing the business a chance to either gain appropriate coverage or enforce the coverage it had.

If you would like a courtesy review of your insurance policies and claim strength, please email a copy of your policies of business insurance to Berding & Weil at:

freepolicyreview@berdingweil.com

[1] Total Intermodal *Servs. v. Travelers Prop. Cas. Co. of Am.* (C.D.Cal. July 11, 2018, No. CV 17-04908 AB (KSx)) 2018 U.S.Dist.LEXIS 216917.

[2] *Sloan v. Phoenix of Hartford Ins. Co.* (1973) 46 Mich. App. 46,51.

[3] *Houston Cas. Co. v. Lexington Ins. Co.* (S.D.Tex. June 15, 2006, No. H-05-1804) 2006 U.S.Dist. LEXIS 45027, at 6.