CAN YOUR ASSOCIATION RECOVER MONEY FOR EXTRAORDINARY EXPENSES AND LOSSES DUE TO THE COVID-19 PANDEMIC?

BERDING | WEIL
ATTORNEYS AT LAW

WWW.BERDING-WEIL.COM

INTRODUCTION

Lost among the commotion and fall-out from the Government ordered COVID-19 closures of restaurants, bars, hotels, entertainment venues, and country clubs, is the *adverse* impact on homeowner associations. While the Government is telling all those businesses to shut down and their customers to shelter-in-place, it is indirectly telling associations to take on the larger burden of having "everyone at home" while also stripping associations and their members of the full use and enjoyment of their common areas and facilities. The pandemic has created panicked claims from businesses to insurance agencies for financial help in covering business losses and expenses, including loss of use of their premises, but homeowner associations are also losing the use of their premises and paying extraordinary expenses to maintain the safety of their common areas.

While many claims and lawsuits have been filed for a broad spectrum of profit-making businesses, both large and small and of many different types, arguing for compensation for their losses and expenses, homeowner associations seem to have been left behind.

What can an association do? Should it try and get coverage like so many others are doing? Should it just continue to push ahead and collect assessments that include premiums for insurance as well as for the maintenance, repair, and replacement of facilities that are not being used? If the association were to pursue some form of recovery, what is the best way to go about it? How can the association file an insurance claim in this pandemic and is there a downside to filing? What are the chances of success?

Additionally, aside from whether the association might be able to recover for its losses and expenses, the Board of Directors should concern themselves with protecting the association from losses and maybe uncovered claim liability in the future. For instance, what if the Board of Directors is later sued for failing to enforce its rights under the insurance policies paid for by the membership? Or, what if a member, guest, employee, or vendor sues the association because it allegedly became sick because the association failed to diligently disinfect the common areas or made them available too soon before the pandemic subsided? Is the association covered? Did the association take the steps *now* to make sure that it will be covered should such a claim be made? These are the questions this paper strives to answer.

CONTENTS

BERDING | WEIL
ATTORNEYS AT LAW

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 association) 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 the 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. (As we will discuss at the end of this paper, Boards must be mindful if they decide not to act since members pay the association dues, some of which pays the premiums to have insurance in the first place. If the members pay for such coverage and the Board fails to act when a claim accrues, members may have a claim that the Board was derelict in its duty owed to the association).

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 risk that they are arbitrarily discriminating against 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. 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 the same regarding 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 coverage under the policy, but in doing so it will also look to see if its coverage is limited by definition, scope, or time, excepted under certain circumstances, or excluded all together. In the follow 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 occurs 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, provide for when and how the claim is to be made, describe 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 meaning 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, members, guests, 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 community room 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 refrain from adding statements or documents which might provide the insurer a basis for denying the claim.

Associations should disregard statements from their brokers and insurers that coverage is unavailable or that 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.

Associations should likewise ignore anecdotal stories about others that tendered and were denied any coverage. While it is true that claims arising out of the COVID-19 crisis are regularly being denied, 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, definitions, exceptions, or exclusions. Also, there are common misconceptions and reports about why coverage was denied. For instance, an insured might tender a claim under its Directors & Officers or Commercial General Liability policy, but those types of insuring contracts likely do not provide coverage for the circumstances arising from the COVID-19 pandemic. Additionally, with such anecdotal stories about denial, it also isn't known if the insured prepared an appropriate tender or provided adequate proof of loss or expense. And because nearly every insurance policy has a duration for tendering a timely claim, some of which can be very short, it might be the case that the claim was covered but denied because it wasn't timely filed. Those parties who do not file when they first become aware of their injury risk that their claim will be considered "late" or beyond the cut-off period for compensating claims. And, what happens if the so-called "next wave" hits when the Fall season arrives?

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 policy(ies). This review should be done by a skilled attorney knowledgeable not only with the insuring language, but also knowledgeable as to what is happening with these claims at the adjustment level in the insurance industry, in the courts, before legislative bodies, and within the insurance agencies.

EVERY POLICY IS DIFFERENT

What Constitutes a "Physical Loss" for Property & Casualty Coverage?

One of the primary burdens to association living right now is the loss of use of common area amenities. These amenities drive sales and are a *fundamental* part of any common interest development. The governing documents of every association legally obligates the association to "maintain, repair, and replace" the common areas and the membership is charged regular dues by the association so that it can fulfill this obligation. However, the shelter-in-place orders that drove all workers to be in their homes 24 hours a day and 7 days a week also shut down the use of the common area facilities at their homes. That is like telling single-family homeowners that their swimming pool and patio deck cannot be used, their dining room table has been removed from the house, there will be no gardening, the bathroom with the sauna is closed, and their home gym is off-limits.

But is this loss of use considered "physical loss" for coverage purposes under an insurance policy? Not every insurance policy sold to an association will define and interpret "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 the insured is covered only if the property suffers "direct physical loss or damage" resulting from a "Covered Cause of Loss." What does that mean? As described above, the insured must read how "Covered Cause of Loss" is defined in the policy. But, in general, this language has been interpreted to mean that the loss of use must be a result of injury or damage to the property itself. Thus, if you lost the use of your swimming pool because it became it cracked and the water came out of it, the insured might have coverage. If, however, the swimming pool is structurally sound but no one is allowed to swim in it, such as with this pandemic, then arguably this language says there is no coverage.

Other insurance policies will say an insured is covered if the property suffers "direct physical loss *of* or damage" resulting from a "Covered Cause of Loss." How is that different and what does it mean? Notice the subtle difference between it and the one in the preceding paragraph. This one includes the word "of" (italicized for emphasis) before the word "or" in front of the word "damage". The addition of the preposition "of" can be the difference between recovering money or not for the loss of use of your amenities because courts have interpreted that language to provide for coverage for loss of use of property in the absence of actual physical damage to the property itself.

In a recent California decision 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*" means a permanent dispossession of something. With this meaning given to the phrase "loss of" the insured is able to prove a "direct physical loss of" the property due to a "Covered Cause of Loss," even though it suffered no actual physical damage. It need only show that it was dispossessed of the use of the property.

Associations have therefore arguably suffered a "direct physical loss of" their property arising from the pandemic and the various Federal, State, and Local government COVID-19 shelter-in-place and anti-gathering orders because associations are unable to make available or allow use of their common area facilities. This is a physical loss notwithstanding that the common areas are not themselves suffering from physical damage.

The likelihood of coverage stems from the particular language used in 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 actual physical damage to the property.

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, common areas exposed to the virus would be disadvantaged, there is an impediment and drawback to their 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 mandatory evacuation order from the Governor for an approaching hurricane even though the hurricane never made landfall. That decision seems pertinent to associations dealing with the COVID-19 pandemic. Associations were forced to close off their common areas 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 association's common area.

The "actual loss" or "extra expense" being incurred by the association may include what the insured is doing to handle the pandemic as required by government orders. This could be something as simple as buying extra cleaning supplies and hiring extra cleaning staff to ensure the property is being maintained (disinfected) pursuant to a government order. This is just one of many examples, and these expenses add up. If an association's policy includes Civil Authority Coverage, there is an additional chance the association 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, but that addition seems to be more prevalent in homeowner associations with associated *commercial* areas. Older policies and those associations that are strictly residential 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.

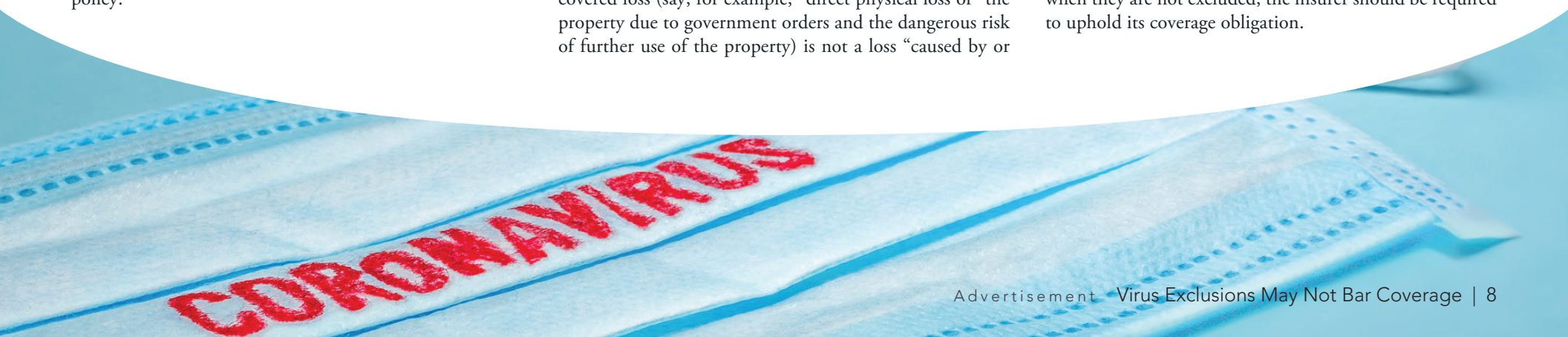
On a much more technical level, when a virus exclusion is provided by what is called a "stand-alone endorsement" (a fancy way of saying an added sheet to the policy), meaning it is an add-on to the original policy, such a stand-alone endorsement will usually apply to "all coverage" and typically only 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.

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 associations to close down their common area facilities – members, guests, and tenants would still be using them today if not for the orders and associations enforcing those orders. It was the orders that precluded the use of such common facilities — 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 extraordinary management expenses, cleaning of common areas, 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 brokerages usually sold the insurance as necessary to the operation of an association 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 associations are sued for not mitigating their damages or properly cleaning and disinfecting their common areas; or when the Board of Directors is sued for either not having secured appropriate coverage or not having enforced the coverage it did have.

YOUR TENDER SHOULD BE TAILORED TO THE POLICY LANGUAGE

This may seem obvious at this point but tendering a claim and making sure the tender is tailored precisely to your policy language should be a priority. A properly worded tender will trigger the insurer to open a claim file and begin an investigation. It will also likely cause the insurer to send the association, as part of its investigation, a detailed questionnaire requesting answers touching on language in your policy. The response, like the tender, must be crafted in a way to prevent an opportunity for the insurance company to deny coverage based on vague, ambiguous, or misapplied information. Every response provided by the insured to the insurance company bears a risk that the information in the response can be used against you.

Equally tricky is understanding the association's rights when the insurer says there is coverage or wants more information about your losses and damages. Those losses may be ongoing and your expenses and damages can be accruing while the insurer is investigating and before they write a check. In the event that losses continue after coverage has been accepted or denied, the association will need to prove the continuous accrual of losses and expenses with the appropriate documentation.

The government orders have been continuous to-date, but even after they are fully lifted, what about on-going expenses? And what happens if there is the second so-called wave. If an insured didn't file initially (during the first wave) is it barred from filing if there is a second wave? This is another reason why vigorous documentation is important.

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 language. This can prevent a denial of coverage that could have been easily avoided if only a tender was done correctly, but moreover a tender will force the insurer to look for coverage and will preserve all of your legal rights.

Of course, attorneys don't come cheap, certainly not those who know how to read policies of insurance, who are knowledgeable about the coverage arguments, and who are aware of other claims ongoing at this same time. Such legal expense is unbudgeted and it is just an extra burden on associations already burdened with the pandemic costs. By providing your claim to Berding and Weil LLP, through our lawyers in Walnut Creek, San Diego, or Costa Mesa, we can do all of this review at no upfront cost to you.

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 Property
- Virus Exclusions May Not Bar Coverage
- Your Tender Should be Tailored to the Policy Language

Notice of Change in Circumstances

Finally, separate and apart from seeking compensation for losses and reimbursement of incurred expenses, associations should consider getting legal advice about what is a *Notice of Circumstance* tender. This "tender" is usually made with a Directors & Officer's insurance policy or maybe a Commercial General Liability policy. This tender is not a claim for money but is a claim to reserve the association's rights to tender a claim under an expiring policy when it doesn't have sufficient information on whether its current circumstances will ripen into a formal claim *against* it.

The association needs to be aware of and understand that *if* certain claims are not made by the date when the policy period of an insurance policy ends, the association will be prohibited from asserting those claims for that expired policy period. With a Notice of Circumstance tender, however, the association may preserve its rights before the policy period ends and coverage under that policy is terminated.

If a Notice of Circumstance is tendered during the policy period and a claim is later asserted after the policy period has ended, but *arising out of* the circumstance described in the Notice of Circumstance, then the insurer must treat the claim as if it were timely made when the Notice of Circumstances was tendered. The purpose behind this procedure – and some policies do not even allow for it — is to allow an association to file an anticipated claim that may not come to fruition until the policy period is over and the insurer adjusts the policy to exclude what may have been covered in the previous policy.

Although this may seem like a catch all way to cover your grounds, there are caveats to tendering a Notice of Circumstance. First, a policy will usually require that the Notice of Circumstance "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 claimants and affected Directors or Officers, names of other parties involved, the nature and scope of the anticipated claim, and all reasons why such a claim is reasonably anticipated."[4] Second, the wording should be done in a way that it doesn't adversely affect the association's other coverages and downstream coverage with a new policy.

Tendering a Notice of Circumstance raises a lot of the same concerns and matters discussed when tendering a claim for compensation. And, it can be difficult to provide such detail when the facts and circumstances are evolving and may only be anticipated as opposed to currently available not to mention it is difficult to avoid impeaching downstream coverage from a policy that has not yet incepted. Thus, an association should secure legal counsel before deciding whether to tender a Notice of Circumstance and if it does, it should strategically draft the Notice of Circumstance with these concerns in mind.

The key takeaway to consider is that the association doesn't know what claims may arise against it or the Board from the pandemic. A claim could arise that the Board handled something wrong during the pandemic and the association should not lose the opportunity to file a claim with the policy that may currently cover the claim after the policy period ends because the renewed policy(ies) will likely include — without specific additional premium payments — 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, associations should seek counsel and gather facts, documents, and any other evidence that might be considered an anticipated claim and consider whether it is prudent to file a Notice of Circumstance. Please note that it is important to send the Notice of Circumstance before the end of the policy period of your current insurance, because it is extremely likely that insurance companies will radically change certain coverages and add more exclusions to coverage in the new policy.

CONCLUSION

It is important to remember you are not in this alone. Many businesses and most associations are experiencing the same or similar situations and are in need of the insurance coverage they already paid for. With experienced, skilled counsel, your approach to your tender will set you apart from the rest and put you in the best position for recovering a payment during these unusual times.

You will be one step closer to obtaining coverage if you remember the FOUR 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 your association some money.

Lastly, time frames for reporting in insurance policies are short, so act now, and do not risk losing your rights. By acting now, you not only give yourself a chance to gain reimbursement for your losses and budgeted expenses, but with the right attorney you can evaluate whether you should tender a Notice of Circumstance to protect the association from denial of coverage from your liability carrier should there be a claim that the association was either negligent and caused harm to its members or failed to act and either get 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 insurance policies 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.

[4] Genesis Ins. Company vs. Crowley, 495 F.Supp.2d 110, 114 (D. Colo. 2007).