Chapter 23
SETTLING INSURANCE COVERAGE DISPUTES

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[*] The views expressed herein are those of the authors only and do not necessarily represent the views of their law firm or clients. Commentaries beginning with "Judge's Perspective:" were written by the Hon. Timothy M. Tymkovich, Circuit Judge of the U.S. Court of Appeals, Tenth Circuit.

New Appleman Insurance Law Practice Guide

I. OVERVIEW.

23.01 Scope. Most coverage disputes are resolved by settlement between the insurer and the insured, either before or after coverage litigation is filed. Unlike coverage litigation, settlement involves creating a new contract to govern the relationship between insured and insurer rather than simply interpreting and enforcing the terms of an existing insurance policy. This makes settlement a much more flexible means of resolving coverage disputes than litigation. The parties can, for example, completely renegotiate the terms on which underlying liability claims will be indemnified by the insurer through a coverage-in-place agreement that essentially replaces the existing insurance policies. But this greater flexibility also raises issues different from those presented in coverage litigation.

The goal of this chapter is to assist counsel in anticipating the various issues that can arise when insureds and insurers attempt to settle their coverage disputes rather than to describe one right way to negotiate and draft a settlement agreement. Settlements are custom documents rather than standard forms. The appropriate way to address a settlement issue in one context may not work in another, and the sample forms provided at the end of this chapter are only one way that such agreements can be drafted. Nevertheless, counsel should know what issues are likely to arise, and what options are available to them, in order to make a reasoned decision how to proceed. The issues discussed in this chapter largely reflect the authors' own experiences in negotiating settlements of complex insurance coverage claims on behalf of insureds under liability insurance policies such as Comprehensive General Liability, directors' and officers' liability, errors and omissions, and other commercial liability forms. Where first-party policies such as property insurance raise different issues, however, we have so noted in the discussion.

This chapter begins with a discussion of the issues involved in valuing a coverage claim and the techniques for applying appropriate discounts to the elements of the claim. We then review different structures of settlements — such as the release of specific claims, the policy buy-back, the coverage-in-place agreement, and others — that are commonly used. Next, we discuss the process of negotiating a settlement and the techniques that the parties can use to encourage settlement and preserve the confidentiality of the negotiations. The chapter then addresses the drafting of term sheets and formal settlement agreements, with an emphasis on the issues that counsel should consider and address in each of the standard clauses in the agreement. Negotiating the rules that will govern the pursuit of subrogation claims is discussed in its own section. The chapter concludes with a discussion of various ways in which settlement may affect the rights and obligations of non-parties to the settlement.

23.02 Key Practice Insights. Thorough preparation is the key to effectively assisting an insured or an insurer to achieve a good settlement. Before making

or responding to a settlement offer, counsel should have considered, and advised his or her client regarding, all the factors that can affect the valuation of the coverage claim. The dynamics of settlement negotiations make it difficult for insureds to increase their demands, or for insurers to decrease their offers, once the parties have begun serious negotiations, so each side should begin negotiating with as clear an understanding as possible of the value of their positions and their client's bottom line regarding an acceptable settlement outcome.

Settlement valuation can involve much more than determining the insured's likely recovery on a specific coverage claim in coverage litigation. Because settlement allows parties not only to resolve existing coverage disputes but also address future coverage disputes, counsel may need to value coverage claims that the insured might assert in the future under insurance policies that are not yet at issue in coverage litigation. Counsel's settlement valuation also should take into account other factors such as the importance of the business relationship of the settling parties and the possibility of offsetting claims such as retrospective premiums or subrogation recoveries.

An equally important part of the preparation for settlement negotiations is to anticipate the drafting issues that are likely to arise if and when an agreement is reached and the parties must prepare a formal settlement agreement. Seemingly small differences in the phrasing of definitions of the settling parties or the subject insurance policies, for example, can have an outsized impact on the value of the settlement to one party or another. The decision whether to include an indemnification clause in the settlement agreement, and what the terms of such a clause will be if one is included, likewise can drastically change each party's perception of the value of the settlement. Failing to anticipate and discuss these issues during settlement negotiations can lead, at best, to awkward efforts to address these issues after the price term has been agreed upon and, at worst, to an unraveling of the entire agreement if these issues are sufficiently material to one or both of the parties. Thus, although this chapter discusses drafting issues after the sections that discuss the valuation of coverage claims and the mechanics of settlement negotiations, counsel negotiating settlements should attempt to anticipate and address the most contentious drafting issues before the parties "shake hands" on an agreement, even if the actual drafting of a formal settlement agreement occurs only afterwards.

23.03 Master Checklist.

☐ Identify the insurance policies to be included in the settlement.

Discussion: § 23.05

☐ Identify the claims and costs to be released in the settlement.

Discussion: § 23.06

☐ Identify any potential offsets to the proposed settlement amount.

Discussion: § 23.07

☐ Apply appropriate discounts to the coverage claim.

Discussion: § 23.08

☐ Select a structure for the settlement offer.

Discussion: §§ 23.09 – 23.13

Forms: §§ 23.32 – 23.35

☐ Decide whether to make the settlement offer before or after initiating coverage litigation.

Discussion: § 23.14

☐ If coverage litigation is pending, decide whether to make an offer of judgment to encourage settlement.

Discussion: § 23.18[1][b]

☐ Analyze the likelihood that exposure to fee shifting, bad faith liability, and late payment interest and penalties may encourage prompt settlement.

Discussion: §§ 23.18[1][a], 23.18[1][c], and 23.18[1][d]

☐ Understand the business relationship between the insured and the insurer and consider how it may influence the settlement of the coverage dispute.

Discussion: § 23.18[2]

☐ Decide whether to offer incentives for early settlement.

Discussion: § 23.18[3]

☐ Decide whether to use mediation to facilitate settlement.

Discussion: § 23.19

☐ Consider the possible impact of settlement on the rights and obligations of third parties such as non-settling insurers and non-settling co-insureds.

Discussion: §§ 23.29 – 23.30

☐ Invoke Rule 408 and obtain a confidentiality agreement before beginning settlement negotiations.

Discussion: § 23.15

Form: § 23.31

☐ Make the opening settlement offer or respond to the other side's opening offer with a counteroffer.

Discussion: §§ 23.16 – 23.17

☐ Include a proposed term sheet with each offer or counteroffer and a final term sheet once agreement on the material terms of the settlement is reached.

Discussion: § 23.20

☐ Anticipate drafting issues that may arise if and when a deal is reached and the final settlement agreement is drafted. Address any material drafting issues in the proposed term sheets during settlement negotiations to minimize the risk that such issues cannot be resolved after the "handshake" on the deal.

Discussion: §§ 23.21 – 23.26

☐ Decide whether the parties will be bound upon execution of the term sheet or only upon execution of a formal settlement agreement.

Discussion: § 23.20

☐ Draft the settlement agreement.

Discussion: §§ 23.21 – 23.26

Forms: §§ 23.32 – 23.35

☐ Check the usage of various definitions of the insurer parties and the insured parties in the agreement to ensure that the definition appropriate to the context is being used.

Discussion: § 23.21[1]

☐ Check the definition of the "Subject Insurance Policies," especially with respect to the description of unnamed or unknown policies and any interaction with the definitions of the parties.

Discussion: § 23.21[2]

☐ Check the definition of the claims being released, especially with respect to the description of unnamed or unknown claims and any interaction with the definitions of the parties and the "Subject Insurance Policies."

Discussion: § 23.21[3]

☐ Draft the payment terms and decide whether to allocate the payment to specific policies or claims if multiple claims and/or policies are being settled.

Discussion: § 23.22

☐ Draft the releases and decide whether to include supplements to the release such as dismissal of coverage litigation, deemed exhaustion of policy limits, or rescission of the policy.

Discussion: § 23.23

23.03 Settling Insurance Coverage Disputes

☐ Consider whether any statutes limit the scope of the release and whether such limitations can or should be waived.

Discussion: § 23.23[4]

☐ Consider whether to include alternatives to an indemnification clause in the settlement agreement.

Discussion: § 23.24[3]

☐ If the insured has agreed to indemnify the insurer, draft the indemnification clause.

Discussion: § 23.24[2]

☐ Decide what information regarding the settlement each side will need to disclose and draft an appropriate confidentiality clause.

Discussion: § 23.25

☐ Decide how disputes regarding the settlement agreement will be resolved and draft an appropriate enforcement and dispute resolution clause.

Discussion: § 23.26

☐ Decide whether to waive the insurer's subrogation and contribution rights.

Discussion: §§ 23.28, 23.29[2]

☐ Address issues likely to arise in a subrogation action through specific provisions in the settlement agreement.

Discussion: § 23.27

Judge's Perspective: If coverage litigation is pending, also consider whether the court will be asked to participate. Some types of settlements may require judicial approval, or the parties may require the court to enter an order as part of the dismissal. Be sure to negotiate the form of the order of dismissal so it is clear the case has been dismissed with prejudice.

II. VALUING THE COVERAGE CLAIM FOR PURPOSES OF SETTLEMENT.

23.04 Steps Involved in Valuing the Coverage Claim. Valuing a coverage claim for purposes of settlement generally involves the following steps:

1. Identify the policies to be included in the settlement.
2. Identify and value the claims and costs to be included in the settlement.
3. Identify and value any offsets to the proposed settlement amount.
4. Apply appropriate discounts to the elements of the coverage claim.

The first step — identifying the policies to be included — yields information about the available limits of liability, applicable deductibles or self-insured retentions, and other policy terms and conditions that the parties will need to assess the insurer's potential liability for the claims being settled, to determine which types of claims and claim costs may be covered under the policies, and to evaluate the strengths and weaknesses of each side's coverage positions in order to apply appropriate settlement discounts.

◗ **Cross Reference:** *See* § 23.05 below for further discussion of this step.

The second step — identifying and valuing the claims and costs to be included — allows the parties to calculate the insurer's potential liability for the coverage claim under the policies to be included in the settlement and also identifies the elements of the coverage claim to which settlement discounts can be applied.

◗ **Cross Reference:** *See* § 23.06 below for further discussion of this step.

The third step — identifying and valuing any offsets — identifies other economic considerations that may decrease the value of the coverage claim to the insured or decrease the cost of a settlement to the insurer.

◗ **Cross Reference:** *See* § 23.07 below for further discussion of this step.

The fourth step — applying appropriate discounts — requires the parties to adjust the value of the items identified in steps 2 and 3 to reflect an assessment of the factual and legal uncertainties surrounding the valuation of those items and the assumption that such items are covered by the policies to be settled. If there were no uncertainty about the amount of claim costs and the availability of coverage for those costs, the valuation of a coverage claim would be simple — add all covered claim costs subject to the limits of all policies included in the settlement. Real coverage disputes are inevitably more complex.

◗ **Cross Reference:** *See* § 23.08 below for further discussion of this step.

23.05 Step 1: Identify the Policies To Be Included in the Settlement.

23.05[1] Settlements May Include Any or All Known and Unknown Policies. Settlements may include a release of coverage claims under any specific insurance policy or policies or under general categories of policies,

including lost, missing or unknown policies. The release contained in the settlement may apply to claims under any of the following:

1. Only the specific policy or policies issued by the settling insurer under which the claim was presented;
2. All policies issued by the settling carrier of a specific type (*e.g.*, all liability policies or all directors' and officers' ("D&O") policies);
3. All known policies issued by the settling insurer, regardless of type;
4. All policies issued by the settling insurer, regardless of type, and whether known or unknown; and
5. Other variations or combinations of the above alternatives.

Counsel should carefully study the language of a proposed release to determine which categories of policies would be affected by a proposed settlement. Slight variations in the language of the release can significantly expand the number of insurance policies affected.

Example: A release that applies to all policies "issued to" the insured may not include policies on which the insured is listed as an additional insured, whereas a release that applies to policies "covering" the insured may include such policies.

Warning: The insurer may envision a release of all policies issued by all member companies in the insurer's corporate group, and a typical insurer group may contain dozens or even hundreds of different insurance companies. In contrast, the insured may be focused only on those policies issued by the insurer that issued the policy directly at issue. This issue should be addressed early in the settlement discussions.

23.05[2] Investigating Lost or Missing Policies. Where a settlement of claims under lost or missing policies is contemplated, the parties should attempt to collect whatever evidence of the terms of such policies may still be available. Often copies of the actual policy can be located. In other cases, secondary evidence (including broker files, underwriting files, premium records, etc.) can be used to establish the existence of the policies. In such situations, specialized "insurance archeology" firms are available to assist in locating the policies or secondary evidence of the existence and terms of the policies.

Judge's Perspective: Lost policy cases could present significant evidentiary problems. Counsel should evaluate the proof questions as a part of valuing claims based on lost policies. Obviously the more difficult the insured's proof problems are, the lower the value of the case. The insured should be ready to demonstrate a good faith fact dispute over the lost policy before filing suit. Courts will not be

sympathetic to the insured's using broad ranging discovery without already demonstrating witnesses or documents — albeit circumstantial — that can establish the basic elements of a contract.

23.06 Step 2: Identify the Claims and Costs To Be Released in the Settlement.

23.06[1] Settlements May Include Any Actual or Potential Claims. Settlements may include any claims that the parties agree to resolve, whether those claims are asserted or unasserted, known or unknown, specific or general. The parties are not limited to settling only those claims that are the subject of coverage litigation or those claims that have been asserted. For example, an insurer whose insured is a defendant in several asbestos bodily injury claims may decide to attempt settlement of any of the following categories of claims:

1. One or more of the claims currently in litigation;
2. All known asbestos bodily injury claims, whether asserted in litigation or not;
3. All known and unknown asbestos bodily injury claims;
4. All known and unknown claims involving asbestos, including asbestos-related property damage claims that may not yet have been asserted against the insured;
5. All known and unknown claims involving asbestos, environmental pollution, or any toxic substance of any kind; or
6. All known and unknown claims potentially covered by the insurer's policy (*i.e.*, a policy buy-back, discussed in § 23.10 below).

Similarly, in the first-party insurance context, a settlement could include:

1. All property damage arising from a specific accident or event;
2. All claims of any kind arising from a specific accident or event;
3. All known claims under the first-party policy; or
4. All known and unknown claims potentially covered under the first-party policy.

The categories of claims that each party wishes to settle will be reflected in the scope of the releases that each party proposes. Counsel should pay attention to the scope of the release in the other party's settlement proposals when evaluating those proposals. The scope of one party's desired release — and therefore the claims proposed to be settled — may be significantly different from the scope of the release desired by the other party. Counsel should come to an understanding early in the settlement process as to the scope of claims that each side is seeking to settle to avoid confusion and possible misvaluation of settlement offers.

23.06[2] Costs of Claims. Calculation of claim costs is of central importance in the settlement process. In many cases, both past and future costs

are at issue and must be calculated. Furthermore, as many policies cover defense costs, both legal costs and indemnity payments must be identified and quantified. In some cases, claim costs are readily ascertainable (*e.g.*, a simple auto accident); in other cases, costs are complex and often require a detailed analysis (*e.g.,* mass tort).

Depending on the breadth of coverage provided by the insurance policy or policies in dispute, the insured may have reasonable arguments for counting many types of expenses as covered claim costs beyond the obvious ones. Examples of less obvious claim costs include:

1. Pre-tender defense costs;
2. Indirect or consequential damages;
3. Fee-shifting awards in the underlying action;
4. Prejudgment and post-judgment interest;
5. Penalties, fines or sanctions; and
6. Non-monetary consideration for an underlying settlement (*e.g.*, agreeing to provide goods or services for free or at below-market cost in return for settlement of the underlying claim).

Some specific illustrations of how these non-obvious claim costs can increase the value of the insured's coverage claim are given below.

Example: In order to settle an underlying claim, the insured agrees to release a counterclaim that the insured had asserted against the claimant in the underlying action. The insured can include the value of the released counterclaim as part of the coverage claim against the insured's liability insurer [*see* Earth Elements, Inc. v. Nat'l Am. Ins. Co. of Cal., 41 Cal. App. 4th 110 (1995), *review denied* (Cal. 1996)].

Example: Judgment is entered against the insured for injunctive relief and an award of the prevailing plaintiff's reasonable attorney's fees pursuant to a fee-shifting statute. Even if the insured's liability insurance provides no coverage for injunctive relief, the insured may be entitled to coverage for the award of attorney's fees [*see* City of Kirtland v. Western World Ins. Co., 43 Ohio App. 3d 167 (1988)].

Example: The insured agrees to establish a scholarship program in order to settle an underlying sex discrimination class action. Even though the plaintiffs in the underlying class action may have had no legal right to compel the establishment of the scholarship program, the costs of implementing the program nevertheless can be part of the insured's coverage claim [*see* Jostens, Inc. v. CNA Ins., 403 N.W.2d 625, 631 (Minn. 1987)].

In the context of settlement, claim costs also can include estimates of future defense and indemnity costs for pending claims or even unasserted claims (including "incurred-but-not-reported" or "IBNR" claims).

Estimates of such costs should be included in settlement demands where a release of unknown or unasserted claims is contemplated. Future costs estimates typically are discounted to net present value based on a stated assumption about future interest rates. The calculation of net present values can involve controversial questions about the amount and timing of the insured's future liabilities and the appropriate discount rate to apply to those liabilities.

Timing: In larger coverage cases, the process of collecting historical costs, and preparing an actuarial analysis of future costs, can require many months. Lead time should be provided so that this work can be completed prior to serious settlement discussions.

23.07 Step 3: Identify Potential Offsets to the Proposed Settlement Amount. Counsel should be alert to factors that tend to offset the insured's potential recovery under its policy or that may offset the burden to the insurer of any payments due under its policy. Such offsets should be taken into account in assessing the value of the coverage claim.

Example: Some insurance policies include provisions for "retrospective premiums," which are additional premiums that are based on the amount of losses paid under the policy. Payments made by the insurer pursuant to a settlement agreement may trigger an offsetting obligation on the insured's part to pay retrospective premiums on the settlement amount, *i.e.*, the insurer may be able to "bill back" part of its settlement payments to the insured. The insured can avoid this offsetting premium obligation by obtaining a release of any claim the insurer has or may have in the future for retrospective premiums attributable to the settlement. The insured should also determine whether retrospective premiums — especially those involving older policies and long-tail claims — remain open and valid. Many retrospective premiums have sunset provisions or other conditions that result in the retrospective premiums ceasing to apply after a certain period of time or after certain conditions are met (or no longer met).

Example: In the first-party context, a potential offset is any claim the insured may have against third parties for damage to the property insured under the first-party policy. First-party insurers typically expect to be subrogated to the insured's claim if the insurer settles the first-party claim, and the insurer may regard the expected value of the subrogated claim as an offset against any amounts that the insurer may pay to the insured. That is, a first-party insurer may be more willing to pay a large settlement amount if it believes that it can obtain an equally large offsetting recovery from any third parties responsible for the property damage.

Example: In some circumstances where more than one insurance policy may provide coverage for the same loss, the insurer that settles a claim for coverage of the entire loss may have an offsetting claim against the other insurer for equitable contribution or indemnification. However, such

claims are often waived as part of the settlement.

23.08 Step 4: Apply Appropriate Discounts to the Coverage Claim. To calculate the settlement value of a coverage claim, counsel should, where appropriate, discount the claim costs and offsets identified above to reflect uncertainties about the true value of such costs and offsets and the strength of the insured's coverage claim (or, equivalently, the strength of the insurer's coverage defenses). Such discounts are not needed or appropriate in all cases. However, where discounting is called for, there are three basic approaches to discounting the value of the coverage claim.

The first approach is to calculate the maximum value of the coverage claim if all uncertainties are resolved in favor of the insured and then apply a single percentage discount to this maximum value. The percentage discount reflects counsel's overall judgment as to the settlement value of the coverage claim taking into account all legal and factual uncertainties and all potential coverage defenses and offsets. This approach may be too crude for purposes of an internal assessment of the settlement value of a coverage claim, but it can be useful during settlement negotiations to justify the amount of a settlement offer without revealing the offeror's opinions about the strength of particular coverage issues.

> ⊠ **Strategic Point:** Where the parties are attempting to "split the difference" or share in the difference by converging on a settlement amount somewhere between the opening offer and the initial counteroffer, using a single overall settlement discount allows the parties to successively raise their offers or lower their demands without having to attribute each move to some specific change in their assessment of the facts or coverage issues in dispute.

The second approach is to identify and value the possible outcomes that could occur and apply a discount to the valuation of each outcome that reflects counsel's subjective assessment of the probability that the outcome would occur.

> **Example:** The insured claims coverage for $ 500,000 in both pre-tender and post-tender defense costs, and the insurer denies coverage on two grounds: (1) there is no coverage for pre-tender defense costs because the insured did not obtain the insurer's consent to incur such costs; and (2) there is no coverage for any defense costs because the allegations in the underlying litigation never triggered the insurer's duty to defend. There are only three possible outcomes, each of which must be discounted by counsel's assessment of the probability of the outcome occurring to determine the discounted value of the coverage claim (*i.e.*, the value of the outcome multiplied by the probability that the outcome will occur):

Insured Recovers:	Value:	Probability:	Discounted Value:
Nothing	$ 0	0.1	$ 0

Insured Recovers:	**Value:**	**Probability:**	**Discounted Value:**
Post-tender costs only	$ 400,000	0.2	$ 80,000
All defense costs	$ 500,000	0.7	$ 350,000
ALL OUTCOMES:		1.0	$ 430,000

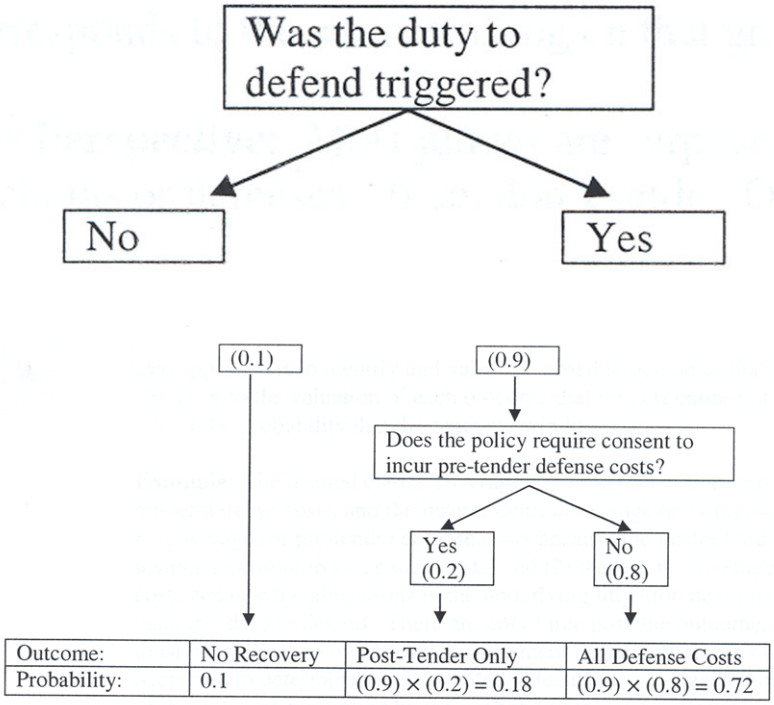
Given the assumptions shown on the table above, the discounted value of the coverage claim is $ 430,000. A settlement above this amount would be favorable to the insured, whereas a settlement below this amount would be favorable to the insurer.

The third approach is to use a decision-tree analysis, in which discounts are applied to individual coverage issues in order to calculate the probability of the various possible outcomes of the coverage claim.

Example: Assume the same coverage claim and coverage defenses as in the previous example. Instead of assessing the probability of the possible outcomes of the coverage claim, assess the probability of the possible outcomes on each coverage defense:

Coverage Defense:	**Probability of Insurer Prevailing:**
No consent to pre-tender costs	0.2
No duty to defend	0.1

The probability of the possible outcomes of the coverage claim (*i.e.*, insured recovers nothing, post-tender defense costs only, or all defense costs) can then be calculated by constructing a decision tree as follows:



Decision-tree analysis can serve as a useful check on counsel's subjective impression of the probability of possible outcomes of a coverage claim. Counsel may discover their assessment of the probability of victory on individual coverage issues is mathematically inconsistent with their subjective impressions of the overall probability of success. Counsel then must consider whether counsel's subjective impressions are ignoring complex relationships and dependencies among the various coverage issues in the case, or whether the decision-tree analysis is failing to include all the factors that affect the probability of the various outcomes.

Warning: The decision-tree analysis illustrated above implicitly assumes that the court's ruling on each coverage defense is an independent event, *i.e.*, a ruling in favor of the insurer on one defense does not affect the probability of a ruling in favor of the insurer on another defense. In practice, this is often not the case. For example, common sense suggests that an insurer that asserts one substantial coverage defense (*e.g.*, one with a 50 % chance of success) is not more likely to win than an insurer that asserts the same substantial coverage defense plus 20 frivolous defenses; to the contrary, the assertion of so many frivolous defenses is likely to color the court's perception of the merits of the one substantial defense. But if a decision-tree analysis treats the court's ruling on each frivolous defense as an independent event with a 5 % probability that the insurer will win each defense, the analysis would show that the second insurer in this example

has an 82% probability of winning on at least one of its 21 coverage defenses (*i.e.*, $0.82 = 1 - (0.5)\times(0.95)^{20}$). Accordingly, when using decision-tree analysis, counsel must group together all issues that are likely to be resolved as a unit and analyze them as a single event with a single overall probability. For example, if in counsel's opinion the court will weigh a group of coverage defenses together, there should be only one branch in the decision tree and one overall probability that corresponds to the court's ruling on that group of defenses.

Judge's Perspective: Most judges are surprised if a party has more than three strong claims or defenses. If so, don't settle. Otherwise, as is the case in most disputes, pare down your list of defenses to the strongest, and heavily discount the rest.

The basic methods of discounting can be used in combination. For example, counsel may use a simplified decision-tree analysis that includes only the major coverage issues in dispute in a complex coverage claim. A subjective overall discount then could be applied to the result of the simplified decision-tree analysis to give collective weight to minor coverage issues and other factors not easily quantified.

III. STRUCTURING THE SETTLEMENT OFFER.

23.09 Settlement and Release of Specific Coverage Claims. This form of settlement releases only those claims or groups of claims specifically identified in the settlement demand or pending coverage litigation. A key aspect of the settlement agreement will be a careful definition of the released claim(s).

◗ **Cross Reference:** The identification of the claims subject to release is discussed in § 23.06[1] above.

Form: A sample settlement and release of a single claim is provided in § 23.32 below.

23.10 Policy Buy-Back. This form of settlement releases all claims — known and unknown — under the specific policies subject to the buyout.

Consider: Even if there is agreement on a policy buy-back, the parties still need to discuss and agree on which policies will be included in the buyout deal [*see* § 23.05[1] above].

⊠ **Strategic Point:** Whether a policy buyback makes sense depends in large part on how much value: (a) the insured places on retaining coverage for unknown or IBNR claims that may arise under the policies to be bought out, and (b) the insurer places on completely "clearing its books" and removing all contingent liability for the subject policies.

Forms: The key terms of a policy buy-back agreement are illustrated in § 23.33 below. Other terms generally applicable to all settlement agreements are illustrated in the sample settlement and release of a specific claim in § 23.32 below.

23.11 Coverage-in-Place Agreements. A coverage-in-place agreement ("CIP") provides a framework for paying claims on a going forward basis. Usually such an agreement will contain additional provisions addressing:

1. Payment for past costs, usually in the form of a lump sum or series of fixed payments over time;
2. The types of future costs that can be submitted for payment or reimbursement by the settling insurer under the CIP;
3. Which policies are covered by the CIP;
4. How to allocate costs to the relevant coverage block;
5. A protocol for submitting claims under the CIP (including frequency of claim submission, names and addresses of contacts, information contained in each claim submission, *etc.*); and
6. Confidentiality and termination of the CIP.

Although not mandatory, a CIP generally replaces the policies. Thus, any future coverage disputes are handled under the dispute resolution provisions

of the CIP rather than a lawsuit brought under the policies.

⊠ **Strategic Point:** CIP agreements are especially useful in cases involving coverage for future costs where there is a wide difference between the parties' respective views of the ultimate amount of such costs. In such cases, the parties may not be able to agree on a lump-sum settlement payment but may be able to agree on a formula for paying future costs as they become due.

⊠ **Strategic Point:** One disadvantage of CIP agreements is that they are often more complex and difficult to negotiate and draft than other types of settlement agreements and more difficult and costly to administer, *e.g.*, because the insured must prepare, and the insurer must review and pay, periodic bills submitted under the terms of the CIP, often for long periods of time.

Forms: The key terms of a coverage-in-place agreement are illustrated in § 23.34 below. Other terms generally applicable to all settlement agreements are illustrated in the sample settlement and release of a specific claim in § 23.32 below.

23.12 Interim Defense Agreements. This form is similar to a CIP except that: (a) it generally pertains only to defense and not indemnity, and (b) it generally does not replace the policies, and upon termination either party is free to sue under the policies in order to resolve questions of defense and indemnity coverage.

⊠ **Strategic Point:** Interim defense agreements are often easier to negotiate than other forms of settlement agreements because the interim defense agreement relates only to the defense obligation and it usually includes a reservation of rights on all coverage issues. One advantage of negotiating an interim defense agreement is that it may facilitate the development of a good working relationship between the parties that can be helpful in the event the parties later need to resolve issues regarding indemnity coverage.

Form: A sample interim defense agreement is provided in § 23.35 below.

23.13 Other Settlement Structures. A contingent settlement agreement is sometimes used to settle a claim for coverage of an underlying claim that is not yet fully resolved and that may be subject to a material future contingency that may undo the settlement in whole or in part. For example, the parties may agree that the insurer will pay $ 1 million to resolve its coverage obligations to the insured for the underlying claim, but the insured retains the right, in its discretion, to revoke the settlement — and to return the settlement proceeds and rescind the release — if the contingency comes to pass (*e.g.*, if the underlying claim is ultimately resolved for more than "x").

IV. NEGOTIATING THE SETTLEMENT.

23.14 Understanding the Relationship Between Settlement Negotiations and Coverage Litigation.

23.14[1] Deciding Whether to Litigate or Negotiate. A party's first move in attempting to resolve a coverage dispute can be either to propose settlement negotiations or to initiate coverage litigation. Which strategy offers the better chances for success depends on the circumstances. Insurance policies sometimes include dispute resolution clauses that require the parties to attempt settlement or to participate in mediation before initiating coverage litigation. In such cases the parties would have no choice to make. Otherwise, each party must weigh the advantages and risks of pursuing negotiation or litigation as its opening move.

Attempting to settle the dispute before litigating has several potential advantages, including the following:

1. Avoidance of the expense and burden of coverage litigation;
2. Control over the information that will be provided to the other side and the ability to withhold sensitive information that otherwise would be discoverable in coverage litigation;
3. A greater likelihood of maintaining the confidentiality of any information that is exchanged in settlement discussions;
4. Avoidance of rulings on issues that could prejudice the insured's defense in the underlying liability case; and
5. A greater likelihood of preserving an amicable business relationship between the insured and the insurer.

However, both sides must perceive negotiation to be preferable to litigation in order for negotiation to occur. A party that proposes negotiation at the outset runs the risk that the other party will try to gain an advantage by filing coverage litigation instead. Winning the race to the courthouse may — in some cases — allow a party to determine the forum in which coverage litigation will occur, which can confer substantial advantages. Caveat: the party that "files first" does not necessarily win the forum fight.

Example: Subject to several caveats, where the resolution of one or more coverage issues is likely to be determined by which state's laws apply to the coverage dispute, the party who files a coverage lawsuit first may be able obtain the advantage of having favorable legal rules apply to the coverage issues in dispute. The choice of forum determines the choice-of-law rules applicable to the coverage dispute. Although the forum's substantive law will not necessarily apply, the forum's choice-of-law rules usually will apply, which may in some cases influence which state's substantive law is chosen to govern the

dispute. The first caveat is noted above, *i.e.*, that the first filer does not necessarily win the forum fight. The second caveat is that just because a party may wish to file suit, it may not the have the legal basis to do so (in other words, certain requirements must be met before a party can properly initiate a coverage action).

Example: Even where the substantive rules of law in different fora are the same, the remedies available to the insured may vary among the available fora. For example, an insured may prefer to litigate in a forum that allows a prevailing insured to recover its legal fees for the coverage litigation from the insurer, whereas the insurer may prefer a forum where such fee-shifting is not permitted. Other variations in procedural or remedial law, such as the right to trial by jury in declaratory judgment actions or the availability of punitive damages for bad faith, may provide reasons for preferring one forum over another.

⊠ **Strategic Point:** Subject to the caveats noted above, obtaining the advantage of a favorable forum can be part of a party's overall strategy. Once the favorable forum is secured, the party may be able to stay the coverage litigation or dismiss the litigation without prejudice with an agreement that any future coverage litigation by either side must be filed in the same forum. Settlement negotiations then can proceed without the distraction of active litigation.

Even where the choice of forum is not a factor, either party may have an incentive to initiate litigation before attempting negotiation. For example, an insurer may be required by applicable law to initiate declaratory judgment litigation in order to avoid liability for bad faith refusal to defend the insured against underlying litigation.

Insureds who choose to negotiate before litigating should consider (a) whether any applicable statute of limitations or contractual time limit for filing suit has begun to run, and (b) the possibility that the statute of limitations or contractual time limit for filing suit may expire before settlement negotiations can be completed. Some courts have held that the statute of limitations is equitably tolled while the insurer is considering whether to pay a claim [*see* Prudential-LMI Commercial Ins. v. Superior Court, 51 Cal. 3d 674 (1990)] or when the insurer lulls the insured into believing that the coverage dispute will be resolved amicably without litigation [*see* Devillers v. Auto Club Ins. Ass'n, 473 Mich. 562 (2005)]. Some courts hold that the statute of limitations for a coverage claim is tolled or does not even begin to run until the underlying matter has been resolved [*see* Ward v. Commonwealth Land Title Ins. Co., 53 Cal. 3d 1072 (1991)]. Nevertheless, to avoid any doubt regarding whether the statute of limitations is running, an insured may seek to enter into a tolling agreement with its insurers.

Consider: The effectiveness of a tolling agreement may depend on state law and the terms of the insurance policy. For example, state law may not permit parties to enter into a tolling agreement that extends the limitations period for an indefinite period. State law also may permit an insurer to include a provision in the insurance policy that creates a contractual deadline by which coverage litigation must be filed, even though the contractual period is shorter than the applicable statute of limitation.

Judge's Perspective: Be sure to understand how courts in the likely forum approach these agreements. Courts will generally hold the parties to their bargains, so do not expect after-the-fact equitable arguments to carry much weight. As a general matter, courts will be sympathetic to side agreements that allow for negotiations or alternative dispute resolution. If state law becomes a problem, the parties can agree to file a case and then seek a stay of proceedings from the court to allow for settlement negotiations.

23.14[2] The Relationship Between Litigation and Settlement. Once coverage litigation begins, events in the litigation may affect — in some cases dramatically — the status of settlement negotiations. Litigation can push the parties closer to or further away from settlement. As a general rule, two types of events are especially likely to generate interest among the parties in negotiating a settlement:

1. Events that threaten to increase the expense or burden of continued coverage litigation; and
2. Events that threaten to resolve uncertainty about the value of the coverage claim.

Examples of the first type of event include discovery requests that seek sensitive information or impose substantial compliance burdens. Motions for summary judgment on key coverage issues are an example of the second type of event. Such motions highlight the risks to both sides of an adverse ruling on the key issues and the risk that, once the issues are decided, the prevailing party will have little incentive to settle on terms attractive to the losing party.

Strategic Point—Insured: The prospect of a trial in the coverage action combines all of these incentives. Preparing for and conducting a trial often involves significant expense and promises to remove all uncertainty about the value of the claim. For these reasons, in most cases, it is in the interest of an insured — the party in the litigation that is generally the one seeking to be paid — to obtain a firm trial date and to resist extensions of the trial date.

Coverage litigation can also push the parties further apart. Each side may be reluctant to make a settlement proposal for fear that the other side will interpret the proposal as a sign of weakness. Litigation also can engender

animosity and distrust, especially if one of the parties is perceived by the other as having rushed into litigation without making adequate efforts to settle the coverage claim amicably.

23.15 Protecting the Confidentiality of Settlement Negotiations. Before participating in settlement negotiations, the parties should take steps to protect the confidentiality of the negotiations. If a negotiation is unsuccessful, neither side will want its statements in the negotiation to be used against it in coverage litigation. Insureds also may need to protect any information they provide to their insurers during settlement negotiations from discovery by the plaintiffs suing the insured in underlying litigation.

The most basic precaution is to invoke Federal Rule of Evidence 408 and/or equivalent rules under state law in all settlement-related communications and to secure an agreement that all settlement negotiations will be subject to the protection of the rule. However, Rule 408 does not create an absolute prohibition against discovery or use of statements made during settlement negotiations. Rule 408 provides that evidence of conduct or statements made in compromise negotiations regarding a claim is not admissible "when offered to prove liability for, invalidity of, or amount of a claim that was disputed as to validity or amount, or to impeach through a prior inconsistent statement or contradiction." Rule 408 does not prevent settlement communications from being used as evidence for other purposes.

Example: Courts have held that an insured's settlement demands are admissible to establish that the insured's coverage claim satisfies the minimum amount-in-controversy requirement for federal diversity jurisdiction, thus permitting an insurer-defendant to remove a coverage lawsuit to federal court despite the insured-plaintiff's allegation in the complaint that the amount in controversy was less than the jurisdictional minimum [*see* Cohn, D.V.M. v. Petsmart, Inc., 281 F.3d 837, 840 (9th Cir. 2002) (collecting cases)].

Example: Evidence that an insurer denied coverage during settlement negotiations may be admissible for the purpose of supporting a claim for bad faith based on the insurer's unreasonable denial of coverage [*see* ABM Indus., Inc. v. Zurich Am. Ins. Co., 237 F.R.D. 225 (N.D. Cal. 2006)].

To obtain additional protection, the parties can enter into a confidentiality agreement that prohibits either party from disclosing information or documentation provided by the other party in the context of settlement negotiations.

Form: *See* § 23.31 below for an example of a confidentiality agreement.

Even after invoking Rule 408 and entering into a confidentiality agreement, the parties should weigh the advantages of such disclosure in terms of promoting settlement against the risk that a court might deem such disclosure to be a waiver of privilege despite the fact that the parties agreed to keep the information confidential.

23.16 Settling Insurance Coverage Disputes

Warning: It can be difficult to predict whether disclosure of privileged information to an insurer pursuant to a confidentiality agreement will later be deemed to be a waiver of privilege. In the context of disclosures to government investigators, courts have reached different conclusions regarding the effectiveness of confidentiality agreements to preserve the privileged status of the disclosed information [*compare In re* Sunrise Sec. Litig., 130 F.R.D. 560, 565–66 (E.D. Pa. 1989) (waiver) *with In re* Natural Gas Commodity Litig., 2005 U.S. Dist. LEXIS 11950 (S.D.N.Y. 2005) (no waiver); *see generally In re* Columbia/HCA Healthcare Corp. Billing Practices Litig., 293 F.3d 289, 295 (6th Cir. 2002) (case law on waiver is "in a state of hopeless confusion")]. In the context of disclosures of the insured's work product to insurers, the case law is likewise split [*compare In re* Imperial Corp. of Am., 167 F.R.D. 447, 454–55 (S.D. Cal. 1995) (finding waiver of privilege) *with In re* Pfizer Inc. Sec. Litig., 1993 U.S. Dist. LEXIS 18215 (S.D.N.Y. 1993) (no waiver of work product privilege, but attorney-client privilege waived)]. The analysis is further complicated when the parties cannot predict the court in which these issues ultimately will be raised and decided.

Insured's Perspective: Preventing waiver of privilege is especially important for insureds when underlying litigation is threatened or pending against the insured.

23.16 Making the Opening Offer. A number of important issues must be considered in making the opening offer, including the following:

What should the opening offer contain? In some negotiations, the opening offer may include little more than a price term and a general description of the scope of the release. Another option is to provide a term sheet that sets forth the key terms of the proposed agreement in summary fashion, including the payment amount, scope of release, and any indemnification clause. In other negotiations, the offeror may provide a complete draft settlement agreement setting forth all of the terms that the offeror desires. Sometimes, where the non-monetary terms are a potential deal-breaker, the offeror may present a draft settlement agreement in which the amount of the settlement payment is left blank. In such cases, the opening offer would state that a preliminary agreement to the non-monetary terms is a condition precedent to any negotiations about the payment amount.

Strategic Point: Presenting a detailed, fully drafted settlement agreement in the opening offer can lead to delays in making and responding to the offer and can result in unproductive negotiation of ancillary points before any consensus on the major issues has been reached. On the other hand, presenting a fully drafted proposed settlement agreement at the outset of negotiations can avoid misunderstandings about the scope of the release being sought, the policies affected by the settlement, or the scope and terms of the desired indemnification clause, all of which can have a

significant effect on the valuation of the offer.

⊠ **Strategic Point—Insured:** The insured is often well served in settlement negotiations by providing detailed information and analysis to support its opening offer. Doing so can establish credibility with the insurer and may highlight the strength of the insured's coverage claim, the robust analysis backing up the claim, and the insured's commitment to pursue it.

How much of a discount or premium to the offeror's best-case outcome should the opening offer reflect? The offeror should not paint itself into a corner by making an opening offer that reflects an unrealistically large discount to the offeror's best-case outcome. Unless there is a significant change in the facts or the law after the opening offer is made, attempting to take back the discount or premium reflected in the opening offer may be considered to be a significant breach of settlement etiquette that can result in a termination of the negotiation. On the other hand, it is generally necessary to offer some discount or premium in order to signal a willingness to deal.

When should the opening offer be made? Should the offer be made before or after filing a complaint? Should the insured wait until all claims have matured before making the offer? There are no "right" answers to these timing questions — the circumstances of each coverage dispute will dictate the proper approach. Experience is often the best guide. Settlement negotiations are usually difficult in the period immediately following the filing of a complaint (unless that complaint is accompanied by an offer to extend the answer date long enough for meaningful settlement discussions), because the parties are often more focused on litigation matters than settlement negotiations. But events occurring later in the coverage litigation — such as the service of discovery requests or a motion for summary judgment on a key coverage issue — can create opportunities for settlement. With regard to claim maturity, the value of catastrophic or "one time" losses are often crystallized by the time that the settlement demand is made. However, for long-tail claims such as environmental pollution claims and toxic tort claims, most insureds make settlement demands based on both past costs and estimates of future or IBNR claims.

◗ **Cross References:** *See* § 23.14 above for discussion of the factors that affect the decision to resort to litigation versus negotiation and the events in coverage litigation that are likely to create opportunities for settlement. *See* § 23.18 below for discussion of legal remedies that can be invoked in coverage litigation to encourage prompt settlement of claims.

Should the offer be made in person, over the phone, or by mail? Cost/benefit issues are crucial here. For large matters, it is often preferable to make an opening offer in person. For small matters, a phone call or letter may be the most sensible approach for making the opening offer.

Who should participate in the initial settlement meeting or telephone conference? First and foremost, both parties will, in most cases, want to have a

principal present at the meeting. The principal is the voice of the insurer or insured, and will often have the most knowledge about the case. When it comes time to negotiate (which may not take place until a second or third meeting), the principal (or his or her designee) should come to the meeting with settlement authority. Second, often times counsel should also be present, especially where counsel was materially involved in preparing the settlement demand. In larger cases, it is common to have settlement counsel and litigation counsel, with only the former attending the settlement meetings. Third, where an outside consultant has played a material role in preparing the settlement demand, that person may also need to be present to explain the assumptions used in the settlement demand.

23.17 Making the Counteroffer. Making a counteroffer raises many of the same practical issues as making the opening offer but also raises some new issues as well. In addition to setting forth a party's own proposal, the counteroffer also should respond to all the terms of the opening offer so that the areas of disagreement are clear. Otherwise the counteroffer's silence on a given point is likely to be construed as acquiescence. The counteroffer may also be accompanied by a "message" that indicates to the other side what the grounds for a potential compromise may be, both in terms of the payment terms and any important non-monetary terms.

⊠ **Strategic Point:** Astute negotiators will listen not only to the numbers in a counteroffer but also to any statements that indicate the likelihood of further concessions if the counteroffer is not accepted. A counteroffer that matches the move made in the opening offer, without any statements suggesting that the party making the counteroffer has limited room for making further concessions, is often interpreted, correctly or not, as a sign that the party may be willing to "split the difference" between the opening offer and the counteroffer.

23.18 Other Factors That May Impact Settlement.

23.18[1] Legal Remedies that May Affect Settlement Negotiations.

23.18[1][a] Fee Shifting Based on Prevailing Party Status. Depending on the applicable law, an insured may be entitled to recover its reasonable attorney's fees for the coverage litigation from the other party based on the insured's status as a prevailing party in coverage litigation [*see, e.g.*, Fla. Stat. § 627.428; N.J. Rule 4:42-9(a)(6); Tex. Civ. Prac. & Rem. Code § 38.001].

Whether the possibility of a fee-shifting award is likely to create incentives for settlement depends in the first instance on the size of the coverage claim at issue. The possibility of a fee award rarely affects the likelihood of settlement in a large matter, where the size of the potential fee award is small in comparison to the other costs at issue. Fee shifting may have more significance in smaller matters, where the potential fee award may be large in comparison to the other amounts

in dispute and the possibility of fee shifting may make it more likely that the coverage claim will be pursued in coverage litigation if negotiation is unsuccessful.

The rules for fee awards to prevailing parties may create other settlement incentives as well.

> **Example:** The Florida Supreme Court has held that an insured "prevails" in coverage litigation for purposes of a fee award under Fla. Stat. § 627.428 only when the insured obtains a judgment greater than any offer of settlement previously tendered by the insurer [*see* Danis Indus. Corp. v. Ground Improvement Techniques, Inc., 645 So. 2d 420 (Fla. 1994)]. By making a settlement offer at least equal to the amount of the insured's damages plus any attorney's fees, taxable costs, and prejudgment interest incurred before the insurer's offer, an insurer can eliminate the insured's entitlement to attorney's fees incurred after the insurer's offer [*see* Scottsdale Ins. Co. v. DeSalvo, 748 So. 2d 941 (Fla. 1999)].

23.18[1][b] Fee Shifting Based on an Offer of Judgment. Fee shifting also may be available against a party that refuses an offer of judgment. Many states have statutes or court rules that allow one party in a litigation to make an offer to another party to allow judgment to be entered against the offeror on terms proposed in the offer. Depending on the state, if the offer is refused or not accepted within a time specified in the applicable statute, the offeree may be liable for the offeror's attorney's fees if the offeree fails to obtain a more favorable judgment than what was offered [*see, e.g.*, Fla. Stat. § 768.79; N.J. Rule 4:58; Mich. R. 2.405]. In other states (and under the Federal Rules of Civil Procedure), an award of attorney's fees is available only if such fees are recoverable as part of the "costs" of the litigation, and attorney's fees incurred in coverage litigation usually will not qualify as "costs" for this purpose [*see, e.g.*, Cal. Civ. Proc. Code § 998; Fed. R. Civ. P. 68]. The particular remedies available and the requirements for making an offer of judgment vary from jurisdiction to jurisdiction, so counsel should consult the applicable statute or rule before making an offer.

Offers of judgment may be made either by insureds or by insurers to create an incentive for the other side to accept a reasonable settlement offer.

> **Strategic Point:** One circumstance in which making an offer of judgment can be particularly advantageous is where the rules of the particular jurisdiction do not permit the party to recover its attorney's fees based on prevailing party status but do permit recovery of attorney's fees when an offer of judgment is refused.

> **Warning:** An offer of judgment must be specific enough to allow

a court to determine whether an offeree that refuses the offer achieved a result better than what was offered. For example, an insurer's offer to settle any and all claims "in, or arising out of, the above-styled action" was held to be too ambiguous to support an award of attorney's fees under the Florida offer-of-judgment statute, where it was unclear whether an unasserted coverage claim factually related to the issues in the coverage litigation would have been released by the proposed settlement [*see* State Farm Mut. Auto. Ins. Co. v. Nichols, 932 So. 2d 1067, 1078–80 (Fla. 2006)].

23.18[1][c] Penalties Based on Bad Faith. The potential for a bad faith claim can create additional incentives for a party to settle or to settle promptly. The grounds for bad faith liability most likely to be implicated by an insurer's refusal to settle a coverage claim include the following:

1. Unreasonable denial of coverage [*see, e.g.*, Fireman's Fund Ins. Cos. v. Alaskan Pride P'ship, 106 F.3d 1465 (9th Cir. 1997)].
2. Unreasonable delay in paying a coverage claim, even if the claim ultimately is paid in full without litigation [*see e.g.*, Pickett v. Lloyd's, 131 N.J. 457 (1993); Filasky v. Preferred Risk Mut. Ins. Co., 152 Ariz. 591 (1987)].
3. Refusal to pay the undisputed portion of a coverage claim, even if another portion of the claim is reasonably in dispute [*see, e.g.*, Real Asset Mgmt., Inc. v. Lloyd's, 61 F.3d 1223, 1232 n.13 (5th Cir. 1995); Millers Mut. Ins. Ass'n of Ill. v. House, 286 Ill. App. 3d 378, 387 (1997); Kehoe v. Lightning Rod Mut. Ins. Co., 115 Ohio App. 3d 234, 238–39 (1996)].

Many states have enacted an unfair claims settlement practices statute that requires insurers to investigate and pay claims promptly and fairly [*see, e.g.*, N.J. Stat. Ann. § 17B:30-13.1; N.Y. Ins. Code § 2601; Tex. Ins. Code § 542.001 *et seq.*]. The statute typically enumerates various prohibited practices and may also enumerate deadlines within which the insurer must take various actions such as accepting or denying coverage. Where applicable law gives the insured a private right of action to enforce the statute, the viable possibility of statutory liability may be present in some cases, and its presence may encourage insurers to participate in settlement negotiations and make prompt decisions regarding settlement offers.

Judge's Perspective: Insurers also must be sure their investigation of the claim was adequate. The failure reasonably to investigate may support a bad faith claim [*see* Sims v. Great Am. Life Ins. Co., 469 F.3d 870 (10th Cir. 2006)].

23.18[1][d] Interest and Penalties Based on Late Payment. Late payment

of a claim may subject the insurer to liability for various forms of interest or other late-payment penalties. The insurer's exposure to such an award creates an incentive to settle coverage claims promptly in order to avoid further accrual of interest. The insured's counsel therefore should consider including calculations of all potentially applicable forms of interest and late-payment penalties in its settlement demands in order to ensure that the insurer is aware of the costs of delay.

Prejudgment interest is the most obvious form of interest that may be available for late payments. Some jurisdictions require that the amount of the coverage claim must be "liquidated" or "certain" before prejudgment interest can accrue [*see, e.g.*, Lyon Metal Prods., L.L.C. v. Protection Mut. Ins. Co., 321 Ill. App. 3d 330, 348–49 (2001)]. Other jurisdictions allow prejudgment interest to accrue regardless of whether the amount of the insurer's liability was liquidated. [*see, e.g.*, Danzeisen v. Selective Ins. Co. of Am., 298 N.J. Super. 383, 388–89 (App. Div. 1997)].

In some jurisdictions, the insured may be entitled to an award specifically intended to penalize the insurer for failing to pay claims promptly. For example, the Texas Insurance Code requires insurers to pay simple interest at an annual rate of 18 percent if an insurer delays payment of a "first party claim" for more than 60 days following the insurer's receipt of all items, statements and forms reasonably requested and required to evaluate the claim [*see* Tex. Ins. Code § 542.051 *et seq*.]. There is a split of authority regarding whether a "first party claim" includes claims for a defense under a liability insurance policy [*compare* Housing Auth. of Dallas v. Northland Ins. Co., 333 F. Supp. 2d 595, 603 (N.D. Tex. 2004) (claims for defense are included) *with* TIG Ins. Co. v. Dallas Basketball Ltd., 129 S.W.3d 232, 242 (Tex. App. 2004) (claims for defense are not included)]. The Texas Supreme Court has not yet resolved the issue but may do so in the near future [*see* Lamar Homes, Inc. v. Mid Continent Cas. Co., 428 F.3d 193 (5th Cir. 2005) (certifying question to the Texas Supreme Court)].

State law may provide other penalties for late payment of particular types of insurance claims [*see, e.g.*, Mich. Comp. Laws § 500.3142 (12 percent penalty interest for late payment of personal protection insurance benefits); Minn. Stat. Ann. § 176.221(3) (penalty awards for late payment of workers compensation claims)]. Counsel should review the applicable state insurance code to determine what penalties are available for late payment of claims under particular lines of coverage.

23.18[2] Considering the Business Relationship Between Insured and Insurer. Counsel representing insureds or insurers in a coverage dispute should be aware of any current business relationship between the parties and the importance of that relationship to each side. One or both of the parties

may have a strong interest in preserving that relationship and therefore may be reluctant to take positions in settlement negotiations that could jeopardize the relationship.

Warning: The existence of a current business relationship between the parties is easy for counsel to overlook when the dispute in question concerns coverage under older insurance policies rather than the insured's current policies or when the insurer has issued more than one line of coverage (*i.e.*, general liability insurance versus first-party property insurance) to the insured. Counsel should ask their clients for information about *any* current business relationship between the parties to a settlement negotiation under *all* lines of coverage.

A party's interest in preserving an amicable business relationship during settlement negotiations is likely to be especially strong when the following circumstances exist:

1. The benefits that the party might lose if the relationship were to sour are substantial in comparison to the value of the issues in dispute in the settlement negotiations; and
2. The other party has feasible alternatives to the current relationship.

Example: The premium that the insured's current insurer would receive if the insured renewed coverage with the current insurer is 10 times the amount of the insured's settlement demand under the current policy. If the insured chose not to renew its coverage with its current insurer, the insured could obtain equivalent insurance coverage from another carrier at a similar premium. In this case, the insurer may, in some cases, be reluctant to take the most aggressive possible position on the meaning of policy language during settlement negotiations out of concern that the insured's risk manager might conclude that the insurer would take a similarly aggressive position on any future claims that might arise under a renewal policy. Even in the hypothetical example noted above, the impact on settlement is uncertain; in some cases there may be a firm separation between the insurer's underwriting and claims handling functions.

Example: Because of a "hard" insurance market for directors' and officers' liability coverage as well as the insured's claims history, an insured could not obtain a replacement directors' and officers' policy if its current insurer decided not to renew the current policy. The value of the coverage claim in dispute under the current policy is 50 times the renewal premium. In this case, concerns about preserving the business relationship between the parties are not likely to influence the insurer's settlement conduct.

23.18[3] Offering "Early Settlement" Incentives. Achieving a prompt settle-

ment may be especially important to one or both of the parties for a variety of reasons. For example, in a complex environmental or toxic tort coverage litigation in which there are multiple insurer defendants, an early settlement may benefit the insurer by allowing it to avoid legal costs, or it may benefit the insured by building settlement momentum. Other motives for early settlement are to avoid a ruling on a key coverage issue or to avoid the substantial commitment of time, resources and key personnel.

One party can create incentives for early settlement by offering the other side a discount or premium if the other side settles within a specified time frame.

23.19 Using Mediation to Facilitate Settlement. "Mediation" generally refers to any non-binding dispute resolution process in which the parties present their case to a neutral third party known as the mediator. Mediation is most likely to prove useful in cases where there are significant differences in each party's perception of the strengths and weaknesses of the coverage issues in dispute. In a multi-party dispute, mediation can also be useful where most of the parties are in agreement but one or a small number of parties are recalcitrant and need to be "brought into the tent." For some entities, hearing the opposing side's case presented by a neutral "authority figure" can be more persuasive than even the best arguments presented by a partisan. An effective mediator can help to close the gap between the parties' perceptions of the case by providing a neutral evaluation of the parties' respective positions and of the advantages of settlement over coverage litigation.

Mediation can be voluntary or mandatory, depending on the circumstances. Before resorting to coverage litigation, the parties may agree to participate in private mediation according to rules agreed upon by the parties themselves before a mediator selected by the parties. Dispute resolution clauses in the insurance policy sometimes require parties to participate in mediation before resorting to coverage litigation. After coverage litigation begins, the parties may be required to participate in mediation pursuant to court rules or order of court. The court may also make available to interested parties opportunities for mediation supervised or sponsored by the court, and the option of private mediation remains available as well.

Where the parties have control over the selection of the mediator and the rules by which mediation will occur, the parties need to decide who will serve as mediator and what role the mediator will play. At a minimum, a mediator should be someone whom both parties accept as an unbiased intermediary who has the knowledge and experience necessary to understand and evaluate the coverage issues in dispute. The mediator's role can be evaluative — limited to receiving briefs and hearing arguments from the parties before expressing his or her opinion as to which party has the better argument on the issues in dispute — or facilitative — brokering a settlement through some form of "shuttle diplomacy," in which the mediator meets privately with each

side to discuss the weaknesses of each side's position and attempt to move the parties toward a compromise.

Consider: Some mediators may have a reputation for "splitting the baby" in terms of their opinions about coverage issues and/or their efforts to broker a settlement, whereas other mediators may have a reputation as "straight shooters" who will favor whichever side they perceive to be in the right. Which type of mediator is preferable in any given case depends on the circumstances and each side's perception of the strength of its case (*e.g.,* a party with a strong case may prefer the latter type of mediator).

Judge's Perspective: Former judges can make good mediators. Try to locate mediators from the likely forum to help better evaluate the legal and factual issues and the "intangibles" inherent in the claim.

V. DOCUMENTING THE SETTLEMENT.

23.20 Preparing a Term Sheet Before the Formal Agreement. Term sheets can serve several purposes. Before the parties have reached agreement on the key terms of a settlement, a proposed term sheet is a useful device for presenting the terms of settlement offers and counteroffers. A proposed term sheet mitigates the risk that the terms of the offer will be misunderstood or misremembered while avoiding the burden of preparing a complete draft settlement agreement before agreement on the major deal points has been reached. After the parties have reached agreement on the key terms of a settlement, but before a formal settlement agreement has been executed, the parties may execute a term sheet in order to memorialize the key terms of the settlements and guide the drafting of the formal settlement agreement.

> ⛌ **Strategic Point:** It is generally preferable to propose term sheets during settlement negotiations rather than waiting until the end of negotiations to begin documenting the major terms of the settlement; otherwise, the parties may discover when they turn to drafting a formal settlement agreement that they have not reached agreement on all the material issues, or one party may attempt to raise new issues that should have been addressed beforehand.

Once the parties have executed a formal settlement agreement, the term sheet generally becomes unimportant (and may be inadmissible under the parol evidence rule). In some cases, however, the parties execute a term sheet but fail to reach agreement on the text of a formal settlement agreement. In such cases, the question arises whether the term sheet itself is a binding contract that can be enforced in court, even though the parties contemplated the execution of a formal settlement agreement. The answer depends on the intentions of the parties. Term sheets can be enforced as binding contracts, even if the term sheet contemplates execution of a formal settlement agreement, if the parties intend the term sheet to be a binding contract and the term sheet states the essential terms of the parties' agreement with sufficient definiteness to be enforced by a court [*see, e.g.*, Foreca, S.A. v. GRD Dev. Co., 758 S.W.2d 744 (Tex. 1988); V'soske v. Barwick, 404 F.2d 495, 499 (2d Cir. 1968)]. The parties can spell out their intentions in the term sheet itself as to whether a binding contract arises at the moment the term sheet is signed or only once a formal settlement agreement is signed. The parties can also choose to remain silent on this point. Where the term sheet is silent, a court would have to infer the intentions of the parties in the event no formal settlement agreement were executed.

> ⚠ **Warning:** Counsel should exercise care in drafting a term sheet that is intended (or may subsequently be deemed by a court) to bind the parties. If the parties execute the term sheet but fail to reach agreement on the language of a formal settlement agreement, the parties' agreement will be enforced according to the language used in the term sheet.

Judge's Perspective: Courts enforcing term sheets will look for the basic elements of a contract. If counsel intends the term sheets to be binding, be sure the basic terms are clear. Term sheets explaining the "big picture" can be helpful in cases where drafting the comprehensive settlement document will be difficult because of opposing counsel or client dynamics.

23.21 Drafting the Definitions.

23.21[1] Defining the Parties Affected by the Settlement Agreement. Some terms in a settlement agreement are intended to apply only to the settling parties themselves, whereas other terms are intended to apply more broadly to various categories of persons and entities related to the settling parties. It is therefore useful to draft *separate* definitions for each of the different groupings of persons and entities to which different terms of the settlement agreement are intended to apply. For example, a settlement agreement might include the following definitions:

1. "Insured" means the specific insured that actually signs the settlement agreement and its future successors and assigns.
2. "Insured-Related Entities" means the Insured and its current parents, subsidiaries, and corporate affiliates, both direct and indirect, and their future successors and assigns.
3. "Insured Releasing Entities" means the Insured-Related Entities and any other person or entity that the Insured has the legal authority to bind to the terms of the release without violating a duty owed to that person or entity.

Categories of persons and entities that can be included in (or excluded from) the definitions of the settling parties include the following:

1. The settling parties, *i.e.*, the parties that actually execute the settlement agreement;
2. *Current* parents, subsidiaries, and corporate affiliates of the parties, both direct and indirect;
3. *Former* parents, subsidiaries, and corporate affiliates of the settling parties;
4. *Future* parents, subsidiaries, and corporate affiliates of the settling parties;
5. Shareholders, members, partners, officers, directors, employees, principals, attorneys, representatives, and agents of any or all of the foregoing, either in any capacity or solely in their capacity as such;
6. Predecessors, successors, and assigns of any of the foregoing, either in any capacity or solely in their capacity as such; and
7. Other specifically named entities (*e.g.*, a recently acquired subsidiary with material liabilities that was not considered or factored

into the settlement negotiations).

However counsel chooses to structure the definitions of the parties affected by the settlement agreement, counsel must be careful that using a broad definition of the parties will not lead to unintended results. Counsel should check all occurrences of broad definitions in the settlement agreement to confirm that the definition appropriately reflects the intentions of the settling parties.

Warning: Definitions commonly refer to the "affiliates" of a settling party without defining what constitutes an "affiliate." In some circumstances, this may be a source of ambiguity in the definitions. Counsel should consider striking the term altogether, limiting the definition to "corporate affiliates," or including more specific terminology such as "corporations under common control" or "joint ventures" to describe the kinds of entities intended to be covered by the definition.

23.21[2] "Subject Insurance Policies." The insurance policies, or categories of policies, that will be subject to the settlement are typically defined as the "Subject Insurance Policies." This is often one of the most important definitions in an insurance settlement.

Cross Reference: *See* § 23.05[1] above for a discussion of the different categories of insurance policies that the parties can agree to settle.

When the settlement agreement applies only to known policies (or parts thereof), the definition can simply list the policies (or parts thereof) by policy number and the name of the issuing insurer. This approach has the advantage of being easy to draft and relatively free of ambiguity. When the settlement is intended to cover unknown policies as well, however, the definition must carefully describe the categories of policies to which the settlement will apply. The description of unknown policies raises several drafting issues:

1. What is the insurer's relationship to the unknown policy? Definitions that refer only to policies "issued by" the insurer may not apply to all policies for which the insurer is financially responsible. For example, an insurer may "subscribe" to a London Market policy, may "participate" in a quota share or pooling arrangement, or may "purchase," be "assigned," or otherwise "assume responsibility for" a policy originally issued by another insurer.
2. What is the insured's relationship to the unknown policy? Definitions that refer only to policies "issued to" the insured may not apply to all policies that cover the insured. Of course, this may be the intent of the settling parties. However, in some cases the parties may wish to settle additional policies. For example, insureds may be "named as an insured" on policies issued to the insured's corporate parent, may be "named as an additional insured" on

policies issued to a contractor or job site owner, and may be "covered" under policies that do not name the insured at all by virtue of an assignment of the right to collect under that policy for an existing loss.

3. What type(s) of insurance policies are included? "Policies" is probably the broadest term in most situations, but it may include categories of policies that the parties do not intend to settle. For example, "Policies" can be defined to include or exclude primary, excess, general liability, directors and officers liability, errors and omissions, environmental impairment liability, property, or professional liability. Workers compensation policies are often excluded entirely from the definition of "Policies."

Counsel should be especially alert to the misunderstandings that can arise when the definition of the term "Subject Insurance Policies" includes other defined terms, such as the terms "Insurer" and "Insured." During the drafting process, the parties may propose and agree to revisions to the definitions of these other terms that incidentally alter the scope of the term "Subject Insurance Policies" in ways not anticipated by one or both of the parties.

Example: In a settlement of a coverage claim under a company's Directors' and Officers' insurance ("D&O") liability policies, the term "Subject Insurance Policies" is defined to include any D&O policies issued to the "Insured." "Insured" is then defined to include current and former officers and directors of the company. Even though it may never have been the intent of the parties, the insurer may take the position after the settlement agreement is signed that the "Subject Insurance Policies" include not only the company's D&O policies but also *personal* D&O policies issued directly to an independent director of the company by the settling insurer.

Example: A draft settlement agreement releases all "Subject Insurance Policies," which are defined to include any insurance policy that the settling insurer issued to the "Insured." The settling insurer proposes that the term "Insured" should be defined to include the corporate insured "and its successors." The settling insured, believing that the inclusion of "successors" is intended only to ensure that its successors would be bound by the release of its *own* policies, agrees to the proposal. After execution of the settlement agreement, the insured merges into an unrelated corporation. The settling insurer may argue, even if it were never intended at the time by either the insured or the insurer, that any policy it issued to the unrelated corporation prior to the merger is included in the "Subject Insurance Policies," and therefore is released, on the ground that the surviving corporation from the merger is the "successor" to the insured and therefore is

included in the definition of the "Insured."

23.21[3] Defining the Released Claims. The claims to be released can be identified in the settlement agreement by a variety of names (*e.g.*, "Environmental Claims," "Non-Environmental Claims," "Released Claims," *etc.*). The definition can describe specific claims to be released or more general categories of known and unknown claims.

Cross Reference: *See* § 23.06[1] above for a discussion of the different categories of coverage claims that the parties can agree to settle.

Problems can arise when the definition of the released claims incorporates other defined terms such as the "Insured Entities" or the "Subject Insurance Policies." Changes in the definitions of "Insured Entities" or "Subject Insurance Policies" could cause unexpected changes in the scope of the definition of the released claims.

Example: A settlement agreement defines the "Released Claims" as "all claims for coverage of asbestos-related bodily injury liabilities under the Subject Insurance Policies." If the definition of "Subject Insurance Policies" refers to any policy issued to the "Insured Entities," an expansion of the definition of the "Insured Entities" could lead to an expansion in the number of "Subject Insurance Policies" and therefore an expansion in the scope of the "Released Claims."

Warning: Counsel should be especially careful when the proposed definitions of "Released Claims," "Subject Insurance Policies," "Insurer Entities," and "Insured Entities" all include unknown members, *i.e.*, a release of unknown claims under unknown policies issued to unknown corporate affiliates of the settling insured by unknown affiliates of the settling insurers.

Cross Reference: Other issues that can arise in the drafting of a release are discussed in § 23.23 below.

23.22 Drafting the Payment Terms.

23.22[1] Standard Payment Terms. The payment terms in the settlement agreement should address the following issues:

1. The amount of the settlement payment;
2. The means by which payment will be made, *i.e.*, by wire transfer, by overnight delivery of a certified check, etc.;
3. The date by which payment must be made and/or received;
4. The person(s) or entity(ies) responsible for paying the settlement amount; and
5. The person(s) or entity(ies) to which payment should be sent or the bank account to which funds should be wired.

⊠ **Strategic Point:** A date certain for payment (*e.g*, "May 30, 2009") can be preferable to a relative date ("30 days after execution"), in that a date certain avoids ambiguity when the date of "execution" is uncertain and creates an incentive for the paying party to cooperate in finalizing the settlement agreement promptly.

Payment terms may also address other payment issues, including the following:

1. The currency in which payment shall be made (*e.g.*, "U.S. Dollars");
2. Whether payment will be "irrevocable;"
3. Whether payment will be in "immediately available funds;"
4. Whether timely payment is "of the essence," such that untimely payment would constitute a material breach of the agreement;
5. Whether payment is "net to the insured," *i.e.*, not subject to any offsets for additional or unpaid premiums, *etc*.; and
6. Whether interest is due on late payments and at what rate.

23.22[2] Allocation of Payment to Specific Policies or Claims. When multiple policies and/or coverage claims are being settled, the parties may want to address in their settlement agreement how the settlement payment should be allocated among the settled claims and policies.

One approach is to agree on a specific allocation that will be binding on the parties to the settlement. An agreed allocation can be advantageous when the insured has not fully released the insurer from liability under the settled insurance policies, so that there is a chance that the insured will submit coverage claims under the same policies in the future. An agreed allocation can avoid future disputes about which policies or which limits of liability within a single policy have been impaired or exhausted by the settlement. However, such an agreed allocation may not be binding on third parties not bound by the settlement for purposes of impairment or exhaustion.

Another approach is for the insured and the insurer each to expressly reserve its right to allocate the settlement payment independently of the other party. This is in effect an agreement not to agree about allocation of the payment amount. Such reservations of rights can be advantageous whenever the allocation of the settlement payment matters only to third parties and not to the settling parties themselves.

Example: The insured and one of its general liability insurers agree to settle the insured's claim for coverage of its past and future environmental liabilities by agreeing to a policy buy-back covering multiple policies issued by the settling insurer. As between the insured and the settling insurer, the allocation of the settlement payment to specific

claims or policies makes no difference, since the insured has released the insurer from any future liability under the settled policies. However, the insurer may prefer to allocate the settlement payment one way for purposes of collecting from its reinsurers, whereas the insured may prefer a different allocation consistent with positions the insured may take in coverage litigation against its remaining non-settled liability insurers. In this situation, each party may prefer to reserve its right to allocate the settlement payment independently of the other party, rather than negotiate for a specific allocation.

23.23 Drafting the Releases.

23.23[1] Releasing the Insurer. Counsel should consider the following issues when drafting or reviewing the release granted by the insured to the insurer:

Who is giving the release? Insurers typically seek to be released not only by the insured but also by various related persons and entities, such as the insured's subsidiaries, parents, "affiliates," officers, employees, agents, etc. Insureds typically prefer to narrow the list of persons and entities granting the release. A compromise between these positions is to release the insurer "to the fullest extent of the policyholder's legal authority to do so without violating a duty owed to another" or similar language.

Who is being released? Insurers typically seek to have persons and entities related to the settling insurer be released as well. It is preferable to list these persons and entities by name so that there is no confusion as to their identity, but sometimes a proposed release includes categories of releasees, such as "shareholders" of the insurer, whose membership is unknown to the insured.

⊠ **Strategic Point—Insured:** In most circumstances, the insured can — on behalf of itself — safely agree to release "all the world," provided that the release clearly applies only to the defined claims the insured intends to release under the defined policies that the insured intends to settle. For example, there is likely to be no practical difference between releasing "all the world" from liability for a specific coverage claim under a specific policy versus releasing only the insurer that issued that policy. The parties may sometimes find that it makes sense to adopt broad definitions of the releasees while using narrower and/or more precise definitions of the claims and policies to which the release applies. A different approach may be advisable, however, in those cases where the insured is agreeing to indemnify the released insurers [*see* § 23.24[2] below].

What claims are being released? Insurers generally can be liable not only for coverage claims asserted by the insured but also for several other types of claims that the insurer might seek to include within the scope of

the release. Counsel should examine the wording of the release carefully to determine its likely effect on these various categories of claims:

1. Coverage claims asserted by non-settling insureds;
2. Direct action claims asserted by injured third parties;
3. Contribution and equitable subrogation claims asserted by other insurers; and
4. Other claims asserted by the insured, including claims for bad faith or violation of statutory claims handling standards, claims for return of premiums, and claims for costs and attorney's fees incurred during coverage litigation.

Example: A release that applies to "claims for coverage of Asbestos Bodily Injury Claims under the Subject Insurance Policies" may not apply to contribution claims asserted by other insurers or statutory claims by the insured for attorney's fees incurred in coverage litigation, because such claims arguably are not claims for "coverage." If a release of such claims were intended, the release should spell out the additional categories of claims other than coverage claims to which the release applies.

Which policies are affected by the release? Generally, the release applies to the policies included in the definition of the "Subject Insurance Policies."

◗ **Cross Reference:** Issues regarding the drafting of the definition of "Subject Insurance Policies" are discussed in § 23.21[2] above.

When will the release become effective? Releases typically become effective only after the insured receives the full settlement payment free and clear, but other effective dates are possible where payment is to be made over time (e.g., upon receipt of the first installment of the settlement payment). In appropriate cases, the effective date of the releases can also tied to other events (*e.g.*, a court ruling, a dismissal, or a judicial approval of a settlement or related documents).

Are there any carve-outs from the release? Concerns about possible overbreadth or ambiguity in the rest of the release can be addressed by expressly excluding specific releasors, releasees, claims, and/or insurance policies from the scope of the release.

23.23[2] Supplements to the Release.

23.23[2][a] Dismissing Coverage Litigation. When the coverage claim being settled is the subject of coverage litigation, the defendant in the coverage litigation typically requests that the plaintiff promise to dismiss the litigation in addition to releasing its claims against the defendant in the settlement agreement. Agreements to dismiss coverage litigation typically provide that each side shall bear its own costs for the litigation. Exceptions to this general rule may apply where the litigation is mature and/or where fee shifting has already been addressed by the court.

23.23[2][b] Deeming Policy Limits Exhausted. The parties to a settlement agreement may agree, in addition to a release, that the limits of liability under one or more insurance policies shall be "deemed" to be exhausted by the payment of the settlement amount. Deeming limits to be exhausted serves little purpose where the limits of liability clearly are exhausted even without an acknowledgement to that effect in the settlement agreement. Parties typically desire to "deem" limits to be exhausted where it otherwise would not appear that the settlement amount is large enough to exhaust the policies in question. There has been relatively little litigation regarding the effect of such "deemed" exhaustion provisions, and the results so far are mixed [*compare* Elliott Co. v. Liberty Mut. Ins. Co., 434 F. Supp. 2d 483, 500 (N.D. Ohio 2006) ("an insured should be allowed to exhaust a policy by good faith agreement, even if payments do not actually exceed the policy limits."); Tenneco Auto., Inc. v. El Paso Corp., 2001 Del. Ch. LEXIS 147, *34–35 (2001) (same) *with In re* Forty-Eight Insulations, Inc., 133 B.R. 973, 979–80 (Bankr. N.D. Ill. 1991), *aff'd*, 149 B.R. 860 (N.D. Ill. 1992) (additional insured cannot extinguish the coverage rights of named insured by agreeing that policy limits are exhausted where the amount of the settlement is less than the face amount of the policies)].

23.23[2][c] Rescinding or Voiding the Policy. Settlements may also include a provision purporting to rescind or declare null and void one or more insurance policies. Such a provision is generally included in a policy buy-back agreement [*see* § 23.10 above]. The insurer may want an agreed rescission as an additional layer of protection against the risk that the insured's release of the insurer will be construed not to apply to all possible coverage claims that the insured may have under the policy or that the release will be unenforceable because of statutory restrictions on the scope of the release [*see* § 23.23[4] below].

23.23[3] Releasing the Insured. Insureds generally should seek a mutual release from the released insurer(s). The release granted by the insurer to the insured typically will parallel the scope and language of the release granted by the insured to the insurer, but release of the insured may include certain types of claims to which the insured is uniquely subject:

1. Claims for retrospective premiums [*see* § 23.07 above];
2. Other claims for additional or unpaid premiums;
3. Claims for an offset based on a deductible, self-insured retention, or fronting arrangement;
4. Claims based on misrepresentations or nondisclosure in the underwriting of the insurance or the insured's presentation of the coverage claim; and
5. Claims for "reverse bad faith" or comparative bad faith. So far, reverse bad faith claims do not have a track record of success [*see, e.g.*, Tokles & Son, Inc. v. Midwestern Indem. Co., 65 Ohio St. 3d 621, 662–63 (1992) (declining to recognize a tort of "reverse bad faith"), *see also* § 6.23 above for a discussion of reverse bad faith] but insureds may include such claims in the release as a precautionary measure.

23.23[4] Statutory Restrictions on the Scope of the Release. Certain states, most notably California, have enacted statutes that provide that a general release is ineffective to discharge claims that currently exist but are unknown to the releasor. Cal. Civil Code § 1542 provides that "[a] general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor." Identical statutes have been adopted by North and South Dakota [*see* N.D. Cent. Code § 9-13-02; S.D. Codified Laws § 20-7-11].

Settlement agreements often specifically acknowledge and then waive the parties' rights under Section 1542 and similar statutes. Under California law, such waivers can be effective [*see* Jefferson v. Dep't of Youth Auth., 28 Cal. 4th 299 (2002)], but whether the waiver is effective in a given case depends on whether the releasor intended to discharge the claims in question [*see* Leaf v. City of San Mateo, 104 Cal. App. 3d 398, 411 (1980) ("mere recital . . . that the protection of Civil Code, § 1542 is waived . . . is not controlling")].

Releases that apply to claims based on *future* conduct might be unenforceable because of separate statutory limitations on exculpatory agreements. For example, Cal. Civil Code § 1668 declares contracts that "exempt anyone from responsibility for his own fraud, or willful injury to the person or property of another, or violation of law," to be against public policy. One court has opined that "contractual releases of future liability for fraud and other intentional wrongs are invariably invalidated" under § 1668 [Farnham v. Superior Court, 60 Cal. App. 4th 69, 71 (1997)].

23.24 Drafting the Indemnification Clause.

23.24[1] Deciding Whether to Include an Indemnification Clause. An indem-

nification clause obligates the insured to defend and indemnify the settling insurer against agreed categories of claims, such as contribution claims asserted against the settling insurer by other insurers, direct action claims by injured tort claimants, or claims by non-settling insureds asserting coverage claims under the settled policies.

A settlement agreement need not include an indemnification clause. Whether to include such a clause, and the scope of such a clause, are often key aspects of the settlement negotiations. Insurers that want to be indemnified should specifically request indemnification rights. Insureds should not assume, however, that an insurer's silence about indemnification means that the insurer does not expect to be indemnified. Sometimes insurers make the mistake of assuming that an indemnification clause will be included in a settlement, and the misunderstanding only becomes clear after the parties have agreed on the other material terms of the settlement and have begun to document the settlement. The insured can avoid this problem by stating in its settlement offers that the settlement will *not* include an indemnification clause. There are alternatives to an indemnification clause that might satisfy the insurer in these situations [*see* § 23.24[3] below].

23.24[2] Issues to Address in the Indemnification Clause. Indemnification clauses typically address the following issues:

1. The types of claims that will be subject to indemnification (*e.g.*, coverage claims by other insureds, direct action claims, contribution and equitable subrogation claims, *etc.*). Often the scope of the indemnity is defined in relation to the scope of the release.
2. Any categories of claims that will be excluded from indemnification (*e.g.*, bad faith claims, claims asserted by one released insurer against another, coverage claims by other insureds, reinsurance claims, claims not released by the settlement, *etc.*).
3. The persons and entities related to the insurer that will be entitled to indemnification (*e.g.*, parents, subsidiaries, officers and directors, *etc.*).
4. Whether and to what extent the insured's obligation to defend and indemnify the insurer will be subject to a retention, dollar cap and/or a time limit, and whether any retentions or caps are satisfied by loss payments, defense expenses, or both. For those settlements that include indemnities, many include a dollar cap, which is generally eroded by both loss and defense payments, and the amount of which is often tied in some way to the amount of the settlement payment.
5. Any conditions precedent to the insured's obligation to defend and indemnify the insurer (*e.g.*, prompt notice of indemnifiable claims, reasonable cooperation from the insurer in responding to discov-

ery requests, receipt of the full settlement payment by the insured, *etc*.).

6. The respective rights of the insured and the insurer to select counsel to defend the indemnifiable claim and to control the defense and settlement of the claim.

Insureds also should consider requiring that the insurer agree not to pursue its rights of contribution and equitable subrogation against the insured's other insurers in order to reduce the likelihood that the settling insurer will become embroiled in litigation with these other insurers and thereby trigger the insured's indemnification obligations.

Warning: In most cases, the scope of the insured's indemnification duties is defined to extend to the insurer entities being released in the settlement agreement. In such cases, counsel for the insured should be careful either to limit the definition of the released entities to those the insured is willing to indemnify or to include carve-outs in the indemnification clause itself. For example, while it may simplify the drafting of the release to release "all the world" from claims under the settled insurance policies [*see* § 23.23[1] above], the insured may not want to indemnify everyone who might claim some right under the policies.

Form: A sample indemnification clause is provided in § 23.32 below.

23.24[3] Alternatives to an Indemnification Clause. In addition to or in lieu of an indemnification clause, the parties may agree to one or more of the following measures to protect the insurer from claims asserted by non-settling parties:

1. A recital in the order dismissing coverage litigation that the settlement is fair and reasonable;
2. An agreement that the insured will not assist other insurers in bringing contribution claims against the settling insurer and will cooperate with the settling insurer in resisting such claims;
3. An agreement that the insured will seek to include waivers of contribution and equitable subrogation rights in the insured's settlements with other insurers; and
4. A "reduction in judgment" agreement, *i.e.*, an agreement that, if the insured obtains judgment against a nonsettling insurer, and that insurer in turn obtains a judgment for contribution against the settling insurer, the insured will reduce its judgment against the nonsettling insurer so as to moot the nonsettling insurer's contribution claim against the settling insurer.

23.25 Drafting the Confidentiality Clause. Settlement agreements typically include a confidentiality clause that defines what information in the settlement

agreement is confidential and under what circumstances the parties may disclose the confidential information. The parties should consider carefully what information about the settlement they will need to disclose to others and make sure that the confidentiality clause will permit such disclosures. Information that one or both of the parties may need to disclose can include:

1. The *fact* that the parties have settled;
2. Information necessary to establish the insurer's right to pursue subrogation claims [*see* § 23.27 below];
3. Any other rights or claims that one party might have assigned to the other in the settlement agreement;
4. The settlement amount, if the actual amount paid by the insurer is necessary to establish the appropriate *pro tanto* settlement credit [*see* § 23.29[3] below], or if the amount is large enough to trigger reporting requirements to the SEC or other regulatory agencies;
5. The settlement allocation, if the settlement pertains to pooled, stamp or quota share arrangements (*e.g.*, London Market settlements), where necessary to establish the amount of a claim against an insolvent insurer or an insurer that does not participate in the settlement; and
6. Any other information required to be disclosed by law or regulation or by court order or subpoena. (The confidentiality clause may require in these circumstances that the party required to disclose give advance notice to the other party to allow the other party to object to the disclosure).

Confidentiality clauses typically provide for disclosure of the settlement agreement to specific categories of persons and entities, such as: inside and outside counsel for the parties; the parties' accountants and auditors; regulatory authorities such as the SEC or IRS; creditors and rating agencies; and the settling insurer's reinsurers. Disclosure to non-governmental entities may be subject to the condition that they agree to the same limitations on disclosure that apply to the settling parties themselves.

Confidentiality clauses also should allow the parties to disclose the settlement agreement when necessary to enforce the terms of the agreement itself or when the parties mutually agree to permit a disclosure. The confidentiality clause may also recite that the settlement is protected by Federal Rule of Evidence 408 and similar provisions under state law [*see* § 23.15 above].

Judge's Perspective: Consider liquidated damages provisions and fee shifting clauses to ensure the incentives remain for compliance with confidentiality clauses. Courts will construe confidentiality clauses narrowly, so be sure to take substantial care in drafting the responsibilities of the parties and the scope of the clause.

Warning: Insureds that are public entities, such as a municipality or government agency, may lack the legal authority to keep the terms of a

settlement with their insurers confidential, because the settlement agreement may be considered a public record subject to disclosure under freedom-of-information or right-to-know statutes [*see, e.g.*, Tribune-Review Publ'g Co. v. Westmoreland County Hous. Auth., 574 Pa. 661, 669 (2003) ("Numerous courts in this country have determined that a settlement document involving a public body that has acted within its official capacity contains information relating to the conduct of the public's business" and thus may be subject to disclosure as a public record) (citing cases)].

Forms: The sample settlement and release of a specific claim in § 23.32 below includes an example of a confidentiality clause.

23.26 Drafting the Enforcement and Dispute Resolution Clause. The enforcement and dispute resolution clause defines the parties' rights and obligations in the event of a breach of the settlement agreement. Counsel should consider whether the same remedies are appropriate for every possible breach. For example, the parties might make disputes about certain provisions subject to arbitration (*e.g.*, whether the insurer can assert a specific coverage defense to payment of a claim submitted under a coverage-in-place agreement) but preserve the parties' right to go to court for other breaches (*e.g.*, failure to pay an installment of the settlement payment).

Form: The sample settlement terms in § 23.32 below include an example of enforcement and dispute resolution clauses.

VI. ADDRESSING SUBROGATION RIGHTS AND CLAIMS.

23.27 Defining Subrogation Rights and Obligations in the Settlement Agreement. If neither the settlement agreement nor the settled insurance policies discuss the subrogation rights and obligations of the settling parties, those rights and obligations will be determined by the applicable law of equitable subrogation. However, the parties can define their subrogation rights and obligations by contract and can agree to modify or waive the rules of equitable subrogation [*see, e.g.*, Culver v. INA, 115 N.J. 451 (1989)]. Subrogation by agreement is known as conventional subrogation.

If subrogation rights are important to one or both of the parties, counsel should consider negotiating specific terms to govern how subrogation claims can be pursued. There are many subrogation issues that the parties may wish to address in their settlement agreement:

1. Will the insurer be allowed to pursue any subrogation claims at all? As discussed in § 23.28 below, the insured may prefer that the insurer waive all of its subrogation rights and agree not to pursue any subrogation claims, or agree to pursue such claims only against certain persons or entities but not others.
2. Must the insured be "made whole" before the insurer can recover on a subrogation claim? Equitable subrogation usually requires that the insured's whole loss be paid before the insurer can recover on a subrogation claim, but courts have held that this requirement can be waived by agreement [*see*, *e.g.*, Peterson v. Ohio Farmers Ins. Co., 175 Ohio St. 34 (1963); Rosa's Café, Inc. v. Wilkerson, 183 S.W.3d 482, 487–88 (Tex. App. 2005)].
3. Has the insured been made whole? Insurers may ask the insured to agree that the settlement payment represents full compensation for the insured's loss in order to avoid a challenge to the insurer's subrogation rights on the ground that the requirements of the "made whole" doctrine have not been satisfied.
4. In whose name will the insurer sue, and will the suit papers identify the insurer's role in the lawsuit? Insureds may be concerned that the insurer will sue in the insured's name without sufficient identification of the insurer's role as subrogee, which could damage the insured's reputation if the targets of the subrogation claim are persons or entities with whom the insured has an ongoing relationship (such as contractors, consultants, building managers, or franchisees). That concern can be addressed by reaching agreement with the insurer as to how the insurer's role in a subrogation lawsuit will be identified and described in the complaint and other suit papers.
5. What cooperation does the insured owe to the insurer in pursuing a subrogation claim? The insurer may want a broad agreement to provide

"full cooperation," whereas the insured may wish to establish some limits on its cooperation, such as requiring only "reasonable" cooperation or providing that the insured need not cooperate if cooperation would prejudice the insured's own interests.

6. Will the insurer reimburse the insured for expenses that the insured incurs in cooperating with the insurer? Cooperation can be costly and time-consuming. For example, the insured may incur costs to review and produce documents requested in discovery and may have to produce its employees as witnesses for depositions and trial.
7. Who will represent the insured's employees in the event they are deposed?
8. Who will control the assertion and waiver of the insured's attorney-client privilege or other privileges in the event the defendants in a subrogation action try to discover privileged information belonging to the insured? What access will the insurer have to such privileged information?
9. How will any recovery obtained in a subrogation action be divided between the insurer and the insured? For example, the insured may want any recovery to be applied first to reimburse the insured for the portion of the loss falling within a deductible, whereas the insurer may want any recovery to be applied first to its own expenses in bringing the subrogation action.

Some of these issues may already be addressed in the insurance policies themselves. Insurance policies often include subrogation clauses that confirm the insurer's right to subrogation and that may also address basic issues such as the division of recoveries between insured and insurer. These clauses can of course be modified by the parties and therefore represent merely the default rules that will apply if the parties do not reach a different understanding in their settlement agreement.

Strategic Point–Insurers: Insurers sometimes ask the insured to execute a separate "subrogation receipt" that recites facts necessary to establish the insurer's right to pursue a subrogation claim, such as the amount of the settlement, an acknowledgement that the insured has been "made whole," and confirmation that the insured has assigned its rights to recover for the loss in question to the insurer. Without such a document, the insurer may find it difficult or even impossible to establish these facts without violating its confidentiality obligations under the settlement agreement.

Warning: Counsel should review the releases in the settlement agreement to determine whether they have any effect on the parties' subrogation rights. To avoid disagreements about the effect of the release on those rights, the release should expressly exempt any subrogation rights or obligations that the parties intend to preserve. For example, without an express exemption, a broad release of "any and all" claims arising out of a

first-party property loss might be interpreted by the insured to negate any obligation to cooperate with the insurer in pursuing a subrogation claim, or might be interpreted by the insurer to negate the insurer's obligation to reimburse the insured for its expenses in rendering that cooperation.

23.28 Waiving Subrogation Rights. Waivers of subrogation rights are commonly demanded by insureds in settlements of coverage claims under liability policies where multiple insurers provide coverage for the loss in question, as in many environmental and toxic tort coverage cases. Without such waivers, a settling insurer may acquire the insured's right to sue the non-settling insurers for any portion of the loss that the settling insurer paid on behalf of the non-settling insurers [*see, e.g.*, Transcontinental Ins. Co. v. Ins. Co. of State of Pennsylvania, 148 Cal. App. 4th 1296, 1305 (2007)]. Allowing the settling insurer to pursue such claims would prejudice the insured's ability to settle its own coverage claims against the non-settling insurers. The settling insurer might also assert similar claims against other settling insurers and thereby trigger the insured's obligation under an indemnity clause to defend the settling insurers against such claims [*see* § 23.24 above]. (For the same reason, insureds likewise demand waivers of the settling insurer's right to contribution against other insurers.)

Waivers of subrogation rights are less common in settlements of first-party coverage claims such as first-party property claims. The perceived value of a subrogation claim to the insurer can be an important factor in the insurer's valuation of the coverage claim and an important inducement to settlement [*see* § 23.07 above]. Requiring the insurer to waive its subrogation rights therefore increases the net cost of settlement to the insurer and reduces the insurer's incentive to settle.

VII. UNDERSTANDING THE EFFECT OF SETTLEMENT ON NON-SETTLING PARTIES.

23.29 Understanding the Effect of Settlement on Claims Against Non-Settling Insurers.

23.29[1] Exhaustion of Underlying Limits Through Settlement. Excess insurance policies typically state that coverage under the excess policy does not attach until the limits of the underlying policies have been exhausted. If the insured settles with the underlying insurers for less than the full limits of the underlying policies, does coverage under the excess policy then attach?

Courts generally will treat the underlying policies as having been exhausted by the settlement notwithstanding the fact that they did not pay their full limits, but will give the non-settling excess insurer a credit for the full amount of the underlying limits. The leading case is *Zeig v. Massachusetts Bonding & Ins. Co.* [23 F.2d 665 (2d Cir. 1928)], but many other jurisdictions follow the same approach [*see, e.g.*, UMC/Stamford, Inc. v. Allianz Underwriters Ins. Co., 276 N.J. Super. 52, 69 (Law Div. 1994); Koppers v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3d Cir. 1996) (applying Pennsylvania law); Reliance Ins. Co. v. Transamerica Ins. Co., 826 So. 2d 998, 999–1000 (Fla. Dist. Ct. App. 2001); Stargatt v. Fidelity and Cas. Co. of N.Y., 67 F.R.D. 689, 690–91 (D. Del. 1975), *(applying Delaware law), aff'd*, 578 F.2d 1375 (3d Cir. 1978); Allstate Ins. Co. v. Dana Corp., 759 N.E.2d 1049, 1063 & n.10 (Ind. 2001); Smit v. State Farm Mut. Auto. Ins. Co., 207 Mich. App. 674, 685–86 (1994)].

> **Example:** A tort judgment for $ 5 million is entered against the insured. The insured settles with its primary liability insurer for $ 750,000, even though the applicable limits of the primary policy are $ 1 million. The insured also has a $ 10 million excess liability policy that provides that coverage shall attach only upon exhaustion of the primary policy by actual payment of claims. Under the *Zeig* approach, coverage under the excess policy attaches upon the settlement of the primary policy, but the excess policy is liable only for $ 4 million (*i.e.*, the $ 5 million judgment minus a credit of $ 1 million for the full amount of the applicable limit of the primary policy). The insured is responsible for the $ 250,000 gap between the settlement amount and the limit of the primary policy.

23.29[2] Effect of Settlement on Non-Settling Insurers' Contribution Rights. Where policies issued by different insurers cover the same loss, and the insured settles with one insurer and obtains a judgment against the other insurer, can the non-settling insurer pursue a contribution claim against the settling insurer? This question can arise in a number of different scenarios, including the following:

1. In a jurisdiction that has adopted the "all-sums" allocation rule, the insured may, for example, settle a claim for coverage of its environmental liabilities with one group of insurers providing coverage during one policy period for less than the full amount of the insured's loss. The insured may then seek a judgment for the remainder of its loss from another group of insurers providing coverage during a different policy period. The question would then arise whether the non-settling insureds can assert a contribution claim against the settling insurers on the theory that the settling insurers paid less than their equitable share of the loss.
2. The insured may be a named insured under one policy and an additional insured under another policy, both of which cover the same loss. The insured settles with its own insurer for part of the loss and seeks a judgment against the other insurer for the remainder of the loss. Can the other insurer assert a contribution claim against the insured's insurer?

Some courts permit non-settling insurers to assert contribution claims against settling insurers in these situations [*see*, *e.g.*, Fireman's Fund Ins. Co. v. Maryland Cas. Co., 65 Cal. App. 4th 1279, 1301 (1998); Rohr Industries, Inc. v. First State Ins. Co., 59 Cal. App. 4th 1480, 1490 (1998)]. Other courts have held that non-settling insurers are barred from asserting contribution claims against settling insurers [*see, e.g.*, Gould, Inc. v. Continental Cas. Co., 585 A.2d 16, 19 (Pa. Super. Ct. 1991); Koppers Co., Inc. v. Aetna Cas. and Sur. Co., 98 F.3d 1440, 1452–54 (3d Cir. 1996) (applying Pennsylvania law); GenCorp, Inc. v. AIU Ins. Co., 297 F. Supp. 2d 995, 1007 (N.D. Ohio 2003)]. Still other courts have assumed that contribution claims against settling insurers would be barred without actually deciding the question [*see, e.g.*, Childs v. N.J. Mfrs. Ins. Co., 108 N.J. 506, 515 (1987)].

A common rationale for barring contribution claims by non-settling insurers against settling insurers is that allowing such claims would discourage insurers from settling. This rationale is supported by the strong public policy favoring settlement rather than litigation [*see* UMC/Stamford, Inc. v. Allianz Underwriters Ins. Co., 276 N.J. Super. 52, 69 (App. Div. 1994)]. Without contribution protection for settling parties, an insurer may have less incentive to settle.

Consider: If the insured settles with *all* of the insurers that cover a given loss, can the insurers then assert contribution claims against each other, even if contribution claims by non-settling insurers are prohibited under applicable law? Such contribution claims could be an expensive problem for the insured if the settlement agreements obligate the insured to defend and indemnify the settling insurers against contribution claims. The issue can be avoided by including a term in each settlement agreement that prohibits each settling insurer

from asserting contribution claims against any other insurer, whether settling or non-settling.

Cross Reference: Some jurisdictions that bar non-settling insurers from asserting contribution claims against settling insurers nevertheless give the non-settling insurer a credit for the settlement. Settlement credits are discussed below in § 23.29[3] below.

23.29[3] Settlement Credits. Some jurisdictions that have adopted the "all sums" allocation method give non-settling insurers a "settlement credit" in lieu of a right to contribution from settling insurers that provide overlapping coverage for the same loss [*see* § 23.29[2] above]. The settlement credit reduces the total amount of the insured's loss before that loss is allocated to the non-settling insurer.

Several different types of settlement credits have been adopted in different jurisdictions:

1. *Pro tanto* credits. The credit equals the amount actually paid by the settling insurer under the settled policy for the loss in question [*see, e.g.*, Rubenstein v. Royal Ins. Co. of Am., 44 Mass. App. Ct. 842, 855 (1998); Childs v. N.J. Manufacturers Ins. Co., 108 N.J. 506, 511–13 (1987); Liberty Mut. Ins. Co. v. Black & Decker Corp., 2004 U.S. Dist. LEXIS 17444 (D. Mass. 2004)]. This approach appears to be the dominant trend in recent court rulings.
2. *Pro rata* credits. The credit equals the equitable share of the total loss that would have been allocated to the settled policy were contribution claims allowed, which typically will be larger than the amount the settling insurer actually paid in settlement [*see, e.g.*, Koppers v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1453 (3d Cir. 1996) (applying Pennsylvania law)].
3. Policy limit credits. The credit equals the applicable limit of the settled insurance policy(ies), which typically will be larger than either the amount actually paid in settlement or the equitable share allocable to the settled policy. A version of this approach was used in *GenCorp., Inc. v. AIU Ins. Co.*, 297 F. Supp. 2d 995 (N.D. Ohio 2003), *aff'd*, 138 F. App'x 732 (6th Cir. 2005). This approach is the least common of the three, and has not been followed in at least one Ohio case subsequent to *GenCorp* [*see* Goodrich Corp. v. Commercial Union Ins. Co., Case No. CV 1999-02-0410, slip op. (Ohio Comm. Pleas Summit Cty. 2006)].

There is also a fourth approach exemplified by *Weyerhaeuser Co. v. Commercial Union Ins. Co.* [142 Wash. 2d 654, 671–75 (2000) (en banc)], which held in the context of an "all sums" allocation that a non-settling insurer is entitled to a settlement credit only if the non-settling insurer proves that the insured otherwise would recover more than the total loss in question, which will not necessarily occur in every case in which an

insured settles with some of its insurers and obtains a judgment against the others. Other jurisdictions have likewise held that settlement credits are available only to prevent the insured from recovering more than its total loss [*see* United Technologies Corp. v. Am. Home Assurance Co., 237 F. Supp. 2d 168 (D. Conn. 2001); *see also* Feurzeig v. Ins. Co. of the West, 2003 Cal. App. Unpub. LEXIS 4490 (2003) (agreeing with *Weyerhaeuser* that the insured must be fully compensated before any settlement credit can apply, but finding that recovery in excess of the total loss had been proven in this case)].

The *Weyerhaeuser* approach and the *pro tanto* settlement credit approach are often favored — and appear to represent the majority position among the states — because they both: (a) allow the insured to obtain full coverage for its loss through a combination of settlements and judgments, and (b) ensure that the insured will not recover more than its total loss. A potential problem with the other approaches to settlement credits (represented by *Koppers* and *GenCorp*) is that they force the insured to absorb the gap between the amount the settling insurers actually pay in settlement and the amount of the credit. In situations with multiple responsible insurers, such an approach may make it difficult to achieve settlements prior to trial, and may therefore run afoul of the strong public policy favoring settlement. This approach may also make it more difficult to achieve a partial settlement of the case, which may be an undesirable feature for insurers interested in an early settlement of their own liability.

Example: Assume that, in an "all sums" jurisdiction that does not permit non-settling insurers to sue settling insurers for contribution, the insured's environmental liabilities for historical waste disposal at a landfill trigger coverage under a series of ten consecutive primary liability policies issued by different insurers, each with an applicable limit of liability of $ 10 million. The insured's total loss is $ 2 million. The insured settles with one insurer for $ 100,000 and obtains a judgment against the other nine insurers. A *pro tanto* settlement credit would reduce the judgment from $ 2 million to $ 1.9 million. The insured then could collect the reduced judgment of $ 1.9 million from one of the non-settling insurers.

Example: Same hypothetical as above, except that the non-settling insurers receive a *pro rata* settlement credit. Each insurer's pro rata share of the $ 2 million loss is $ 200,000. The settlement credit therefore would be $ 200,000, the reduced judgment would be only $ 1.8 million, and the insured would have no coverage for the $ 100,000 gap between the amount the insured actually received in settlement and the settling insurer's pro rata share of the total loss.

Example: Same hypothetical as above, except that the non-settling insurers receive a credit for the policy limit of the settled policy. The

amount of the credit would be $ 10 million, and any judgment that the insured obtained against the non-settling insurers would be reduced to zero by the settlement credit. The insured could recover only the $ 100,000 that it obtained through settlement with the settling insurer. Realistically, the insured would not agree to settle at all unless the settlement amount represented a fair value of the insured's *entire* coverage claim.

Warning: Settlement credits might be disallowed entirely in a particular case if the non-settling insurer refused to settle in bad faith in an attempt to gain an advantage through the use of settlement credits [*see* INA v. Kayser-Roth Corp., 770 A.2d 403 (R.I. 2001)].

23.29[4] Discovery of Settlement Terms by Non-Settling Insurers. Requests by non-settling insurers for discovery of the terms of the insured's settlements with other insurers typically raise two competing considerations. On the one hand, the non-settling insurer may argue that such discovery is necessary to prevent the insured from recovering more than the amount of its loss. The insurer may suspect that the insured's settlements have fully compensated the insured for the loss in question, but those suspicions cannot be proven without discovery of the terms of the settlements. On the other hand, allowing such discovery tends to discourage settlement of coverage disputes, because settling insurers typically insist on confidentiality as a condition of settlement.

The outcome of this conflict varies from case to case. Sometimes, concerns about recovery in excess of the total loss prevail and discovery is allowed [*see, e.g.*, Home Ins. Co. v. Superior Court, 46 Cal. App. 4th 1286, 1291–92 (1996)]. On other occasions, concerns about discouraging settlement of coverage disputes prevail and discovery is denied [*see, e.g.*, UMC/Stamford, Inc. v. Allianz Underwriters Ins. Co., 276 N.J. Super. 52, 67–71 (App. Div. 1994)].

Concerns about compensating the insured for more than its total loss may be a less compelling justification for discovery of settlement terms when the applicable allocation rule is "pro rata" or when non-settling insurers in an "all sums" jurisdiction receive a *pro rata* settlement credit rather than a *pro tanto* credit [*see* § 23.29[3] above]. In these situations, the insured runs the risk that its settlements will turn out to be less than the amount of the settling insurers' pro rata share of the total loss, in which case the insured cannot recover the shortfall from the non-settling insurers. Courts therefore may not find it troubling that the insured might instead settle for more than the settling insurers' pro rata shares of the loss [*see, e.g.*, E.R. Squibb & Sons, Inc. v. Lloyd's & Cos., 241 F.3d 154, 173 (2d Cir. 2001) ("While Squibb may have gained from the settlements, it undoubtedly took the risk that the size of the settlements would be inadequate to cover the settling insurers' pro rata share. . . . That hardly seems unfair.")]. Even in jurisdictions that apply a *pro tanto* settlement

credit, the need for disclosure of the settlement agreements may be obviated in a number of ways.

> **Example:** The insured could submit an affidavit stating that its total aggregate settlement recovery is less than "x" — *i.e.*, less than a specific sum — for the loss at issue. By reducing the insured's claim by this amount (*pro tanto*), the insurers are fully protected against any risk of an excess recovery.

23.30 Understanding the Effect of Settlement on the Rights of Non-Settling Co-Insureds. Insurers may propose a settlement that not only extinguishes the settling insured's coverage rights under the settled policies but also purports to extinguish the rights of co-insureds or additional insureds that are not parties to the settlement. Such proposals may take various forms, including a broad release that applies to the settling insured's former subsidiaries, a clause that "deems" the limits of the settled policies to be exhausted, or a clause that purports to cancel, rescind, or declare "null and void" the settled policies. These proposals raise issues regarding whether the settling parties have the power to extinguish the rights of non-settling insureds.

Relatively few courts have addressed these issues. There are several possible grounds on which the settling parties might have the power to extinguish the coverage rights of non-settling insureds, including:

1. The insurance policy itself might designate one insured (typically the first named insured) as the agent of all other insureds for various purposes. The policy may specifically authorize the first named insured to take actions, such as settling coverage claims, agreeing to amend the policy, or giving notice of cancellation, that can result in the extinguishment of other insureds' coverage rights.
2. The settling insured might have a separate agreement with the other insureds that gives the settling insured the authority to compromise the coverage rights of all insureds. For example, if the named insured sells one of its subsidiaries, the sale agreement may specify which party — the named insured or the subsidiary — will have control over any insurance policies that cover both entities and what limitations, if any, apply to the exercise of that control [*see* Tenneco Auto. Inc., v. El Paso Corp., 2001 Del. Ch. LEXIS 147 (Del. Ch. 2001)].
3. Applicable law might give the settling insured the right to compromise the coverage rights of other insureds without their consent in order to achieve a settlement of the settling insured's own coverage claims [*see* Elliott Co. v. Liberty Mut. Ins. Co., 434 F. Supp. 2d 483, 500 (N.D. Ohio 2006) (settlement by one insured that deems policy limits to be exhausted allowed); Tenneco Auto. Inc., v. El Paso Corp., 2001 Del. Ch. LEXIS 147, at *34–35 (Del. Ch. 2001) (same holding, but only as to policies with *aggregate* limits)]. One court has held otherwise where the settling insured was an additional insured that was attempting to

compromise the rights of the named insured [*In re* Forty-Eight Insulations, Inc., 133 B.R. 973, 979–80 (Bankr. N.D. Ill. 1991), *aff'd*, 149 B.R. 860 (N.D. Ill. 1992)].

4. Applicable law and/or the provisions of the insurance policy may deem the non-settling insureds to be third-party beneficiaries of the insurance contract whose rights under the contract may be amended or rescinded by the settling parties under certain circumstances without the consent of the non-settling third-party beneficiaries.

5. Applicable law may permit the insurer to exhaust its policy to pay one insured's coverage claim without considering the interests of other insureds. Some courts hold that, where an insurer is presented with multiple coverage claims from different insureds under the same insurance policy, "an insurer is free to make a reasonable settlement of the claim before it without considering other possible claims affecting the same policy limits" [Travelers Indem. Co. v. Citgo Petroleum Corp., 166 F.3d 761, 765 (5th Cir. 1999) (collecting cases); *see also* Voccio v. Reliance Ins. Cos., 703 F.2d 1, 3 (1st Cir. 1983) (settling claims on a "first come, first served" basis is not bad faith)]. Other courts hold that "[a]n insurer owes the duty of good faith and fair dealing to each of its insureds, and cannot favor the interests of one insured over the other" [*see* Lehto v. Allstate Ins. Co., 31 Cal. App. 4th 60, 72 (1994); *see also* Smoral v. Hanover Ins. Co., 37 A.D.2d 23 (N.Y. App. Div. 1971) (leading case for this position)].

VIII. FORMS

23.31 Confidentiality Agreement.

Use of Form: This sample confidentiality agreement may be used to protect the confidentiality of information and documents exchanged between the insured and the insurer during settlement negotiations.

This Confidentiality Agreement ("Agreement") is made and entered into this _____ day of _____, by and between _____ [*insert name of insured*] ("Insured") and _____ [*insert name of insurer*] ("Insurer").

WHEREAS, Insured and Insurer (the "Parties") wish to engage in discussions to try to amicably resolve insurance coverage claims under policies issued by Insurer to Insured for _____ [*describe the underlying claims or losses for which coverage is sought*] ("Underlying Claims"); and

WHEREAS, the Parties wish to ensure that the content of said discussions will remain confidential and inadmissible; and

WHEREAS, in the course of settlement discussions, the Parties may disclose to each other documents or other information that are privileged, confidential or otherwise protected from disclosure, which protections the Parties wish to ensure are not waived by virtue of their disclosure to each other in the context of these settlement discussions; and

WHEREAS, the Parties wish to establish various other procedures intended to facilitate settlement discussions;

NOW, THEREFORE, in consideration of the mutual covenants contained herein and intending to be legally bound, Insured and Insurer agree that:

1. The substance and content of all settlement discussions and negotiations will remain confidential between the Parties and will not be discoverable or admissible in any proceeding for any purpose, nor will the content of the settlement discussions or the conduct of either Party in the settlement discussions form the basis for any cause of action against the other Party.

2. The disclosure, in the course of settlement discussions, of non-public documents, communications, or other information ("Confidential Information") is not intended and will not be construed as a waiver of the attorney-client privilege, the work product doctrine or any other applicable privilege or protection.

3. If a Party intends to designate information it is disclosing as Confidential Information, it must do so in a manner reasonably designed to alert the other Party to such intent. With respect to documents or other information disclosed in the course of settlement discussions that any Party designates as Confidential Information, the Parties agree not to disclose such information to any

person or entity except: (i) the Parties' employees, auditors, attorneys and consultants, provided they agree to maintain the confidentiality of the information; (ii) the Parties' reinsurers, provided that they agree to maintain the confidentiality of the information; (iii) by order of court or as otherwise required by law; or (iv) as may be agreed to in writing by the Parties. A Party in receipt of a subpoena or other formal request for disclosure of Confidential Information shall provide written notice to the other Party as soon as possible, and in any event prior to disclosure, so that such other Party can take appropriate steps to protect its interests.

4. Insurer and Insured will use Confidential Information solely for the purpose of analyzing the Underlying Claims and the amicable resolution of insurance coverage for those claims, and not for any litigation or other adverse purpose.

5. Any Party may terminate this Agreement by providing to the other Party written notice of its intent to terminate the Agreement within a time period of not less than 30 days. Said termination, however, shall not affect the confidentiality of any of the settlement discussions or negotiations or any Confidential Information, including any offers and demands and any statements made or positions asserted in the course of settlement discussions, all of which shall remain protected from disclosure and inadmissible for any purpose in coverage litigation.

6. Upon notice of termination of this Agreement by any Party, each Party will, upon request of the disclosing Party, return all Confidential Information disclosed in the course of settlement discussions.

7. Nothing in this Agreement shall be construed as a waiver by either Insured or Insurer of any claims for or defenses to coverage under any policies, and the Parties hereto expressly reserve all rights in this regard.

8. Nothing in this Agreement shall prevent either Party from obtaining in discovery from the other Party any documents that would otherwise be discoverable in the absence of this Agreement.

9. Each person signing this Agreement represents and warrants that he/she is a duly authorized representative of the Party for which the signature is provided and is authorized to enter into this Agreement on behalf of and binding such Party.

[*Insert name of Insured here*]	[*Insert name of Insurer here*]
By: _____	By: _____
Date:_____	Date:_____

23.32 Settlement and Release of Specific Claims.

Use of Form: This sample settlement agreement shown below may be used to document the settlement of specific claims under a single insurance

policy. This particular example assumes that coverage litigation is already pending between the insured and insurer and the insurer's corporate affiliates (as well other non-settling insurers) regarding coverage for a specific category of underlying tort claims, such as toxic tort or product liability claims, under general liability policies issued by the insurer or its corporate affiliates to the insured and the insured's corporate affiliates. This example was chosen to provide illustrations of several types of clauses, such as an indemnification clause, that are discussed in this chapter but which settling parties may decide to omit depending on the terms of their own settlement. At the same time, this example, like most of the forms included in this chapter, was adapted from an actual settlement agreement and therefore may not explicitly address every drafting issue discussed in the text.

This Confidential Settlement Agreement and Mutual Release ("Settlement Agreement") is entered into by and between _____ ("Insured") and _____ ("Insurer") and the entities listed on Attachment B (collectively, the "Insurer Companies").

RECITALS

WHEREAS, certain Insurer Companies issued certain general liability insurance policies (defined herein as the "Subject Insurance Policies") to Insured and certain of its subsidiaries and other related entities;

WHEREAS, certain Insured-Related Entities (as defined herein) have been named as defendants in numerous Underlying Claims (as defined herein) and likely will be named as defendants in future Underlying Claims;

WHEREAS, in connection with Underlying Claims, Insured has made certain requests and demands to certain Insurer Companies for insurance coverage under the Subject Insurance Policies;

WHEREAS, Insured and the Insurer Companies disagree with respect to whether and to what extent the Subject Insurance Policies provide coverage for Underlying Claims (the "Coverage Dispute");

WHEREAS, Insured and certain Insurer Companies are parties to a pending Coverage Action (as defined herein) involving certain disputed claims concerning the application of the Subject Insurance Policies to Underlying Claims;

WHEREAS, Insured and the Insurer Companies, without any admission of liability or the validity of positions or arguments advanced by the other Party, now wish fully and finally to compromise and resolve the Coverage Dispute and the Coverage Action, and to provide for a complete and permanent release, subject to the terms provided herein, of the Insurer Companies' obligations to the Insured-Related Entities for all Underlying Liabilities (as defined herein) under the Subject Insurance Policies;

NOW THEREFORE, in consideration of the mutual promises and covenants made herein and for other good and valuable consideration, the adequacy and

sufficiency of which are acknowledged by the Parties (as defined herein), Insured and the Insurer Companies, intending to be legally bound, agree as follows:

1. DEFINITIONS

The following definitions will apply to the listed terms wherever those terms appear in this Settlement Agreement. Each defined term stated in a singular form shall include the plural form, and each defined term stated in plural form shall include the singular form. The terms "include" and "including" wherever used in this Settlement Agreement shall mean including without limitation.

1.1 "Insured-Related Entities" means Insured, _____ [*list entities currently related to Insured*].

1.2 "Insurer Releasors" means the Insurer Companies, their current subsidiaries and the successors of the foregoing entities.

1.3 "Insurer Releasees" means (1) the Insurer Companies; (2) the past and current corporate parents and subsidiaries of the Insurer Companies (but only in their capacities as parents or subsidiaries of such entities); (3) the predecessors, successors, and assigns of the corporate entities identified in subparts (1) and (2) of this paragraph (but only in their capacities as predecessors, successors or assigns of such entities); and (4) the officers, directors, employees and attorneys of the corporate entities identified in subparts (1), (2) and (3) of this paragraph (but only in their capacities as such)

1.4 "Insured Releasors" means the Insured-Related Entities, their current subsidiaries and the successors of the foregoing entities.

1.5 "Insured Releasees" means (1) the Insured-Related Entities; (2) the past and current corporate parents and subsidiaries of the entities identified in subpart (1) (but only in their capacities as parents or subsidiaries of such entities); (3) the predecessors, successors, and assigns of the corporate entities identified in subparts (1) and (2) of this paragraph (but only in their capacities as predecessors, successors or assigns of such entities); and (4) the officers, directors, employees and attorneys of the corporate entities identified in subparts (1), (2) and (3) of this paragraph (but only in their capacities as such).

1.6 "Parties" means Insured and the Insurer Companies.

1.7 "Party" means either Insured or any of the Insurer Companies.

1.8 "Person" means an individual, a corporation, a partnership, an association, a trust, any other entity or organization and any federal, state or local government or any governmental or quasi-governmental body or political subdivision or any agency, department, board or instrumentality thereof.

1.9 "Claim" means any past, present or future claim, demand, suit, action or liability of any nature whatsoever, whether at law or in equity, known or unknown, anticipated or unanticipated, foreseen or unforeseen, direct or

indirect, fixed or contingent, accrued or unaccrued, which has been or may be asserted by or on behalf of any Person, including any crossclaim, counterclaim, third-party claim, right, suit, lawsuit, administrative proceeding, count, judgment, execution, attachment, debt, lawsuit, arbitration, cause of action or order.

1.10 "Underlying Claim" means any Claims against Insured-Related Entities alleging _____ [*describe the allegations of the Underlying Claims*].

1.11 "Underlying Liabilities" means any costs incurred by an Insured-Related Entity for defense expenses or indemnity payments, whether for settlement or judgment, in connection with an Underlying Claim.

1.12 "Indemnifiable Claim" means any Claim for which Insured has agreed to indemnify and hold the Insurer Releasees harmless as provided in paragraph 7.1 of this Settlement Agreement.

1.13 "Coverage Action" means the pending insurance coverage action captioned _____ [*insert caption of the coverage action, e.g.,* "Insured v. Insurer Companies, Civ. No. 07-0001 (S.D.N.Y.)"].

1.14 "Settlement Amount" means the amount of the payment due from the Insurer Companies as set forth in paragraph 2.1 hereof.

1.15 "Subject Insurance Policies" means (1) the insurance policies listed on Attachment A, and (2) any other general liability policies, whether primary or excess, issued by the Insurer Companies on or before the Effective Date to one or more of the Insured-Related Entities, their current subsidiaries and the successors of the foregoing entities. The term Subject Insurance Policies does not include (i) any insurance policies not listed on Attachment A that were issued by any Person that first has a corporate affiliation with the Insurer Companies after the Effective Date; (ii) insurance policies not listed on Attachment A issued to any Person that first has a corporate affiliation with Insured after the Effective Date; or (iii) any directors and officers policies, errors and omissions policies, or workers compensation policies.

1.16 "Effective Date" means the earliest date as of which all Parties have affixed their signatures to the signature pages of this Settlement Agreement, and this Settlement Agreement shall be effective as of such date.

2. PAYMENT OF SETTLEMENT AMOUNT

2.1 On or before ten (10) business days after the Effective Date, the Insurer Companies shall pay to Insured the amount of _____ Dollars ($ _____) (the "Settlement Amount"). Such payment shall be made by wire transfer to the following account:

[*Provide wire transfer instructions here.*]

2.2 The Parties agree that the Settlement Amount is fair and reasonable consideration for the releases and other consideration provided pursuant to this Settlement Agreement.

3. MUTUAL RELEASES

3.1 Upon actual receipt of the full payment of the Settlement Amount, Insured on behalf of itself — and, to the fullest extent of its authority to do so, on behalf of all other Insured-Related Entities — shall release and forever discharge the Insurer Releasees from: (1) any Claim for coverage for any past, present and future, known and unknown, Underlying Liabilities under the Subject Insurance Policies; and (2) any Claim for bad faith, unfair claim handling, refusal to defend or settle or any other alleged breach of a duty related to handling of Underlying Liabilities under the Subject Insurance Policies committed or allegedly committed prior to the Effective Date; provided, however, that nothing in this Settlement Agreement shall be construed to release any rights of (i) entities other than Insured-Related Entities; or (ii) the Insured-Related Entities relating to (a) any policies other than the Subject Insurance Policies; or (b) any Claims other than those specified in subparts (1) and (2) of this paragraph 3.1. The Claims released under this paragraph 3.1 are referred to herein as "Released Claims."

3.2 Effective simultaneously with the release in paragraph 3.1 hereof, the Insurer Companies on behalf of themselves — and, to the fullest extent of their authority, on behalf of all other Insurer Releasors — shall release and forever discharge the Insured Releasees from any and all Claims, causes of action, liabilities, obligations and demands of every kind and nature, known and unknown, past, present and future, arising out of or in any way related to: (1) any alleged debts or breaches of obligations (including the payment of deductibles, retentions, retrospective or other premium obligations) or any other Claim related to Underlying Liabilities under the Subject Insurance Policies; and (2) any Claim for reverse, contributory or comparative bad faith, unfair claim handling, refusal to defend or settle, or any other alleged breach of a duty related to Underlying Liabilities under the Subject Insurance Policies committed or allegedly committed prior to the Effective Date.

3.3 Notwithstanding anything in this paragraph 3 or elsewhere in this Settlement Agreement, it is expressly understood and agreed that the releases set forth in this paragraph 3 shall not apply to (a) any Claim that any of the Insurer Companies might have against another Person based upon a contract and/or agreement of reinsurance; or (b) any Claim that either Party might have against the other for breach of this Settlement Agreement.

3.4 The Parties assume the risk that acts, omissions, matters, causes or things may have occurred that they do not know or do not suspect to exist. The Parties expressly waive any and all rights they may have under any statute, code, regulation, ordinance or the common law, which may limit or restrict the effect of a general release as to Claims, including Claims that the Parties do not know or suspect to exist in their favor at the time of this release. Specifically, the Parties acknowledge that they have been advised by their attorneys concerning, and are familiar with, California Civil Code Section 1542, and they expressly waive any and all rights under California Civil Code Section 1542

and under any other federal or state statute of similar effect.

3.5 Notwithstanding anything in this paragraph 3 or elsewhere in this Settlement Agreement, the release set forth in paragraph 3.1 shall not apply to any entity or Person for which Insured does not have authority to settle, or for which Insured cannot settle without violating a duty owed to such entity or Person.

4. DISMISSAL FROM COVERAGE ACTION

4.1 Within five (5) business days after actual receipt of full payment of the Settlement Amount, Insured will move to dismiss its Claims against the Insurer Companies in the Coverage Action and with each Party to bear its own costs and attorney's fees. Further, the Parties will discuss and agree on an appropriate time and manner in which to seek the Insurer Companies' complete dismissal from the Coverage Action, including seeking stipulations of dismissal from all appropriate parties to such action, and the Parties will work cooperatively, with Insured devoting reasonable best efforts, to achieve such complete dismissal. Each Party shall bear its own costs and attorney's fees incurred prior to the Effective Date in connection with the Coverage Action and any costs and fees related to obtaining a complete dismissal from the Coverage Action.

5. THIRD-PARTY MATTERS

5.1 The Insurer Companies on their own behalf — and, to the fullest extent of their authority to do so, on behalf of all other Insurer Releasees — agree not to pursue any rights of contribution, indemnity, subrogation and/or apportionment that they may have against any other Person (including other Insurers of the Insured-Related Entities) relating to the Released Claims. The Insurer Companies represent that neither they nor any other Insurer Releasee has assigned, transferred, conveyed, sold or otherwise disposed of any such rights to any other Person, nor in any other way impaired the full benefit of the payment made under this Settlement Agreement, and further agree for themselves and the other Insurer Releasees not to purport to do so in the future.

5.2 Nothing in this Settlement Agreement shall affect any Claims or rights that the Insurer Companies may have with respect to their reinsurers (in their capacity as reinsurers), pursuant to reinsurance agreements, contracts, treaties or other reinsurance relationships.

5.3 Insured agrees that, whenever it shall seek to settle its insurance claims with any other Insurer with regard to Underlying Liabilities, Insured shall use its best efforts to obtain from such Insurers a non-contribution provision similar to that in paragraph 5.1 for the benefit of Insurer Releasees.

6. REDUCTION IN JUDGMENT

6.1 If any insurer of Insured asserts a Claim against one or more Insurer Releasees arising in connection with the Underlying Liabilities released under

this Settlement Agreement, Insured and the Insurer Releasees will take the position that, subject to paragraphs 3.1 and 3.5 above, the Subject Insurance Policies have no further payment obligations whatsoever.

6.2 If Insured obtains a judgment against any other insurer pertaining to the Underlying Liabilities released under this Settlement Agreement, and that insurer obtains a judgment against any Insurer Releasees for all or a part of the judgment obtained by Insured, Insured will reduce the amount of any unsatisfied judgment that it obtains from such other insurer by the amount of such insurer's judgment against the Insurer Releasee in question; provided, however, that the total amount of such reduction shall not exceed the Settlement Amount and shall count toward the exhaustion of the Indemnity Limit in paragraph 7.1.d below.

7. INDEMNIFICATION/HOLD HARMLESS

7.1 a. Subject to all of the terms and conditions set forth in this paragraph 7.1, and effective only upon actual receipt by Insured of full payment of the Settlement Amount, Insured ("Indemnitor") agrees to defend, indemnify and hold the Insurer Releasees harmless against (i) Claims against the Insurer Releasees that arise under the Subject Insurance Policies and arise solely from the Released Claims; and (ii) Claims against the Insurer Releasees that arise under the Subject Insurance Policies by insurers of the Insured-Related Entities (in their capacity as insurers of the Insured-Related Entities) seeking apportionment, indemnity or contribution for Underlying Liabilities covered or allegedly covered under such insurers' policies and also covered or allegedly covered under the Subject Insurance Policies (collectively the "Indemnifiable Claims").

b. (i) As conditions precedent to any defense, indemnification or hold harmless obligations under subparagraph 7.1.a. hereof, the Insurer Releasees shall promptly notify Indemnitor of any Claim for which the Insurer Releasees are seeking to be defended, indemnified or otherwise held harmless, shall promptly provide all relevant information that Indemnitor may reasonably request, shall promptly comply with all reasonable requests for cooperation, and shall not settle such Claim without Indemnitor's prior written consent (not to be unreasonably withheld). Subject to such conditions, Indemnitor — at its sole discretion — may seek to substitute itself for the Insurer Releasees as defendant to any Indemnifiable Claims. If Indemnitor chooses not to substitute itself as defendant, it shall defend any Indemnifiable Claims (including payment of all reasonable attorney's fees, costs, reasonable expenses of expert witnesses and other reasonable expenses incurred in the investigation, defense, trial and appeal (if any)) on behalf of the Insurer Releasees, with counsel of Indemnitor's choice. Unless there is an unwaivable conflict, such counsel may be counsel currently representing Indemnitor in the Coverage Action ("Current Coverage Counsel"), and if so, the Insurer Releasees shall waive all waivable conflicts. Indemnitor's choice of counsel shall be subject to the Insurer Companies' consent, which consent may not be

unreasonably withheld, except that Indemnitor shall not be required to obtain the Insurer Companies' consent if it chooses its Current Coverage Counsel. The Insurer Releasees shall have the right, at their own expense, to participate in the defense of an Indemnifiable Claim and shall have the right, at their own expense, to retain their own counsel. Indemnitor shall keep the Insurer Releasees advised of all significant developments in the defense of an Indemnifiable Claim.

(ii) With regard to an Indemnifiable Claim for which Indemnitor or its counsel are providing the defense on behalf of the Insurer Releasees, all pleadings shall contain a disclaimer indicating that Indemnitor is defending as indemnitor, using language substantially similar to the following:

> "Pursuant to and subject to the terms and limitations of a settlement agreement, Insured has agreed to defend and indemnify the Insurer Companies in this proceeding. Accordingly, although Insured is authorized to defend the Insurer Companies and to resolve this litigation as Insured deems appropriate, the Insurer Companies take no position with respect to the Subject Insurance Policies. All statements and positions are solely those of Insured and shall not constitute any representation or admission by the Insurer Companies."

Indemnitor and the Insurer Releasees shall cooperate in the investigation, defense and settlement of the Claim.

(iii) Indemnitor may settle or compromise an Indemnifiable Claim, but if all or a portion of such settlement or compromise shall exceed the Indemnity Limit in paragraph 7.1.d, then such compromise shall be subject to the Insurer Companies' consent, which consent shall not be unreasonably withheld. Such consent shall be deemed to be given if not expressly refused within five business days of its request.

c. The Insurer Releasees may elect to forego any defense provided by Indemnitor pursuant to this paragraph 7 and conduct their own defense of an Indemnifiable Claim, with counsel of the Insurer Releasees' own choice. If the Insurer Releasees so elect, Indemnitor shall have no obligation to defend, indemnify or hold them harmless or to reimburse any attorney's fees or other legal expenses that the Insurer Releasees incur.

d. Notwithstanding anything in this paragraph 7 or elsewhere in this Settlement Agreement, the maximum amount that Indemnitor is obligated to pay to defend, indemnify or hold the Insurer Releasees harmless (the "Indemnity Limit") is the total Settlement Amount. Once Indemnitor has expended an amount equal to the Indemnity Limit, whether in defense or indemnity or both, the Indemnity Limit shall be deemed to be exhausted and all defense and indemnification obligations of Indemnitor and the counsel it has selected to represent the Insurer Releasees shall cease under this Settlement Agreement.

e. Furthermore, notwithstanding any statement or implication to the contrary in this Settlement Agreement, Indemnitor shall have no defense, indem-

nity, or other obligation to hold the Insurer Releasees harmless with respect to: (1) any defense costs incurred by the Insurer Releasees in conducting their own defense pursuant to subparagraph 7.1.c. or in retaining their own counsel pursuant to subparagraph 7.1.b.; (2) any Claim brought by the Insured-Related Entities against the Insurer Releasees for breach of this Settlement Agreement; (3) any Claims or allegations between the Insurer Releasees and one or more of their reinsurers; (4) any Claims against the Insurer Releasees in their capacity as reinsurers; (5) any Claims brought by one Insurer Releasee against another Insurer Releasee; (6) the salaries of any employee of any Insurer Releasee, including any temporary employee, staff counsel, administrative or paralegal personnel, and any overhead charges or other similar costs or disbursements incurred by the any Insurer Releasee; (7) any payments made or agreed to be made by the Insurer Companies regarding the Subject Insurance Policies prior to the Effective Date; (8) any Claims made against the Insurer Releasees regarding the Subject Insurance Policies prior to the Effective Date other than Claims in the Coverage Action; or (9) any Claims asserting bad faith on the part of the Insurer Releasees and/or seeking fines, penalties, punitive or exemplary damages or sanctions.

f. Nothing in this Settlement Agreement shall be construed to impose on Insured-Related Entities any obligations or attributes of an Insurer (as opposed to an indemnitor), nor any obligation to defend, indemnify or hold the Insurer Releasees harmless from any Claim or allegation other than an Indemnifiable Claim.

8. DISPUTE RESOLUTION

8.1 The Parties agree that they will attempt to resolve any dispute arising from this Settlement Agreement through good faith negotiations for a period of sixty (60) days after written notification regarding such dispute. Thereafter, if the dispute remains unresolved, the Parties agree to submit the dispute to mediation pursuant to the Commercial Mediation Procedures of the American Arbitration Association ("AAA") with the administrative costs to be borne equally by each Party. To the extent the Parties cannot agree on a mediator, they will permit the executive officer of the AAA to select one. The Parties further agree that the mediation will take place within sixty (60) days after selection of a mediator, subject to the mediator's availability, with each Party to bear its respective cost. Thereafter, if the dispute remains unresolved, the Parties agree to submit the dispute to binding arbitration administered by the AAA under its Commercial Arbitration Rules in effect as of the Effective Date. Unless the Parties agree otherwise, mediation and/or arbitration shall take place in _____ [*insert location for the mediation and/or arbitration*].

8.2 Notwithstanding any other provision in this Agreement, the Parties may immediately seek to resolve any dispute regarding the payment obligation set forth in paragraph 2.1 through litigation.

9. CONFIDENTIALITY

9.1 Any Party may disclose the fact (as opposed to the amount or terms) of this Settlement Agreement to third parties. Except as otherwise provided herein, the amount and terms of this Settlement Agreement and all matters relating to the Settlement Agreement's negotiation and implementation shall be confidential and are not to be disclosed except by order of court or agreement, in writing, of the Parties. The Parties may disclose such aforementioned confidential information and this Settlement Agreement to (i) any person who is an officer, director, employee, attorney, or agent of a Party; (ii) the Parties' accountants, auditors, lenders, rating agencies, or attorneys, or the Insurer Companies' reinsurers or reinsurance intermediaries (solely in their role as reinsurers); (iii) any other Person as required by operation of law or lawful subpoena or order of court; (iv) any state regulator, governmental agency or securities exchange in connection with any reporting, disclosure, or other regulatory requirements; (v) in any proceeding to enforce the terms of this Settlement Agreement, subject to an appropriate form of confidentiality order; and (vi) any Person with the written consent of the other Party. Disclosures under subparagraphs (i), (ii), and (vi) above shall be made subject to the same or similar confidentiality obligations as apply to the Parties set forth herein. This Settlement Agreement has been executed in reliance upon the provisions of Rule 408 of the Federal Rules of Evidence, and of all cognate state rules, which preclude the introduction of evidence regarding settlement negotiations or agreements.

10. REPRESENTATIONS AND WARRANTIES

10.1 Each Party hereby represents and warrants that it is fully authorized to enter into this Settlement Agreement and that it has taken all necessary corporate and internal legal actions to duly approve the making and performance of this Settlement Agreement, and that no further internal approval is necessary, and that the making and performance of this Settlement Agreement will not violate any provision of its Articles of Incorporation, Charter and/or By-laws.

10.2 Insured represents and warrants that it has full authority to enter this Settlement Agreement on behalf of itself, its current subsidiaries and the successors of the foregoing entities.

10.3 Insurer represents and warrants that it has full authority to enter this Settlement Agreement on behalf of itself, its current subsidiaries and the successors of the foregoing entities.

10.4 Each of the Companies listed in Attachment B represents and warrants that it has full authority to enter this Settlement Agreement on behalf of (1) itself, (2) its current subsidiaries, and (3) the successors of the entities identified in subparts (1) and (2) of this paragraph.

10.5 The Insurer Companies represent and warrant that they have conducted a diligent search of their reasonably available records for general

liability policies coming within the definition of Subject Insurance Policies, and that, as of the Effective Date, they are aware of no such policies other than those listed on Attachment A.

10.6 The Insurer Companies represent and warrant that, as of the Effective Date, they are not aware of any Claims that would fall within the scope of the defense, indemnity or hold-harmless obligations set forth in paragraph 7.1 above, except for cross-claims that have been asserted against the Insurer Companies in the Coverage Action.

11. NOTICES

11.1 All notices or other communications that any Party desires or is required to give to the other Party hereunder shall be delivered in writing to the following contact persons at the following addresses, or to such other individual(s) and/or address(es) as a Party may designate in writing from time to time upon reasonable notice to the other Party:

[*Provide contact information for Insured and Insurer.*]

12. GENERAL TERMS AND CONDITIONS

12.1 This Settlement Agreement constitutes a compromise of all Claims, obligations, rights and demands arising out of or in any way related to Underlying Liabilities under the Subject Insurance Policies. By entering into this Settlement Agreement, no Party acquiesces in any contention made by any other Party relating to any Claim or the applicability of insurance coverage for any Claim, including any assertions made by either Party in any dispute, including the Coverage Action or in the presentation or response to any other Claim. This Settlement Agreement is not intended to be, nor shall it be construed as, an admission with respect to policy application or interpretation, nor as an admission by any Party regarding any duties, rights or obligations under the Subject Insurance Policies. Except as otherwise provided herein, each Party expressly reserves all its respective rights, remedies, defenses and Claims with respect to all other insurers and with respect to the Coverage Action and any other coverage dispute to which it is or may be a party.

12.2 Attorneys representing Insured and the Insurer Companies have participated in the drafting of this Settlement Agreement and, accordingly, any claimed ambiguity herein shall not be presumptively resolved either in favor of or against any Party hereto.

12.3 This Settlement Agreement is intended to confer rights and benefits only upon, and shall inure only to the benefit of, Insured Releasees and Insurer Releasees. This Settlement Agreement shall not be deemed to confer any rights on any third party, including any rights based upon a claim of collateral estoppel or res judicata. The Parties agree that no third parties shall be beneficiaries of this Settlement Agreement.

12.4 This Settlement Agreement constitutes the complete and entire agreement of the Parties and may not be modified, contradicted, added to or altered

in any way by previous written or oral agreements, nor by any contemporaneous or subsequent oral agreements. No amendments, modifications or variations of the terms of this Settlement Agreement shall be valid unless made in writing and signed by the Parties. This Settlement Agreement supersedes and nullifies the Term Sheet previously entered into by the Parties.

12.5 In connection with Insured's prosecution of the Coverage Action, the Insurer Companies shall make reasonably available to Insured witnesses, documents, and information relevant to issues that may arise in the Coverage Action regarding the terms and conditions of the Subject Insurance Policies. Insured shall reimburse the Insurer Companies for their reasonable costs in connection with making such witnesses, documents, and information available to Insured.

12.6 The Parties to this Settlement Agreement each reserve to themselves the right to allocate the Settlement Amount to any policy or policies they deem appropriate; provided, however, that any such allocation by either Party shall in no way be construed as an acknowledgement by the other Party that it concurs with the appropriateness or reasonableness of such allocation.

12.7 Except as expressly agreed by the Parties, all equitable and legal remedies, whether sounding in contract or otherwise, shall be available against any Party that fails to comply with any of its obligations under this Settlement Agreement.

12.8 This Settlement Agreement shall be interpreted and construed in accordance with the laws of _____ [*insert jurisdiction whose law shall govern the Settlement Agreement*] without regard to principles of conflict of laws. Notwithstanding the foregoing, the Parties explicitly reserve their respective rights as to what law applies to the Subject Insurance Policies or to the interpretation of the terms and conditions of the Subject Insurance Polices or any other insurance policies, and acknowledge that this Settlement Agreement shall have no effect on, and would not serve as precedent with respect to, any dispute concerning which law(s) applies to any insurance policies, including any insurance policies at issue in the Coverage Action.

12.9 The Parties agree that this Settlement Agreement may be executed in multiple counterparts, each of which, when so executed and delivered, shall be an original, but such counterparts shall together constitute one and the same instrument and agreement. Each counterpart may be delivered by facsimile transmission or by e-mailing a scanned version, and a faxed or scanned signature page shall have the same force and effect as an original signature.

[*Insert name of Insured here*]
By: _____
Date:_____

[*Insert name of Insurer here*]
By: _____
Date:_____
[*Insert signature blocks for other Insurer Companies here*]

ATTACHMENTS

Attachment A: List of Identified Subject Insurance Policies

Attachment B: List of Insurer Companies

23.33 Policy Buy-Back Agreement.

Use of Form: This sample policy buy-back agreement may be used where the settling insurer wants a complete release from all present or future liability to the insured under one or more insurance policies. This particular example assumes that coverage litigation is already pending between the insured and insurer regarding one category of underlying tort claims under the insurer's general liability policies but that the insurer and insured have agreed that their settlement will apply more broadly to any underlying claim that might be covered under those policies.

This settlement agreement, policy buy-back and release ("Agreement") is entered into by and between _____ ("Insured") and _____ ("Insurer"). The above parties are sometimes collectively referred to herein as the "Parties," and individually as "Party."

WHEREAS, Insurer issued to Insured the various insurance policies listed on Attachment A hereto (collectively the "Insurer Policies"), which Attachment A is incorporated in this Agreement as an integral part of its terms.

WHEREAS, the Insurer Policies provide for insurance coverage to the Insured Entities; as used herein, the "Insured Entities" means Insured and its current subsidiaries, and the successors and assigns of the foregoing entities (solely in their capacities as successors and assigns of the foregoing entities).

WHEREAS, certain Claims have been asserted against one or more Insured Entities and additional such claims may be asserted in the future. As used herein, "Claims," except as otherwise noted or excepted herein, means any and all past, present and future claims, demands, actions, causes of action, suits, proceedings, counterclaims, third party claims, or cross-claims, of any type or nature whatsoever, including claims or demands for or relating to liabilities, losses, obligations, adjustments, executions, offsets, costs, defenses, debts, sums of money, accounts, rights, notices, arbitrations, orders, reckonings, bond, bills, covenants, contracts, controversies, agreements, promises, damages, expenses (including court costs and attorney's fees), judgments, decrees, or declarations, and including any claims or demands for bad faith or extracontractual damages, all whether known or unknown, claimed or suspected, anticipated or unanticipated, accrued or unaccrued, fixed or contingent, asserted or unasserted, by or on behalf of any person or entity, direct or indirect, whether grounded in law or in equity, in contract or in tort, by statute or common law, or otherwise, and whether obtained by subrogation, assignment or otherwise (including without limitation claims or demands for or relating to actual, potential, or alleged property damage or bodily injury).

WHEREAS, Insured filed an insurance coverage action against Insurer and other insurance carriers regarding certain Claims, captioned _____ [*identify the coverage litigation*] (the "Coverage Action").

WHEREAS, it is now the desire of the Parties, fully and finally, to settle and resolve all claims, disputes and differences that exist or may exist between them with respect to the Coverage Action and all Claims arising under the Insurer Policies. By this Agreement, the Parties intend to effect by way of compromise and accord, as a business decision, a monetary settlement without addressing the merits of the respective positions of the Parties.

NOW THEREFORE, in consideration of the mutual promises and covenants made herein, and for other good and valuable consideration, the Parties agree as follows:

1. Settlement Payment.

(a) Within thirty (30) calendar days from the effective date of this Agreement (the "Payment Due Date"), in consideration of the mutual covenants stated in this Agreement, Insurer shall irrevocably pay to Insured the total Settlement Amount of _____ U.S. dollars (U.S. $ _____) (hereinafter the "Payment").

(b) The Payment shall be made by a single check payable to _____ [*name of payee*] and delivered to the Insured contact identified in Paragraph 8 hereof in time to be received by Insured by the Payment Due Date.

(c) If all or any portion of the Settlement Amount is not received by Insured by the Payment Due Date, interest thereon shall accrue from such due date at the then current prime rate published by the Wall Street Journal, plus _____ percent [*specify the interest rate for late payments*], compounded daily ("Late Fees").

(d) In addition to any Late Fees, Insurer agrees to indemnify Insured for its reasonable legal fees and expenses (including, without limitation, attorney's fees) if the following conditions are met: (i) Insurer fails to pay to Insured the entire Settlement Amount by the Payment Due Date, (ii) Insured files a lawsuit or other proceeding against Insurer seeking payment of such unpaid Settlement Amount (or portion thereof), and (iii) as a result of such lawsuit or proceeding, Insurer is ordered to pay the Settlement Amount (or any portion thereof) to Insured.

2. Release by Insured Entities.

Effective only upon actual receipt of full payment of the Settlement Amount provided in Paragraph 1 herein, including clearance of the Payment, and in consideration of the mutual promises herein, Insured, on behalf of itself and, to the extent it has the authority to do so without violating a duty owed to another, on behalf of all other Insured Entities, shall completely release and

forever discharge Insurer and its parents, subsidiaries, affiliates, managers, and/or managing agents from: (i) each and every Claim under the Insurer Policies asserted by the Insured Entities in the Coverage Action; (ii) any Claim under the Insurer Policies that the Insured Entities might otherwise assert or have against Insurer; and (iii) any Claim for compensatory, punitive, statutory or other damages of whatever kind or nature based upon any allegations of bad faith, unfair claim practice, unfair trade practice, refusal to defend or settle, or any other alleged breach of a duty arising under the Insurer Policies. The Claims released under parts (ii) and (iii) of this paragraph shall include such Claims whether known or unknown, asserted or unasserted, and whether at law or in equity. To the full extent of their authority, it is the intention of the Insured, on behalf of itself and, to the extent it has the authority to do so, on behalf of the Insured Entities, to reserve no rights or benefits whatsoever in respect of Claims, either past, present or future, that would fall within the Insurer Policies, to transfer all Claims under the Insurer Policies back to Insurer, and deem such policies terminated, and to assure Insurer its peace and freedom from all such Claims under the Insurer Policies. Provided, however, that nothing in this Agreement shall release any Claims: (x) against any insurer other than Insurer; or (y) arising under or in any way relating to any policies other than the Insurer Policies.

3. Release by Insurer.

Upon making the Payment provided in Paragraph 1 herein, and in consideration of the mutual promises herein, Insurer, on behalf of itself and, to the extent it has the authority to do so, on behalf of all of its parents, subsidiaries, affiliates, managers, and/or managing agents, shall release and forever discharge the Insured Entities, their respective corporate parents, subsidiaries, officers, directors, employees, predecessors, successors, and assigns, and all other persons, firms or entities that might be claimed to have obligations of insureds under the Insurer Policies, from: (a) each and every Claim asserted by Insurer in the Coverage Action; (b) any Claim for debts or breach of obligations (including without limitation the payment of deductibles, dividend reimbursements, service fees, or retrospective or other premiums) arising under the Insurer Policies; and (c) any Claim for reverse, contributory or comparative bad faith, unfair claim handling, unfair trade practice, refusal to defend or settle, or any other alleged breach of a duty that relates to Claims arising under the Insurer Policies. Provided, however, that nothing in this Agreement shall release any Claims: (x) against any insured other than the Insured Entities; or (y) arising under or in any way relating to policies other than the Insurer Policies.

4. Unknown Claims.

(a) The Parties hereby acknowledge that they may have sustained or acquired against each other Claims of a presently unknown and unforeseen nature which arise from or relate to the matters released in this Agreement. Nevertheless, in making and executing this Agreement, the Parties to this

Agreement are aware of the existence of Section 1542 of the California Civil Code, which provides as follows:

> "A general release does not extend to claims which the creditor does not know or suspect to exist in his or her favor at the time of executing the release, which if known by him or her must have materially affected his or her settlement with the debtor."

(b) The Parties to this Agreement hereby waive the applicability of Section 1542 to the releases contained herein. The Parties hereto similarly waive with respect to the releases contained herein any and all rights and benefits conferred by any statute, regulation, or principle or common law or civil law of the United States, of any state, commonwealth, territory or other jurisdiction thereof, or of any foreign country or other foreign jurisdiction, or jurisdiction which is similar, comparable, or equivalent to Section 1542 of the California Civil Code. This Release is a full and complete release of the matters released herein, regardless of whether those matters are presently known, unknown, foreseen or unforeseen.

5. Dismissal of Coverage Action.

The Parties, by and through their counsel, agree to execute and file a stipulated "Order of Dismissal" from the Coverage Action as to Insurer, without costs, within 30 days after Insured receives the Payment in full.

6. Defense and Indemnification.

This agreement does not create or impose any defense, indemnification or hold harmless obligation on any Party.

7. Agreement Not to Assert Contribution Rights.

Insurer agrees not to assert any rights of contribution, indemnity, subrogation and/or apportionment that it may have against any person or entity (including without limitation other insurers of the Insured Entities) relating to the Claims released in Paragraph 2 of this Agreement, unless such person or entity first initiates a Claim for similar relief from Insurer. Insurer represents and warrants that it has not assigned, transferred, conveyed, sold or otherwise disposed of any such rights to any other person or entity, nor in any other way impaired the full benefit of the payments made under this Agreement, and it further agrees not to purport to do so in the future. Insured in turn agrees to use its best efforts to obtain an agreement substantially similar to that provided in this paragraph from each insurer with which it may settle in the Coverage Action. Nothing in this section restricts Insurer's right to pursue reinsurance recoveries from its reinsurers.

8. Notices.

All notices or other communications that any Party desires or is required to give to the other Party hereunder, including notice of any payments made hereunder, shall be delivered in writing to the following contact persons at the following addresses, or to such other individual(s) and/or address(es) as a

Party may designate in writing from time to time upon reasonable notice to the other Party:

[*Provide contact information for Insured and Insurer.*]

9. Non-Prejudice and Construction of Agreement.

(a) This Agreement is intended to be and is a commercial accommodation between the Parties hereto and shall not be construed as an admission of coverage under the Insurer Policies or any other policies subscribed to or issued by Insurer, or as an admission by any Party regarding any duties, rights or obligations under the Insurer Policies. Each Party expressly reserves all its respective rights, remedies, defenses, and Claims with respect to all other insurers, and with respect to the Coverage Action any other coverage dispute to which it is or may be a party.

(b) This Agreement constitutes the complete and entire agreement between the Parties with respect to the subject matter hereof, supersedes any prior communications regarding the matters contained herein, and may not be modified, contradicted, added to or altered in any way by previous written or oral agreements or by contemporaneous or subsequent oral agreements. This Agreement is the product of informed negotiations and involves compromises of previously stated legal positions. This Agreement has been reviewed by counsel for the signatories hereto, and shall not presumptively be construed in favor of or against any Party, each Party expressly waiving the doctrine of contra proferentem, and, it is the intent of the Parties that no part of this Agreement be presumptively construed against or in favor of any of the Parties because of the drafter's identity or the fact that Insurer is an insurance company. This Agreement has no implications for the Parties' views as to their rights and obligations with respect to matters or persons outside the scope of this Agreement.

(c) This Agreement is not a policy of insurance and the signatories do not intend same to be interpreted as such. This Agreement shall be interpreted and construed in accordance with the internal law of _____ [*specify the jurisdiction whose law will govern the Agreement*] in effect as of the effective date of this Agreement.

(d) The Parties hereto agree that evidence of the existence, terms or negotiation of this Agreement shall not be admissible in any suit, action or other proceeding, except as shall be necessary to enforce the terms of this Agreement. This Agreement has been executed in reliance upon the provisions of Rule 408 of the Federal Rules of Evidence, and of all cognate state rules, which preclude the introduction of evidence regarding settlement negotiations or agreements.

(e) Nothing in this Agreement shall be deemed to alter, modify or delete any of the terms or conditions of the Insurer Policy.

10. No Modification.

No amendment, change or modification of this Agreement shall be valid unless it is contained in writing and signed by the Parties hereto.

11. Confidentiality.

This Agreement and all matters relating to the terms and negotiations of this Agreement shall be confidential and are not to be disclosed to any person or entity other than Insurer and the Insured Entities without the prior written consent (not to be unreasonably withheld) of the affected Party, except by order of court, and except that it may be disclosed to: (i) attorneys representing any of the Parties; (ii) the Parties' respective auditors or accountants with appropriate assurances of confidentiality; and (iii) reinsurers, reinsurance intermediaries and retrocessionaries of Insurer, provided that Insurer notifies these parties, prior to disclosure, that the Agreement is confidential and should be treated accordingly. In addition, any Party may make such disclosure as is required to the Internal Revenue Service or the Securities and Exchange Commission or other governmental authority that properly requires disclosure by a Party hereto. In the event either Party to this Agreement is served with a valid subpoena or court order, the Party served shall immediate notify the other Party to this Agreement, to allow such Party to intervene or otherwise oppose the subpoena or court order prior to the disclosure of this Agreement. If a court or other authority orders a Party to disclose the terms of this Agreement to any other person or entity, that Party shall use its best efforts to maintain those terms under seal and/or protective order. Provided, however, that the fact that the Parties have reached this Agreement shall not be deemed confidential; and if a Party determines on the basis of advice from its outside auditor, accountant or corporate counsel that public disclosure of the Settlement Amount is required by law or regulation, such disclosure may be made.

12. Beneficiaries of the Agreement.

This Agreement is intended to confer rights and benefits only on, and shall inure only to the benefit of, the Insured Entities and Insurer, and their respective successors and assigns, and is not intended to confer any right or benefit upon any other person or entity, including any rights based upon a Claim of collateral estoppel or res judicata. No other person or entity shall have any legally enforceable right under this Agreement. All rights of action for any breach of this Agreement are hereby reserved to the Insured Entities and Insurer.

13. Warranties.

Each Party represents and warrants:

(a) That it is fully authorized to enter into this Agreement and to receive or pay the sums specified in it;

(b) That, to the extent required, it has taken all necessary corporate, regulatory and internal legal actions to duly approve the making and

performance of this Agreement; and that no further corporate, regulatory or other approval is necessary;

(c) That the making and performance of this Agreement will not violate any provision of law or of its Articles of Incorporation, Charter and/or Bylaws;

(d) That it has read this Agreement and knows the contents hereof, that the terms hereof are contractual and not by way of recital, and that it has signed this Agreement of its own free act; and

(e) That in making this Agreement, it has obtained the advice of legal counsel.

14. No Other Known Policies.

Each Party has undertaken a thorough and diligent search for all policies or secondary evidence of policies issued by Insurer to the Insured Entities and, after such search, each Party represents and warrants that the policies listed in Attachment A hereto are the only general liability policies known by it to have been issued by Insurer to the Insured Entities.

15. Enforcement of the Agreement.

Except as expressly agreed by the Parties, all equitable and legal remedies, whether sounding in contract or otherwise (including but not limited to the specific remedies provided in this Agreement), shall be available against any Party that fails to comply with any of its obligations under this Agreement. The parties agree that the _____ [*specify forum for enforcement actions*] will have jurisdiction to enforce this Settlement Agreement.

16. Execution in Counterparts.

This Agreement may be executed in multiple counterparts, which together shall constitute the original or originals.

17. Effective Date.

The effective date of this Agreement shall be the date of the last signature hereon.

[*Insert name of Insured here*]	[*Insert name of Insurer here*]
By: _____	By: _____
Date:_____	Date:_____

ATTACHMENT

Attachment A: List of Insurer Policies

23.34 Coverage-in-Place Agreement.

Use of Form: This form illustrates a simple type of coverage-in-place agreement that essentially provides a mechanism for the insured to submit a certain type of underlying tort claim to the insurer for expeditious payment of a specified percentage of each claim. This particular example

assumes that the insured is subject to a series of underlying tort claims arising from exposure to allegedly injurious conditions, such as toxic tort claims arising from exposure to the insured's product, for which the insured is claiming coverage under general liability policies issued by the insurer. More complicated examples of coverage-in-place agreements are possible; for example, the agreement may limit the coverage defenses that the insurer may assert to avoid payment of submitted claims, may include annual caps on the total amount that the insurer is obligated to pay under the agreement, and/or may supplant the insurance policies entirely, so that the agreement defines the exclusive basis under which the underlying claims will be indemnified by the insurer.

Insured (as defined below) and Insurer (as defined below) (referred to herein collectively as the "Parties" or individually as a "Party") hereby enter into the following Coverage-in-Place Agreement (this "Agreement").

RECITALS

WHEREAS, Insurer issued to Insured certain insurance policies (hereinafter defined as the "Insurer Policies"); and

WHEREAS, Insured is alleged to be liable for Underlying Claims (as defined below) involving _____ [*describe subject matter of underlying claims*] that have been and may continue to be asserted against Insured and against persons whom Insured has a duty to defend or indemnify against such Underlying Claims; and

WHEREAS, a dispute has arisen between Insured and Insurer concerning the application of the Insurer Policies to Underlying Claims; and

WHEREAS, by this Agreement, Insured and Insurer wish to resolve certain disputes between them regarding the application of the Insurer Policies to such Underlying Claims as provided in this Agreement;

NOW, THEREFORE, in consideration of the mutual promises contained herein, and intending to be legally bound hereby, Insured and Insurer agree as follows:

I. DEFINITIONS

The definitions contained herein shall apply only to this Agreement and shall not apply to any other agreement, including, but not limited to, any policy of insurance or other settlement agreement, nor shall they be used, except with respect to this Agreement, as evidence of the meaning of any term. Furthermore, each defined term stated in a singular form shall include the plural form, and each defined term stated in a plural form shall include the singular form.

1.1 Insurer. "Insurer" shall mean _____ [*insert name of Insurer here*], and its current parents, subsidiaries, successors and assigns.

1.2 Insured. "Insured" shall mean _____ [*insert name of*

Insured here] and its current parents, subsidiaries, successors and assigns.

1.3 Parties. "Parties" means Insurer and Insured. The term "Party" shall mean either Insurer or Insured.

1.4 Agreed Amount. "Agreed Amount" shall have the meaning given in Section 2.

1.5 Effective Date. The "Effective Date" means the date on which all the Parties execute this Agreement. If the Parties execute this Agreement on different dates, the Effective Date shall be the date on which the last Party executes this Agreement.

1.6 Indemnity Costs. "Indemnity Costs" shall mean (i) all amounts paid by or on behalf of Insured in settlement of, or judgment on, one or more Underlying Claims; and (ii) all amounts paid by or on behalf of any other Person in settlement of, or judgment on, one or more Underlying Claims as to which Insured has a duty, whether contractual or otherwise, to indemnify such Person.

1.7 Underlying Claim. "Underlying Claim" shall mean a Claim by a single Claimant alleging that [*describe the type(s) of injury and cause(s) of injury alleged in the underlying claims*], but only if such Claim is asserted against (i) Insured; or (ii) any other Person that Insured has a duty, whether contractual or otherwise, to defend and/or indemnify against such Claim.

1.8 Claim. "Claim" shall mean any assertion of liability, even if the underlying basis for the claim or the liability for the claim is disputed, whether or not filed in a court, and whether such assertion is made by a direct action, third party action, cross claim or other legal procedure.

1.9 Claimant. "Claimant" shall mean any Person alleging a Claim.

1.10 Person. "Person" shall mean an individual, estate, fiduciary, personal representative, third-party beneficiary, corporation, partnership, association, trust or any other entity or organization, including, but not limited to, any governmental or political subdivision, or any agency or instrumentality thereof.

1.11 Bodily Injury. "Bodily Injury" means any injury defined as "bodily injury" in any of the Policies.

1.12 Defense Costs. "Defense Costs" shall mean all reasonable fees, expenses and other amounts incurred in investigating and defending one or more Underlying Claims or any Suit in which one or more Underlying Claims are pending at the time such amounts are incurred, if such amounts are incurred by (a) Insured or (b) by any other Person that Insured has a duty, whether contractual or otherwise, to defend against the Underlying Claim(s) to which such amounts relate. "Defense Costs" include but are not limited to: (i) all fees and expenses paid for outside lawyers and their staff; (ii) all fees and expenses paid for agents, experts, consultants, investigators and other persons whose services are utilized in the investigation, defense, or adjustment of Underlying

Claims; and (iii) other amounts mutually agreeable to Insurer and Insured which are paid in the investigation, defense or adjustment of Underlying Claims. However, the term "Defense Costs" shall not include amounts paid as salaries or benefits or expenses of employees of Insured or Insurer.

1.13 Suit. "Suit" means any adjudicatory proceeding, including without limitation any litigation or arbitration.

1.14 Past Costs. "Past Costs" shall have the meaning given in Section 2.

1.15 Submitted Claim. "Submitted Claim" shall have the meaning given in Section 3.1(a).

1.16 Date of Claim. The "Date of Claim" shall mean, with respect to an Underlying Claim asserted against Insured, (i) the date on which an Underlying Claim filed with a court, tribunal or other adjudicatory entity is served on Insured; or (ii) if such Underlying Claim is not filed with a court, tribunal or other adjudicatory entity, the date on which Insured receives written notice of such Claim. With respect to an Underlying Claim asserted against a Person other than Insured, the "Date of Claim" shall mean the date on which Insured receives a written demand to defend and/or indemnify such Person against such Underlying Claim or to reimburse such Person for Indemnity Costs and/or Defense Costs with respect to such Underlying Claim.

1.17 Cumulative Indemnity Costs. "Cumulative Indemnity Costs" shall have the meaning given in Section 3.4(b)(vii).

1.18 Date of First Exposure. The "Date of First Exposure" shall mean the date of a Claimant's first alleged exposure to _____ [*describe the exposure allegedly responsible for the underlying injury, e.g., exposure to asbestos-containing products sold by Insured*] ("First Allegation Date"); provided however, that: (a) if the month containing the First Allegation Date can be determined, but the specific First Allegation Date (i.e., the specific day) cannot be ascertained from readily available and reasonably credible information, then the Date of First Exposure for such Underlying Claim shall be deemed to be the first day of such month; (b) if the year containing the First Allegation Date can be determined, but neither the First Allegation Date nor the month containing such date can be ascertained from readily available and reasonably credible information, then the Date of First Exposure for such Underlying Claim shall be deemed to be the first day of such year; and (c) if neither the First Allegation Date nor the month or year containing such date can be ascertained from readily available and reasonably credible information, then the Date of First Exposure for such Underlying Claim shall be deemed to be _____ [*insert a default date, e.g., the earliest date that any Insurer Policy was in effect*].

1.19 Period of Claim. The "Period of Claim" for each Underlying Claim shall mean the entire period from and including the Date of First Exposure to and including _____ [*insert an agreed end date for the allocation of Underlying Claims*].

1.20 Policy. "Policy" means any of the policies listed in Attachment A to this Agreement.

1.21 DCI. "DCI" means a Defense Cost Invoice as defined in Section 3.3(a).

1.22 Insurer Policy. "Insurer Policy" means any Policy for which the insurer is listed as Insurer on Attachment A.

1.23 Insurer Primary Policy. "Insurer Primary Policy" means any Insurer Policy listed as primary on Attachment A.

1.24 Aggregate Limit. "Aggregate Limit" means, with respect to a particular Policy, the aggregate limit of liability, if any, that applies to Claims for Bodily Injury included in the products hazard.

1.25 Per Occurrence Limit. "Per Occurrence Limit" means, with respect to a particular Policy, the limit of liability, if any, that applies to Claims for Bodily Injury included in the products hazard or the operations hazard on a "per occurrence" or "each occurrence" basis or otherwise with respect to insurance afforded by the Policy as the result of any one occurrence.

1.26 QBR. "QBR" means a Quarterly Billing Report as defined in Section 3.4(a).

1.27 Retention. "Retention" means, with respect to a particular Policy, the deductible or self-insured retention, if any, that applies to Claims for Bodily Injury included in the products hazard or the operations hazard on a "per occurrence" or "each occurrence" basis or otherwise with respect to insurance afforded by the Policy as the result of any one occurrence.

1.28 Aggregate Retention. "Aggregate Retention" means, with respect to a particular Policy, the deductible aggregate or self-insured retention aggregate, if any, that applies to Claims arising from the products hazard or the operations hazard.

1.29 Tolling Period. "Tolling Period" shall have the meaning given in Section 5.2.

II. PAYMENT FOR INDEMNITY COSTS AND DEFENSE COSTS INCURRED PRIOR TO EFFECTIVE DATE

2.1 Payment for Past Costs. For and in consideration of the mutual covenants stated in this Agreement, Insurer shall irrevocably pay to Insured the sum of $ _____ [*insert settlement payment amount for costs incurred prior to the Effective Date*] (the "Agreed Amount") in immediately available funds, to be received by Insured within ten (10) days after the Effective Date of this Agreement. Payment of the Agreed Amount shall be in full and final satisfaction of all Indemnity Costs and Defense Costs that were incurred by Insured prior to the Effective Date in connection with an Underlying Claim ("Past Costs").

III. COVERAGE IN PLACE

3.1 Claims to which this Section Applies.

(a) The provisions of this Section 3 shall apply to any Underlying Claim that Insured submits under this Agreement ("Submitted Claim") by providing written notice of such Underlying Claim to Insurer subsequent to the Effective Date and within 60 days of the Effective Date or the Date of Claim, whichever is later. The provisions of this Section 3 shall not apply to any Past Costs incurred with respect to a Submitted Claim except for purposes of determining and allocating Cumulative Indemnity Costs pursuant to Section 3.5.

(b) The written notice required by Section 3.1(a) shall include the following information: (i) the name of the Claimant; (ii) the state and court in which the Underlying Claim is pending; (iv) a copy of the pleading or other document in which the Underlying Claim was first asserted in writing against Insured; (v) Insured's best estimate of the Date of First Exposure for the Claim based on the best evidence reasonably available to Insured; (vi) a brief description of the circumstances of the Claimant's alleged injury based on the best evidence reasonably available to Insured; and (vii) the name of the defense counsel that Insured has retained or proposes to retain to defend the Underlying Claim.

(c) Upon reasonable written notice, Insurer shall be afforded the opportunity to conduct, at its own expenses, a reasonable review of the case files and related materials pertaining to any Submitted Claim. Insured shall cooperate in good faith with Insurer and shall provide reasonable assistance to Insurer in connection with carrying out any such review.

3.2 Defense and Settlement of Submitted Claims.

(a) Insured shall have the right to select defense counsel to defend Submitted Claims, and to direct and control the defense of Submitted Claims, subject to reasonable consultation with Insurer and reasonable consideration of Insurer's expressed views and interests, provided that any defense counsel retained prior to the Effective Date to defend a Submitted Claim may continue to defend that Claim without further consultation with Insurer.

(b) Insured shall have the right to settle Submitted Claims subject to the following limitations:

(i) Insured shall have the right to settle a Submitted Claim for an amount less than $ _____ [*specify the lower threshhold amount, e.g., $ 10,000*] without consultation with or notice to Insurer.

(ii) Insured shall have the right to settle a Submitted Claim for an amount greater than $ _____ [*specify the lower threshhold amount, e.g., $ 10,000*] but less than $ _____ [*specify the higher threshhold amount, e.g., $ 100,000*] subject to reasonable consultation with Insurer and reasonable consideration of Insurer's expressed views and interests regarding such settlements. No such consultation shall be required if there is insufficient time to consult with Insurer, despite Insured's best efforts to consult with Insurer in a timely manner, before Insured must decide whether to enter into a settlement.

(iii) Insured shall have the right to settle a Submitted Claim for an amount

greater than $ _____ [*specify the higher threshhold amount, e.g., $ 100,000*] subject to the consent of Insurer, such consent not to be unreasonably withheld. Insurer shall be deemed to have consented to a settlement if Insurer does not respond to a request from Insured for Insurer's consent to the settlement within five business days after Insurer receives such request.

3.3 Invoicing and Payment of Defense Costs.

(a) Insured and the defense counsel defending Submitted Claims shall periodically submit invoices to Insurer for Defense Costs incurred in the defense of one or more Submitted Claims ("Defense Cost Invoice" or "DCI"). Each DCI shall contain: (i) an identification of the Submitted Claim(s) covered by the DCI; (ii) the amount of Defense Costs associated with the Submitted Claim(s) covered by the current DCI; (iii) a reasonable description of the professional services and expenses associated with the current charges for such Defense Costs; (iv) the name of the person(s) providing such services; and (v) payment instructions for payment by Insurer of the invoiced amount.

(b) Except as provided in Sections 3.3(c) and (d) below, Insurer shall pay _____ percent (_____ %) of the total amount of the Defense Costs set forth in each DCI. Payment shall be made to the party submitting the DCI within 30 days of Insurer's receipt of the DCI. [*Note: the percentage of defense costs that the insurer will agree to pay pursuant to the Agreement is a key term for negotiation.*]

(c) Insurer shall have no obligation to pay Defense Costs associated with a particular Submitted Claim if: (i) there is no Insurer Primary Policy in effect during any portion of the Period of Claim for such Submitted Claim; (ii) at the time such Defense Costs were incurred, none of the Insurer Primary Policies in effect at any time during the Period of Claim for such Submitted Claim would have had any obligation to pay Indemnity Costs for such Claim because of exhaustion of the Aggregate Limits and/or Per Occurrence Limits of such Policies; or (iii) at the time such Defense Costs were incurred, the Submitted Claim had been fully resolved by judgment, settlement, or otherwise.

(d) Insurer shall have no obligation to pay Defense Costs incurred after Insured receives a valid written determination by Insurer that Insurer has no duty to defend the Submitted Claim under the terms of any of the Insurer Primary Policies. Such written determination shall set forth the specific reason(s) why Insurer believes that it is not obligated to pay such Defense Costs. Any dispute about the validity of Insurer's determination shall be resolved pursuant to Section 8.8. Any Defense Costs as to which Insurer's payment obligation is not in dispute shall be paid within the period required by Section 3.3(b).

3.4 Invoices for Indemnity Costs.

(a) Except as provided in Section 3.4(c) below, Insured shall submit quarterly invoices to Insurer for Indemnity Costs paid by Insured for Submitted Claims ("Quarterly Billing Reports" or "QBR"). The first QBR shall include all such

Indemnity Costs paid by Insured at any time during the three-month period ("Quarterly Period") immediately following the Effective Date. Insured shall submit the QBR to Insurer within 30 days of the end of the first such Quarterly Period. Subsequent QBR's shall include Indemnity Costs paid by Insured during subsequent Quarterly Periods and shall be submitted within 30 days after the end of the Quarterly Period covered by that QBR.

(b) Notwithstanding the preceding Sections 3.4(a), Insured and Insurer may at any time agree that Insurer shall pay particular Indemnity Costs directly (rather than having Insured pay such costs and then submit them to Insurer for payment under this Agreement). Any such payment of Indemnity Costs by Insurer shall be noted and accounted for as set forth in Section 3.4(c).

(c) Each QBR shall contain: (i) the name of each Claimant for which Indemnity Costs were paid by Insured; (ii) an identification of the Claim(s) to which such Indemnity Costs relate; (iii) the amount of Indemnity Costs paid by Insured on account of each Claim and the date of payment; (iv) the Period of Claim for each Claim; (v) a calculation of the amount of such Indemnity Costs for which Insurer is responsible under this Agreement showing how the Indemnity Costs were allocated pursuant to Section 3.5 below; (vi) a calculation of the current erosion of the Retention, Aggregate Retention, Aggregate Limit, and Per Occurrence Limit of each Policy pursuant to Section 3.6 below; and (vii) a calculation of the cumulative amount of Indemnity Costs and the current allocation of such Indemnity Costs pursuant to Section 3.5 below as a result of: (1) the current QBR; (2) all prior QBRs; (3) payments that Insurer has agreed to make pursuant to Section 3.4(b) above; (4) Past Costs that are Indemnity Costs; and (5) payments (other than payments of Defense Costs) made by Insurer under the Policies prior to the Effective Date (the cumulative total of items (1) through (5) being the "Cumulative Indemnity Costs").

3.5 Allocation of Indemnity Costs

(a) The parties agree that, as of the Effective Date, the Cumulative Indemnity Costs, including all Past Costs that are Indemnity Costs and all payments (other than payments of Defense Costs) made by Insurer under the Policies prior to the Effective Date, shall be allocated as shown on Attachment B.

(b) Indemnity Costs included in a QBR and Indemnity Costs that Insurer has agreed to pay directly pursuant to Section 3.4(b) shall be allocated according to the following method: The total dollar amount of all Indemnity Costs attributable to a particular Claim shall be allocated equally among all of the days included within the Period of Claim for such Claim.

3.6 Retentions and Limits of Liability

(a) The parties agree that, as of the Effective Date, the uneroded amounts of the Retentions, Aggregate Retentions, Per Occurrence Limits and Aggregate Limits of each of the Policies are as shown on Attachment A.

(b) The Retentions, Aggregate Retentions, Per Occurrence Limits and

Aggregate Limits of a particular Policy shall be further eroded only to the extent that Indemnity Costs allocated to such Policy pursuant to pursuant to Section 3.5 are paid by Insurer and shall not be eroded by Defense Costs. For purposes of this Agreement, such erosion shall be calculated as if all Underlying Claims arose out of a single occurrence.

3.7 Payment of Indemnity Costs

(a) Within 30 days of receiving a QBR pursuant to Section 3.4 for such Indemnity Costs, Insurer shall pay to Insured _____ percent (_____ %) of the Indemnity Costs included in such QBR for which it is responsible pursuant to Sections 3.7(b) and (c). [*Note: the percentage of indemnity costs that the insurer will agree to pay under the Agreement is a key term for negotiation.*]

(b) Insurer shall be responsible for all portions of the Cumulative Indemnity Costs allocated pursuant to Section 3.5 to any Insurer Policy after taking into account the erosion and/or exhaustion of the applicable Retentions, Aggregate Retentions, Per-Occurrence Limits and Aggregate Limits pursuant to Section 3.6 above.

(c) Notwithstanding anything to the contrary in Sections 3.7(a) or (b), Insurer shall not be responsible for Indemnity Costs allocated to a particular Insurer Policy if Insurer would have no duty under the terms of such Policy to pay such Indemnity Costs assuming that such Indemnity Costs were properly allocated to such Policy.

3.8 Cooperation. Insured shall cooperate in good faith with Insurer in the processing, verification, and payment of DCI's and QBR's. Insured shall use its best efforts to respond to reasonable requests from Insurer for information or clarification with regard to a pending DCI or QBR.

3.9 Correction of Errors

(a) Insured may supplement a prior DCI or QBR within 60 days of the initial submission of such invoice to correct any item inadvertently misstated on or omitted from such invoice.

(b) If Insurer pays any amount to Insured under Section 3.3 or Section 3.7 that is subsequently determined not to be properly payable under this Agreement, then Insured shall promptly return such amounts to Insurer.

IV. RELEASES

4.1 Releases by Insured.

(a) Upon Insurer's payment of all amounts that are required to be paid by Insurer under this Agreement with respect to a Submitted Claim, Insured shall remise, release, covenant not to sue, and forever discharge Insurer from all liabilities whatsoever, whether presently known or unknown, asserted or unasserted, whether sounding in tort or contract, arising under or related to the Insurer Policies with respect to such Submitted Claim.

(b) Upon Insurer's payment of the Agreed Amount pursuant to Section 2,

Insured shall remise, release, covenant not to sue, and forever discharge Insurer from all liabilities whatsoever, whether presently known or unknown, asserted or unasserted, whether sounding in tort or contract, arising under or related to the Insurer Policies with respect to Past Costs.

4.2 Releases by Insurer.

(a) At the time that the release described in Section 4.1(a) becomes effective, Insurer shall remise, release, covenant not to sue, and forever discharge Insured from all liabilities whatsoever, whether presently known or unknown, asserted or unasserted, whether sounding in tort or contract, arising under or related to the Insurer Policies with respect to the Claim to which the release described in Section 4.1(a) above applies.

(b) At the time that the release described in Section 4.1(b) becomes effective, Insurer shall remise, release, covenant not to sue, and forever discharge Insured from all liabilities whatsoever, whether presently known or unknown, asserted or unasserted, whether sounding in tort or contract, arising under or related to the Insurer Policies with respect to Past Costs.

V. EXCLUSIVE REMEDY AND TOLLING

5.1 Forbearance from Litigation. While this Agreement is in force, no Party shall initiate or maintain any action or proceeding in any court or any other forum asserting a claim against the other Party concerning the application of any Policy to a Submitted Claim.

5.2 Tolling Period. Any statute of limitation applicable to a Submitted Claim shall be tolled during the period (the "Tolling Period") beginning on the Effective Date of this Agreement and ending on the date on which the releases described in Sections 4.1(a) and 4.2(a) both have become effective with respect to such Submitted Claim.

5.3 Agreement Not to Assert Time-Based Defenses. Neither Party shall assert in any action or proceeding in any court or any other forum, including any action or proceeding concerning the application of any other insurance policy to a Submitted Claim, that any statute of limitation has run on a Submitted Claim during the Tolling Period or that either Party's rights with respect to a Submitted Claim are time barred under the doctrine of laches or any other legal or equitable theory because of either Party's inaction during the Tolling Period.

VI. NO ADMISSIONS

6.1 No Admissions. By entering into this Agreement, neither Insured nor Insurer has made, nor will either be deemed to have made, any admissions of any kind, including without limitation any admissions regarding whether all Underlying Claims arise from a single occurrence. This Agreement does not necessarily reflect the views of either of the Parties as to their rights or obligations to one another or to any other party with regard to matters outside of this Agreement. No provision of this Agreement will constitute a waiver of,

or be binding with respect to, positions that Insured or Insurer may take with respect to other claims, other insurers, other insureds, or other insurance policies. The Parties reserve all of their rights with respect to the application of any insurance policy other than the Insurer Policies or with respect to any Claims other than Underlying Claims.

6.2 Confidential Settlement Negotiations. All actions taken and statements made by the Parties hereto or their representatives relating in any way to their participation in this Agreement, including its development, execution and implementation, were taken and made in the context of confidential settlement negotiations and shall be without prejudice and without value as precedent.

VII. CONFIDENTIALITY

7.1 Confidentiality. The terms of this Agreement, all of its attachments, and all information provided to either Party pursuant to this Agreement, will be subject to the Confidentiality Agreement signed by the Parties on _____ [*insert date of Confidentiality Agreement previously executed by the parties*] and will be deemed to be "Confidential Information" as that term is defined in such Confidentiality Agreement.

VIII. OTHER PROVISIONS

8.1 Counterparts. This Agreement will be executed in duplicate originals. One duplicate original of the Agreement is to be delivered to Insurer and one duplicate original of the Agreement is to be delivered to Insured. This Agreement may be executed in multiple counterparts, each of which, when so executed, shall be deemed to be an original, and all of such counterparts together shall constitute the entire Agreement.

8.2 Entire Agreement. This Agreement constitutes the entire agreement between the Parties and may be amended only by a subsequent written instrument executed by all of the Parties.

8.3 Headings. The headings of Sections and Subsections are designed to facilitate ready reference to subject matter and shall be disregarded when resolving any dispute concerning the meaning or interpretation of any language contained in this Agreement.

8.4 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of _____ [*specify the jurisdiction whose laws will govern the Agreement*] without regard to principles of conflict of laws.

8.5 Notices. All notices, invoices, payments, determinations, designations, or other communications to be provided pursuant to this Agreement shall be in writing and sent by first-class mail, postage prepaid, to the addresses set forth below, or to such other address as either Party may designate in writing from time to time:

For Insured:
[*Provide name and contact information for Insured contact*]
With a copy to:
[*Provide name and contact information for Insured's coverage counsel*]

For Insurer:
[*Provide name and contact information for Insurer contact*]
With a copy to:
[*Provide name and contact information for Insurer's coverage counsel*]

8.6 Payments. Payments to Insured by check pursuant to this Agreement shall be made payable to Insured, and sent by overnight mail to the designated addressee set forth in Section 8.5. Payments by check shall be deemed to be made on the date the check is received by the designated addressee. Payments to Insured by wire transfer pursuant to this Agreement shall be wired to the account set forth below, and such wire transfer shall include all of the information set forth below:

[*Provide wire transfer instructions here*]

Payment by wire transfer shall be deemed to be made on the date payment is sent.

8.7 Interest. Late payments under this Agreement shall bear interest at the base rate on corporate loans charged by Citibank, N.A., New York, New York, from time to time, compounded daily beginning on the due date of the payment as provided by this Agreement until payment is made.

8.8 Dispute Resolution. Insured and Insurer shall negotiate in good faith to resolve any disputes between them involving the validity, interpretation, or application of this Agreement or any provision hereof. Any dispute concerning the validity, interpretation, or application of this Agreement that the Parties are unable to resolve after a 30-day period of good-faith negotiation may be submitted by either Insured or Insurer to either the Center for Public Resources ("CPR") or the American Arbitration Association ("AAA"), for binding resolution under procedures to be established and expeditiously carried out by CPR or AAA. Pending the final resolution of any such dispute and the award of costs, Insured and Insurer will share equally the fees and/or expenses of any third-party arbitrator. The prevailing party shall be entitled to full reimbursement for its costs (including attorney's fees) from the non-prevailing party.

IX. TERMINATION

9.1 Termination. Either Party may terminate this Agreement at any time after the date of the tenth anniversary of the Effective Date by giving written notice of termination to the other Party. The Agreement shall terminate upon

receipt of such written notice by the other Party. Sections 1, 2, 4, 6, 7, and 8 and any payment obligations that had arisen under Sections 3.3 or 3.7 prior to receipt of a written notice of termination shall continue in force notwithstanding any termination. Otherwise, the Parties shall have no further obligations to each other upon the termination of the Agreement.

IN WITNESS WHEREOF, Insured and Insurer by their authorized representatives, have duly executed this Agreement as of the date(s) indicated below.

[*Insert name of Insured here*]	[*Insert name of Insurer here*]
By: _____	By: _____
Date:_____	Date:_____

SCHEDULE OF ATTACHMENTS

Attachment A: Policies

Attachment B: Cumulative Indemnity Costs as of the Effective Date

23.35 Interim Defense Agreement.

Use of Form: This sample interim defense agreement may be used to faciliate payment of defense costs where multiple liability insurers may owe a defense obligation to the insured.

_____ ("Insured"), _____ ("Insurer A"), _____ ("Insurer B"), and _____("Insurer C") hereby enter into this Interim Defense Agreement ("this Agreement").

WHEREAS, Insurer A, Insurer B, and Insurer C ("the Insurers") issued to Insured the comprehensive general liability policies listed in Schedule A ("the Policies"); and

WHEREAS, Insured has been named as a defendant in the cases listed in Schedule B ("the Underlying Litigation"); and

WHEREAS, Insured and the Insurers disagree as to the application of the Policies to the Underlying Litigation; and

WHEREAS, Insured and the Insurers wish to provide, on an interim basis, for an allocation among the Insurers of Defense Costs, as defined herein, in the Underlying Litigation, while deferring any resolution of the issue of indemnity obligations under the Policies for the Underlying Litigation and while fully reserving their respective rights and positions concerning Defense Costs, indemnity obligations, and the applicability of the Policies to the Underlying Litigation;

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and intending to be legally bound hereby, Insured and the Insurers agree as follows:

1. Definition of Defense Costs. As used in this Agreement, the term "Defense

Costs" shall mean all reasonable and necessary fees and expenses incurred by or on behalf of Insured in the defense or investigation of the Underlying Litigation, (including, but not limited to, fees of outside counsel, court costs, deposition expenses, witness fees, and expert fees reasonably necessary to the defense of the Underlying Litigation) and in the preparation by outside counsel of reports to the Insurers as required under Section 3 of this Agreement; provided, however, that the Insurers shall not be obligated to pay any fees to outside counsel in excess of the outside counsel's customary rate for similar work.

2. Scope of Agreement and Reservation of Rights. This Agreement applies to all Defense Costs incurred prior to or during the term of this Agreement. With respect to coverage for the Underlying Litigation under the Policies, Insured and the Insurers fully reserve their respective rights. All payments made under this Agreement shall be made without prejudice. Payments under this Agreement shall not be construed as an admission of liability or coverage, or as acceptance of any particular theory of coverage. All payments made under this Agreement are subject to reallocation as a result of a final resolution, by settlement or court order, between Insured and the Insurers concerning the application of the Policies to the Underlying Litigation. This Agreement applies only to the suits listed in Schedule B, and the parties reserve all rights with respect to other present or future disputes. This Agreement shall not be used or admissible in future litigation among the parties.

3. Defense of Underlying Litigation By Insured. Insured shall direct the defense of the Underlying Litigation, and may in its discretion defend, settle, or otherwise dispose of such suits; provided that (1) Insured shall keep the Insurers apprised of the status of the Underlying Litigation by requesting its outside counsel to provide reports to the Insurers on a quarterly basis, (2) Insured shall provide the Insurers with advance notice of, and an opportunity for consultation on, major strategic decisions in the Underlying Litigation, and (3) Insured shall advise the Insurers of its intention to settle any portion of the cases within a reasonable time (at least two weeks if reasonably practicable) in advance of so doing, and shall communicate all relevant information attendant to that decision, including but not limited to all of the terms of said settlement agreements.

4. Payment of Defense Costs.

(a) The total amount of Defense Costs incurred through _____ [*insert date*] ("the Cutoff Date"), and the respective amounts due from each of the Insurers for their share of these Defense Costs, are set forth in Schedule C. The Insurers shall pay to Insured their respective amounts due of these Defense Costs as set forth in Schedule C within thirty days (30) of the effective date of this Agreement. The Insurers acknowledge that the total amount of Defense Costs incurred through the Cutoff Date is reasonable and necessary, and these costs shall not be subject to provisions of Section 4(c) below.

(b) Insured shall arrange for its outside counsel and any expert witnesses, and court reporting services to send detailed, itemized quarterly statements to the Insurers for Defense Costs incurred after the Cutoff Date. Subject to the provisions of Section 4(c), the Insurers shall pay such Defense Costs in accordance with the following respective shares:

Insurer A: _____ % [*insert agreed percentage*]
Insurer B: _____ % [*insert agreed percentage*]
Insurer C: _____ % [*insert agreed percentage*]

Such payments shall be made by the Insurers directly to Insured's outside counsel, expert witnesses or court reporting services. In the event that Insured has already paid its outside counsel, expert witnesses or court reporting services for any Defense Costs incurred after the Cutoff Date, Insured shall so notify the Insurers, and the Insurers shall instead reimburse Insured for the appropriate amount under Section 4 of this Agreement.

(c) If any Insurer determines that any fees or expenses incurred after the Cutoff Date in the defense, investigation or handling of the Underlying Litigation are not reasonable, the Insurer shall pay any uncontested amounts and provide prompt written notice to Insured of the contested amount. The notice shall include a statement setting forth why the Insurer has concluded that the fees or expenses are not reasonable. Any disputes between Insured and the Insurers regarding whether any fees or expenses incurred after the Cutoff Date in the defense, investigation or handling of the Underlying Litigation are reasonable shall be resolved in accordance with the dispute resolution procedures set forth in Section 6.

5. Duration of Agreement.

(a) This Agreement shall continue in full force between the parties until a final resolution, whether by settlement, judgment or otherwise, is reached between Insured and the Insurers concerning the application of the Policies to the Underlying Litigation; provided that any Insurer or Insured may opt out of this Agreement upon thirty (30) days written notice at any time after the effective date of this Agreement. If any Insurer opts out of this Agreement, the Agreement shall remain in force among the other Insurers and Insured.

(b) If an Insurer determines it has exhausted an applicable policy limit, it shall notify all other Insurers and Insured of such determination. Once an Insurer's limits are exhausted, its obligations under this Agreement shall cease. As soon as it becomes apparent, each Insurer will advise the parties of any approaching exhaustion-of-limits issues.

(c) The withdrawal of any Insurer pursuant to Section 5(a) or 5(b) shall not operate to increase the percentage share of any remaining Insurer under this

Agreement, except as may be agreed upon by written amendment pursuant to Section 8 hereunder.

6. Resolution of Disputes Concerning Agreement. Insured and the Insurers shall negotiate in good faith to resolve any disputes between them involving the validity, interpretation or application of this Agreement or any provision thereof. If the parties are unable to resolve any such dispute through negotiation, they shall submit the dispute to a form of Alternative Dispute Resolution (ADR) — including, but not limited to, ADR by the Center for Public Resources or the American Arbitration Association — to be mutually agreed upon. Pending the final resolution of such dispute and award of costs, Insured and the Insurer shall share equally the fees and expenses of any third-party neutral or arbitrator.

7. Confidentiality. The terms of this Agreement may be disclosed by the Insurers or Insured to any excess and other primary insurers of Insured, to their auditors and lenders, and, in the case of the Insurers, to their respective reinsurers, but the terms of the Agreement shall otherwise be deemed to be confidential and shall not be disclosed by Insured or any of the Insurers except as provided herein or as required by law or order of court or with the written consent of all other parties hereto. Any party making such a disclosure shall notify the entity receiving information of the terms of the Agreement that this information is confidential and shall obtain a written commitment from the entity to maintain its confidentiality.

8. Entire Agreement. This Agreement constitutes the entire Agreement between the parties. Except as explicitly set forth in this Agreement, there are no representations, warranties or inducements, whether oral, written, express or implied, that in any way affect or condition the validity of this Agreement or alter its terms. This agreement may be amended only by a written instrument executed by all the parties hereto.

9. Counterpart. This Agreement may be executed in counterparts, each of which shall have the effect of an original.

10. Effective Date. This Agreement shall be effective on the date that all parties execute this Agreement. If the parties execute this Agreement on different dates, this Agreement shall be effective on the date that the last party executes this Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Interim Agreement as of the date(s) indicated below.

[*Insert name of Insured here*]	[*Insert name of Insurer A here*]
By: _____	By: _____
Date:_____	Date:_____

23.35 Settling Insurance Coverage Disputes

[*Insert name of Insurer B here*]	[*Insert name of Insurer C here*]
By: _____	By: _____
Date:_____	Date:_____

ATTACHMENTS

Schedule A: Insurance Policies Issued by the Insurers to Insured

Schedule B: Underlying Cases in which Insured is Named as a Defendant

Schedule C: Defense Costs Incurred Prior to the Cutoff Date