tive; it was plaintiff's decision to pull nails out of walls on a nine-foot ladder and he therefore assumed the significant risk involved in that activity.

Insurance Litigation

Disability Insurance

Genuine dispute existed as to whether insured was entitled to extended disability payments.

Bosetti v United States Life Ins. Co. (July 17, 2009, B206896) 2009 Cal App Lexis 1166

The insured was employed by defendant school district; her employment benefits included coverage under a group long-term disability insurance policy. Shortly after learning that her employment would be terminated for economic reasons, the insured saw a doctor for depression and was placed on temporary disability. Her disability would ultimately extend for 2 years, and had both physical and emotional components. Under the policy, the insured could obtain disability benefits for 2 years if she was disabled from her own occupation. After that time, she could only obtain disability benefits if she was disabled from any occupation. At the end of 2 years, plaintiff was found to be able to perform sedentary or light physical work, and thus she was not disabled from any occupation. When the insurer terminated her disability benefits, she sued the insurer, seeking additional disability benefits. During the litigation, the insurer raised another defense, namely that the policy limited benefits for disabilities due to "mental, nervous or emotional disorder[s]" to only 2 years and, because the insured did not suffer a physical disability before termination of her employment (when her coverage ceased), she had received all policy benefits. The trial court granted the insurer summary judgment on this basis. The insured appealed.

The Second District Court of Appeal reversed. Triable issues exist as to two material facts: whether the insured was totally disabled from "any employment" when her benefits were terminated, and whether such disability had a physical component. Given these triable issues, the insured's breach of contract and declaratory relief causes of action should proceed. The insured's tort claims, however, lack merit as a matter of law; there was a genuine dispute as to whether the insured was entitled to extended disability payments, thus precluding a finding that the insurer acted in bad faith. See *Wilson v 21st Century Ins. Co.* (2007) 42 C4th 713, 723, 68 CR3d 746.

COMMENT: Mental disorder exclusions are commonly inserted into disability policies to limit or eliminate a source of disabling conditions. *Bosetti*'s discussion of these mental disorder provisions reflects the difficulty of trying to separate mental and physical conditions. As so-called "mental" conditions are increasingly identified with physical causes, it becomes more and more difficult to separate mental from physical disabilities. The court concludes that, absent explicit language, such exclusions cannot apply to defeat a disability claim when the physical problems "contributed to the disability or were a cause or symptom."

The court also confirms that the essence of bad faith is the unreasonable delay or denial of benefits. It then says that this is an objective test, not a subjective test. The court discusses the genuine dispute doctrine and confirms that it is now only a shorthand way of saying that the delay or denial of benefits was "reasonable under all the circumstances."

Unfortunately, the conclusion of the court's opinion is published under circumstances in which all the facts are unclear. It holds that there was conflicting evidence as to whether the insured was disabled. It then references a so-called "independent physician" who reviewed the file "in great detail" and concluded the insured could work consistent with a vocational report, a Functional Capacity Evaluation, and plaintiff's own recent physician. It concluded that there was no evidence of bad faith. Critical to the court's analysis was its conclusion that "[t]here is nothing in this record to suggest that U.S. Lifes' investigation into Bosetti's claim was in any way biased, inadequate, superficial or otherwise unworthy of reliance by an objectively reasonable insurer." We can't tell from the facts discussed in the opinon how the court arrived at this opinion. There is no discussion of the report itself. The reasons for the "independent" physician's conclusions, whether the report was provided to the insured or her physician for response, whether any responses were provided, whether the physician could actually be called "independent," the extent to which the report was inconsistent with the opinions of the treating physicians, the scope of the investigation, and the extent to which the insured's own doctors conceded that plaintiff could, in fact, work are not set out in the opinion, thus leaving its conclusion highly questionable. Certainly, it is no defense to bad faith to simply obtain an "independent physician" report, which is in conflict with a treating physician's report, and then claim that there is no bad faith because there is a genuine dispute.—*Arnold R. Levinson*

Duty to Indemnify

Insurer has no obligation to pay costs arising solely from claims that were not potentially covered, and it also has no duty to indemnify for damages awarded for insureds' willful acts relating to false imprisonment of domestic servant.

State Farm Gen. Ins. Co. v Mintarsih (2009) 175 CA4th 274, ___ CR3d ___

Mimin Mintarsih sued the insureds for false imprisonment and negligence arising from her employment as a domestic servant. The insureds tended their defense to the insurer under a homeowners policy and an umbrella policy. The insurer agreed to defend the insureds under a reservation of rights. The jury found the insureds liable on each count and awarded noneconomic and economic damages, statutory penalties for the wage and hour violations, and punitive damages. The trial court later granted Mintarsih's motion for attorney fees as the prevailing party on the wage and hour claims. The insurer then filed this complaint for declaratory relief, seeking a determination of the parties' rights and duties under the two policies. The trial court determined that the policies

provided coverage for compensatory damages and for the award of costs, but that the insurer had no obligation to pay the attorney fee award based on wage and hour claims for which the policies provided no coverage. Both parties appealed.

The Second District Court of Appeal affirmed in part and reversed in part. The trial court properly found that the insurer was not obligated to pay the attorney fee award. The policies at issue included "supplemental payments" provisions that promise to pay costs awarded against the insureds only if the insurer had a duty to defend the insureds. The duty to defend, however, arises only for those claims for which there is at least potential coverage under the policy. Thus, the insurer has no obligation to pay costs arising solely from claims that were not even potentially covered under one or both of the policies. Mintarsih conceded that the policies do not cover her wage and hour claims, and her statutory right to recover attorney fees was based solely on these claims. The trial court erred, however, in finding that the insurer had a duty to indemnify the insureds for the compensatory damages award for false imprisonment and negligence because an insurer has no duty to indemnify a loss caused by the insured's willful act. See Ins C §533. The jury verdict established that the insureds's misconduct was willful for the purposes of §533, *i.e.*, the deprivation of Mintarsih's freedom for purposes of exploiting her as a domestic servant while depriving her of the wages and breaks to which she was entitled was inherently harmful. The insureds' negligent conduct was "intimately connected with their intentional misconduct," so as to constitute the same course of conduct for purposes of §533. Because the insurer has no duty to indemnify under either policy for the damages awarded against the insureds, it has no obligation to pay postjudgment interest on the judgment awarded against them.

COMMENT: This is a rare example of a court interpreting an insurance policy to say that it does not provide the benefit that the policy clearly seems to provide. Nonetheless, it is difficult to fault the court's reasoning.

The policy provided that supplemental benefits in the form of attorney fees and costs were payable for claims that the company defended. Yet, in this case, these fees and costs were clearly payable only under causes of action for which there was no coverage. Because there was a covered claim, the insurer was obligated to defend the entire action. *Buss v Superior Court* (1997) 16 C4th 35, 48, 65 CR2d 366. However, the insurer had the right to obtain reimbursement from the insured for defense costs solely attributable to the defense of noncovered claims. 16 C4th at 50. Under these circumstances, the court held that it was not within the intention of the parties when the policy was issued that expenses clearly attributable to noncovered claims would be covered.—*Arnold R. Levinson*

Policy Interpretation

Trial court properly applied unambiguous definition of "occurrence" as stated in policy.

Supervalu, Inc. v Wexford Underwriting Managers, Inc. (2009) 175 CA4th 64, ___ CR3d ___

The insurers provided the insured with excess workers' compensation insurance under which the insured's self-insured retention for each occurrence was $500,000. The policies provided that indemnity coverage was subject to the insurer's maximum limit of liability for loss arising out of any one "occurrence" of $1,000,000 in excess of the insured's retention. The policies defined "occurrence," as applied to bodily injury, to "mean accident"; an employee's occupational disease was deemed to be a separate occurrence occurring on the last date of the employee's exposure to the deleterious work conditions. At issue in this declaratory relief action brought by the insured is the interpretation of the word "occurrence" as used in the policies. The trial court agreed with the insurer that there was an "occurrence," and thus the insured was required to pay a self-insured retention, whenever an employee sustained injury due to an accident or occupational disease. On appeal, the insured argued that, in the workers' compensation industry, "occurrence" means a claim that results in one award or compromise and release regardless of the number of injuries involved, and that this technical meaning controls interpretation of the policies.

The Second District Court of Appeal affirmed. The contract language governs its interpretation "if the language is clear and explicit and does not involve an absurdity." See CC §§1638, 1639. Here, the policy language is neither patently nor latently ambiguous; rather, it is clear and explicit and does not involve an absurdity. The policy language unambiguously suggests that an occurrence involves either an accident or cumulative injuries. The definition of occurrence does not distinguish between situations in which single employees or multiple employees are injured, because an occurrence is an event—either an accident or occupational disease. As to an accident, the number of employees injured is irrelevant, *i.e.*, it could be one or many employees and it would still be one occurrence. In contrast, there are as many occurrences as there are employees who suffer occupational disease.

COMMENT: Periodically, an insurer adopts an interpretation of the policy and pays benefits that the policy does not actually provide. When it discovers the error, it informs the usually surprised insured that benefits that were previously being paid will no longer be paid. The natural reaction is to claim waiver or estoppel or that the insurer's past interpretation establishes that the policy is, at a minimum, ambiguous, and thus it must be interpreted as the insurer has been doing for a long time.

When presented with such a situation, the first thing to assess is whether, in fact, the insured has been receiving benefits that truly were not covered. If so, it may not be so wise to sue the insurer. As this court explains, waiver and estoppel do not apply unless the insured has relied to