

The Duty to Give Notice to Excess Insurers

Timothy M. Thornton Jr.

Timothy M. Thornton Jr. is a partner in Nelsen, Thompson, Pegue & Thornton, APC, in Los Angeles. He represents major insurance carriers in coverage disputes, concentrating on commercial general liability, commercial automobile, employer's liability, excess/umbrella, commercial property insurance, entertainment, professional liability, and media liability insurance. Thornton can be reached at tthornton@ntptlaw.com.

TIP

Excess policies require notice when the loss is reasonably likely to reach the excess policy, and that puts the focus on defense counsel's evaluation.

Most liability insurance policies contain a notice provision. The language relating to the notice of claims to the insurer has varied between a requirement that loss be reported "at once," "immediately," "as soon as practicable," or that "prompt notice" be given. For example, the current Insurance Services Office commercial general liability policy uses several different formulations: notify the insurer "as soon as practicable" of an occurrence, offense, or claim; "immediately" record specifics of a suit or claim, and date received; notify the insurer "as soon as practicable" of this; and send copies of demands, notices, and other legal papers "immediately."

The notice requirement allows the insurer to take steps to investigate the claims and to preserve testimony or evidence that may be helpful in defending the claim, and in pursuing subrogation where appropriate. If the insured delays in reporting a loss, important information about it could be lost.

Excess Notice Provisions

Excess policies do not normally have a duty to defend. And excess policies are not implicated by most losses. Accordingly, excess policy notice requirements usually express a different standard. Most frequently the standard is that notice must be given "when the loss is reasonably likely to involve the excess policy." However, many variations on this language exist.

Some provisions are very precise in requiring notice of specific types of cases. This is often the case when the first layer of coverage is self-insurance and the excess policy attaches above that self-insurance. For example, notice may be required for cases reserved for more than 50 percent of the self-insured retention or for cases involving spinal injury.¹

Many self-insured retention endorsements, or overlying excess policies, specify two types of cases that trigger a reporting duty: (1) where reserves exceed a certain value, and (2) with specific types of serious injuries. One example is an endorsement that requires notice in the case of a claim involving death, loss of sight or hearing, loss of a limb (in whole or in part), spinal cord damage, or second- or third-degree burns.

Finally, certain policies require notice to the excess insurer of an occurrence "regardless of amount."

In an appropriate case, defense counsel should either ask for the excess policies or information about them. Or, instead, defense counsel might advise the insured—or its risk manager or broker—to review those policies. In the latter case, defense counsel might consider disclaiming any responsibility to notify the excess insurer, but this is not always so easy. Defense counsel's evaluation of the case is one of the components in determining if the injury comes within such an endorsement or if the policy is likely to involve excess coverage. But, at the very least, defense counsel should ask for the policy or confirm that someone else is watching the store on this issue.

Prejudice Requirement

Such excess policy notice provisions are enforceable, but most states require prejudice, and most likely will apply the same rule to excess coverage. There are, however, many fewer opinions addressing this late-notice/prejudice issue at the excess layer than at the primary layer. A majority of states require an insurer to show prejudice to support a late notice defense to coverage. Before an insurer's liability can be extinguished due to untimely notice, the insurer bears the burden of proving that it has actually been prejudiced by the delay.² On the other hand, a minority of states apply a strict late-notice rule that does not require a showing of prejudice.³ In most states, the rule requiring prejudice developed in the common law. However, in some states the prejudice requirement has been added by statute, by regulation, or by approval of forms by the state insurance commissioner.⁴

In 2008 the New York legislature amended Insurance Law 3420 to adopt a prejudice standard applicable to denial for late notice, that is, insurers may not deny a claim for late notice unless the failure to provide timely notice materially impairs the ability of the insurer to investigate or defend the claim. The bill applies to all liability policies "issued or delivered" in New York on or after the effective date of January 17, 2009, that insure against "liability for injury to person . . . or against liability for injury to, or destruction of, property . . ."⁵ Before this, New York had long been a strict late-notice state.

In Texas in March 1973, the State Board of Insurance issued Board Order 23080, which required a mandatory endorsement to all Texas commercial general liability policies that precludes forfeiture of coverage for an insured's failure to comply with notice or

forwarding conditions unless the insurer is prejudiced thereby.⁶

Some states draw a distinction between primary and excess coverage. For example, Alabama maintains the “no prejudice” rule for primary insurers but requires that excess insurers show prejudice.⁷

Courts and commentators have observed that the modern trend in many American jurisdictions is to consider prejudice to the insurer as a material factor in determining whether liability has been extinguished. Those courts and commentators find such a rule is consistent with the purpose behind prompt notice provisions: to give the insurer an opportunity to make a timely and adequate investigation of all the circumstances so that reasonable compromises and settlements may be made, avoiding prolonged and unnecessary litigation.⁸ Thus, “[i]n short, the notice requirement is designed to protect the insurer from prejudice. In the absence of prejudice, regardless of the reasons for the delayed notice, there is no justification for excusing the insurer from its obligations under the policy.”⁹

Not all of these factors will apply to an excess insurer. For instance, the excess insurer generally does not have a duty to defend, and so does not select defense counsel. But excess insurers argue that they have a right to associate in the defense, and a right to provide input into the defense. And most of the other factors apply to excess insurers as well. Excess insurers can argue a right to investigate the claim and evaluate coverage—and an interest in doing so.

Rationales for the Prejudice Requirement

At least three rationales have been articulated for the rule requiring prejudice. The most commonly stated rationale is to avoid disproportionate forfeitures: The insured has paid its premium for coverage and should not forfeit that coverage on account of late notice unless the insurer has been prejudiced. A second theory applies adhesion contract theory: A court will not interpret an insurance policy (offered to the applicant on a take-it-or-leave-it basis)—and, in particular, the late-notice provision—as strictly as other types of contracts. A third rationale involves the public policy of compensating victims of torts.¹⁰ Some courts also mention the inequity of the insurer receiving a windfall due to a technicality.¹¹ This may be viewed as the flip side of the first rationale.

When prejudice is required, who must prove it? Normally, that falls to the insurer. Some states shift the burden by establishing a presumption of prejudice from late notice. The rationales for putting the burden of proving prejudice on the insurer are:

- It is more equitable since the insurer seeks to disclaim.
- It is more difficult for the insured to prove a negative (i.e., that the insurer is not prejudiced).
- The insurer is in a superior position to produce evidence that it suffered prejudice.¹²
- This rule encourages the insurer to undertake a timely preliminary investigation.¹³

The rationale for putting the burden of proving prejudice on the insured, as articulated in *Washington v. Federal Kemper Insurance Co.*,¹⁴ is:

- It is impossible for the insurer to demonstrate
- what witnesses it might have called,
- what defense it might have made, and
- what disposition it might have reached in settlement if it had received notice before the verdict was rendered.¹⁵

However, *Federal Kemper Insurance Co.* is a postjudgment tender case, and most courts will either presume prejudice in that fact pattern or find prejudice as a matter of law.

The activities of defense counsel are often discussed in determining whether the insured has acted promptly under the circumstances, and whether the excess insurer has been prejudiced. For example, in *Prince George’s County v. Local Government Insurance Trust*,¹⁶ the insured complained of second-guessing and “20/20 hindsight”—to no avail—when the excess insurer criticized trial choices made by the insured county. The court did not hang its hat on that criticism because it did not need to do so. But, without doubt, this was not a comfortable situation for the defense counsel. On the other hand, in *Trustees of the University of Pennsylvania v. Lexington Insurance Co.*,¹⁷ the court discussed the amount of information the defense counsel had and counsel’s efforts to get that information from the plaintiff in a relatively prompt fashion. This helped the insured in that case and the defense counsel was likely happy to have been prompt in seeking out information for purposes of evaluation. Nonetheless, the excess carrier criticized the defense counsel in that case, too.

A minority of courts presume prejudice and require the insured to rebut that presumption even if it is not a postjudgment tender.¹⁸ An even smaller minority of courts include prejudice as a factor in determining whether the insured provided timely notice.¹⁹

Excess Notice Cases

Understanding how courts actually apply these principles in particular circumstances in actual cases is useful. These cases suggest facts that need to be developed by the parties to understand if notice to the excess insurer is timely, and if the excess insurer is in fact prejudiced. And these cases suggest arguments that need to be advanced or rebutted by the parties if timeliness of notice is contested.

In *American Home Assurance Co. v. Republic Insurance Co.*,²⁰ American Home, a first level excess insurer, sought to require Republic and others, which were second level excess insurers, to contribute to a settlement of \$11.5 million that was made by American Home without the approval of the second level excess insurers. This settlement amount exhausted the first level excess coverage and invaded the second level coverage. The district court found against American Home, and the court of appeals affirmed.

In that case, five people—a young couple, their infant child, and the wife’s parents—died in their home as a result of carbon monoxide poisoning caused by an improperly installed gas furnace. The insured company, Mobile Gas Service Corp., had received a number of service complaints and had detected the furnace’s improper installation but had failed to correct the problem. The primary coverage was \$300,000 with Liberty Mutual, \$5 million more with American Home, and then a quota share layer of \$10 million (of which Republic had 10 percent, United National had 10 percent, and American Home and others had the remaining 80 percent). The trial court held that Mobile Gas must have realized within a few days after the accident that there was a serious likelihood that recovery would exceed the primary limits. It found late notice and no coverage under the Republic excess quota share policy.²¹ The court of appeals affirmed.

In *Prince George’s County v. Local Government Insurance Trust*,²² the county was self-insured for the first \$1 million and then had \$4 million in coverage with the insurance trust, a government entity risk-pooling structure. The county gave notice long after the loss and, indeed, postverdict.

In June 1997, following a traffic stop, county officers entered Freddie McCollum’s home without a warrant and beat him. McCollum suffered severe injuries, including the loss of his right eye. In November, McCollum asserted a \$50 million claim by letter, and on March 19, 1998, he filed suit in federal court. On April 3, 2000, a \$4.1 million verdict was rendered, which, on post-trial motions, was remitted to \$1,597,670. This was affirmed by the Fourth Circuit Court of Appeals. Finally, on April 13, the county gave notice to the insurance trust.

Prince George’s County was a member of the Local Government Insurance Trust. It was self-insured for first \$1 million and above that had \$4 million in coverage with the excess liability program of the trust. The trial court held there was late notice and prejudice as a matter of law. The court of special appeals affirmed, and the court of appeals affirmed by writ of certiorari.

The scope of coverage form required notice where the occurrence was “likely to create an obligation under this Scope of Coverage.” But the self-insurance program excess coverage endorsement required notice within 60 days for claims reserved for \$100,000 or more, certain other serious claims, and claims involving violations of civil rights. The court found that these two provisions did not conflict.²³ Also, the scope of coverage form provided that it controlled unless inconsistent with the endorsement. And the court found that a harmonious reading of that form and the endorsement was consistent with the purpose of ensuring that the trust was informed of lawsuits before judgment.²⁴ The court also found that the trust was prejudiced as a matter of law because it did not receive notice until after the verdict. Therefore, coverage was properly denied.²⁵

The county claimed that the scope of coverage form reporting requirements only applied if that form was used as primary coverage for the government entity. The county argued that where the entity only had excess insurance under the trust, as was the county’s situation, then the endorsement alone applied. Thus the county argued that the policy only required pretrial notice for claims and suits that the trust was required to investigate, settle, and defend. However, the court noted that while the trust did not have the right to control the defense, settlement, and investigation, it could encourage settlement and propose trial strategies, and notice would have given it the information it needed to exercise these rights.²⁶

In *Hartford Accident & Indemnity Co. v. Rush-Presbyterian-St. Luke’s Medical Center*,²⁷ Garanda Eiland gave birth to a daughter, Vernetta, at Rush Hospital in November 1976. Sometime after 1977 Hartford’s policies expired, and Rush became self-insured. In August 1984, Garanda and Vernetta Eiland sued Rush, alleging negligent delivery that caused brain damage. The suit was referred to Rush’s defense counsel, but notice was not given to Hartford.

In April 1986, Rush discovered its oversight regarding notice and notified Hartford for both layers. In December, Hartford sued for declaratory relief. The following January, during trial, the case settled for \$6 million. Hartford funded the settlement, yet reserved its rights against Rush.

Rush had two policies with Hartford: a \$1 million primary policy and an \$8 million excess policy. The excess policy required notice “whenever it appears that an occurrence is likely to involve indemnity under this policy.”

The appellate court observed that an excess insurer does not undertake the defense, so it does not typically require notice unless it appears likely that the claim will involve the excess. Excess notice provisions, therefore, contemplate the exercise of some judgment on the part of the insured in evaluating the case.²⁸ Where timing of the notice is left up to the discretion of the insured, the issue is whether the insured abused its discretion, “i.e., whether the insured acted unreasonably under the circumstances.”²⁹ Under Illinois law, part of the equation is prejudice, and the more prejudice the insurer can show, the more likely it is that the failure to notify was unreasonable.

Despite the fact that the complaint indicated brain damage, and a \$10 million demand was involved, the “able defense counsel” lacked sufficient information to determine if Rush’s liability would exceed \$1 million. Under the “appears likely” language, some consideration must be given to the insured’s investigation and evaluation of the case and the reasonableness of the insured’s actions within this context. Here Rush did not sit idly by. Hartford’s interests were protected by Rush’s actions. The trial did not take place until several months after Hartford had been notified, and thus Hartford had ample time to make its own investigation. The appellate court therefore rejected Hartford’s late notice defense.³⁰

In *Harbor Insurance Co. v. Trammell Crow Co.*,³¹ Chasewood had primary insurance with U.S. Fire with a limit of \$500,000 and excess insurance with Harbor attaching above that. The Harbor policy required notice “as soon as practicable” when Chasewood “has information upon which [it] may reasonably conclude that an occurrence . . . involves injuries or damages, which in the event that [Chasewood] should be held liable, is likely to involve this policy.”³²

In 1981 Chasewood, a general contractor, subcontracted with Rico to perform framing and trim work on an apartment complex. In December, due to deficiencies in the work and allegations that Rico employees had been stealing materials from the job site,

Chasewood terminated Rico. The following May Rico sued Chasewood for breach of contract, seeking \$50,000. Subsequent amendments steadily increased the damages sought, added defamation claims, and finally added a claim for punitive damages. Chasewood notified U.S. Fire, the primary insurer, which retained defense counsel.

On September 22, 1983, a jury verdict of \$2,487,000—including \$650,000 in actual damages and \$1,750,000 in punitive damages on the libel and slander claim—was delivered in favor of Rico. On September 26, \$250,000 in punitive damages was remitted and the court entered a judgment. The next day Chasewood gave notice to Harbor, and the day after that Harbor reserved its rights.

The district court granted summary judgment to Harbor. It found that Chasewood had information from which it knew that the case was likely to involve the excess policy. It noted that (1) plaintiffs counsel was “able and experienced,” (2) local juries had awarded verdicts in libel and slander cases in excess of \$500,000, and (3) plaintiffs counsel had obtained verdicts in that county in excess of \$500,000.³³

The Fifth Circuit Court of Appeals reversed. It found that until the jury returned its verdict, a reasonably prudent person in Chasewood’s position may have concluded that the potential damages were not likely to involve Harbor’s policy.³⁴

Harbor argued that the language “in the event that [Chasewood] should be held liable” meant that Chasewood essentially had to evaluate the case assuming it was liable. But the court disagreed, looking to other language in the policy to temper this language. The notice provision stated that “failure to give notice of any occurrence which at the time of its happening did not appear to involve this Policy but which at a later date, would appear to give rise to claims hereunder, shall not prejudice such claims.” Chasewood argued that this meant liability should be considered. The Fifth Circuit did not find this interpretation unreasonable. At the least, it presented a triable issue of fact.

Harbor also argued that given the language “has information from which [it] may reasonably conclude,” and that given the evidence on which the district court relied, that Chasewood did have information from which it could reasonably conclude that the excess policy might be involved. But the court felt that Chasewood had other information to the contrary, suggesting no need to give notice, and any reading of the policy that would ignore this was “tortured.”³⁵ That is, the insured must make this determination considering all available information, not just that which suggested that exposure might reach the excess layer.

In *Trustees of the University of Pennsylvania v. Lexington Insurance Co.*,³⁶ the hospital involved was self-insured up to \$100,000 for itself and for the involved physician. Above that was a \$1 million layer for each health care provider with the Pennsylvania Medical Professional Liability Catastrophe Loss Fund (CAT Fund), a state agency, and above that was a layer with Lexington that provided \$10 million in coverage.

On June 9, 1981, Estelle Soppe suffered catastrophic injuries while undergoing a simple diagnostic procedure at the hospital, supervised by Dr. Bruce Trotman. Soppe sued the hospital and Trotman for medical malpractice in February 1983. The hospital hired defense counsel. Defense counsel investigated the case, filed an answer, and conducted discovery.

The hospital notified the excess insurers 10 months after the suit was filed. Lexington disclaimed on the ground of late notice. It asserted prejudice from “gross mishandling” of the investigation and defense, failure of defense counsel to explore additional liability theories to involve other health care professionals and the hospital’s products liability insurer, and the failure of the hospital’s counsel to cross-claim against Trotman because of a conflict of interest.

On the eve of trial in April 1984, Soppe, the hospital, and Trotman settled for \$2.2 million from the self-insurance and CAT Fund. The hospital also agreed to pay \$4.8 million if it were successful in coverage litigation with Lexington, but pending that paid Soppe \$550,000, to be reimbursed out of the proceeds of the suit. If the hospital did not win, it would pay an additional \$1.6 million to Soppe and would guarantee lifetime medical expenses. The court approved the settlement.

The hospital argued that it did not know the cause of the injuries until it received an expert report in October 1983. The court was “not impressed with this argument.” The court noted that the language was not contingent upon the insured believing it was liable: The policy required notice if the excess policy would be triggered if the insured were liable.³⁷

The hospital argued it was not aware that the excess policy would be implicated until the December 1983 damages evaluation, and that as late as November 1983 the hospital’s “seasoned and capable trial counsel” believed the case would settle for roughly \$1.5 million. The court noted that there was evidence on both sides of this issue, and in view of the conflicting testimony, the issue of late notice was a question for the jury. So the court let stand the jury’s finding that the hospital was not late in reporting.

The court found error in a jury instruction that stated that determination of potential value was left to the insured, not the insurer. The court held that the policy language set out an objective standard for determining when notice was required: “may reasonably conclude [that the loss was] likely to involve” the excess policy.³⁸ However, this error in instruction only required reversal if Lexington was prejudiced.³⁹ First, the court held that the notice/prejudice rule applied to an excess medical errors and omissions policy.⁴⁰

As to Lexington’s three arguments of prejudice, discussed above, on appeal it also argued that it was deprived of sufficient time to hire an expert to testify to Soppe’s reduced life expectancy, so as to reduce the future damages award. The jury had found no late notice and had not answered the interrogatory regarding prejudice. But the court of appeals found that the finding of bad faith by the jury implicitly was a rejection of Lexington’s first three prejudice arguments, in light of the jury instruction on bad faith, and that its finding that the settlement was reasonable was a rejection of the argument that the life expectancy expert would have changed the result.⁴¹

Final Thoughts

Whose duty is it to give notice to the excess insurer? Under the contract language, it is the insured’s duty.⁴² The insured may be

looking to its defense counsel or to the broker—or both—for guidance here.

Defense counsel, the insured, or the broker may need to consider the many factors that affect whether exposure may exist above the policy limit. What if there is an additional insured on the insured's policy, and the additional insured's exposure exceeds policy limits but the named insured's exposure does not? What about exhaustion or impairment of aggregates under the policy that might affect the likelihood that the excess policy may be involved? Also, are there other pending claims that have potential to exhaust the aggregate before the case is concluded? What if this is a more complex trigger, such as a progressive or continuous loss such as an environmental suit, a toxic exposure, or a subsidence claim? How does this affect the likelihood of involvement of an excess insurer?

One surprising holding in some of these cases was the use of The Guiding Principles for Primary and Excess Insurance Companies to establish duties on the part of the primary insurer to provide notice to the excess insurer. The Guiding Principles is a set of rules promulgated by the insurance industry in 1974 to govern the relationships between primary and excess insurers. In *American Centennial Insurance Co. v. Warner-Lambert Co.*,⁴³ the court referred to the Guiding Principles and actually suggested that they could be used to establish the standard of care that a primary insurer must use when settling a claim where an excess insurer may also ultimately be responsible for coverage.⁴⁴

Endnotes

1. See *Midwest Emp'rs Cas. Co. v. E. Ala. Health Care*, 695 So. 2d 1169, 1174 (Ala. 1997) (Hooper, J., dissenting) (excess workers' compensation policy over self-insurance).
2. *Weaver Bros., Inc. v. Chappel*, 684 P.2d 123, 126 (Alaska 1984); *Unigard Ins. Co. v. Leven*, 983 P.2d 1155, 1161 (Wash. Ct. App. 1991); *Campbell v. Allstate Ins. Co.*, 384 P.2d 155, 157 (Cal. 1959) (violation of cooperation clause); *Prince George's Cnty. v. Local Gov't Ins. Trust*, 879 A.2d 81, 96–97 (Md. 2005).
3. *E.g.*, *Bolivar Cnty. Bd. of Supervisors v. Forum Ins. Co.*, 779 F.2d 1081, 1085–86 (5th Cir. 1986) (applying Mississippi law); *Greenway v. Selected Risks Ins. Co.*, 307 A.2d 753, 756 (D.C. 1973); *Caldwell v. State Farm Fire & Cas. Ins. Co.*, 385 S.E.2d 97, 99 (Ga. Ct. App. 1989); *State Farm Mut. Auto. Ins. Co. v. Cassinelli*, 216 P.2d 606, 616 (Nev. 1950).
4. See MD. INS. CODE § 19-110 (to disclaim coverage, insurer must show lack of cooperation or notice resulted in actual prejudice); WIS. STAT. ANN. § 631.81 (policy may not be forfeited pursuant to a notice provision if notice is provided within one year of the time provided in the policy “unless the insurer is prejudiced thereby and it was reasonably possible to meet the time limit”).
5. S.B. 8610, § 2, 2008 N.Y. Sess. Laws 388 (McKinney).
6. *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630, 632 (Tex. 2008) (noting that Order 23080 requires endorsement in all commercial general liability policies precluding forfeiture of coverage for insured's failure to comply with notice or forwarding requirements unless insurer is prejudiced).
7. See, e.g., *Midwest Emp'rs Cas. Co. v. E. Ala. Health Care*, 695 So. 2d 1169, 1173 (Ala. 1997); but see *Am. Home Assurance Co. v. Int'l Ins. Co.*, 684 N.E.2d 14, 18 (N.Y. 1997) (no prejudice required for late notice defense by an excess insurer under New York law); see *Trs. of Univ. of Pa. v. Lexington Ins. Co.*, 815 F.2d 890, 893 (3d Cir. 1987) (finding that excess insurance presented even more compelling reason to require prejudice than primary coverage).
8. *Weaver Bros., Inc. v. Chappel*, 684 P.2d 123, 125 (Alaska 1984) (quoting 8 J. APPLEMAN, INSURANCE LAW AND PRACTICE § 4731, at 2–5 (rev. ed. 1981)).
9. *Id.* at 125; see *Prince George's Cnty. v. Local Gov't Ins. Trust*, 879 A.2d 81, 95 (Md. 2005) (reason for notice provisions are to protect interests of insurer and allow insurer the opportunity to acquire full information about circumstances of case, assess its rights and liabilities, and take early control of proceedings); *Wash. v. Fed. Kemper Ins. Co.*, 482 A.2d 503 (Md. App. 1984) (purpose is to protect insurer's rights to investigate claim, evaluate coverage, choose defense counsel, and attempt to settle).
10. *Prince George's Cnty.*, 879 A.2d at 96, n.10; *Brakeman v. Potomac Ins. Co.*, 371 A.2d 193, 196 (Pa. 1977).
11. *Alcazar v. Hayes*, 982 S.W.2d 845, 850 (Tenn. 1998).
12. To which one might ask, how does an insurer know if it lost settlement opportunities, witnesses, documents, or other evidence, especially early in its handling of the claim, just after a late tender is made?
13. *Prince George's Cnty.*, 879 A.2d at 97.
14. 482 A.2d 503 (Md. App. 1984).
15. *Fed. Kemper Ins. Co.*, 482 A.2d 503 (Md. App. 1984), *disapproved on other grounds*, *Sherwood Brands v. Hartford Accident & Indem. Co.*, 698 A.2d 1078 (Md. 1997).
16. 879 A.2d 81 (Md. 2005).
17. 815 F.2d 890 (3d Cir. 1987).
18. *Alcazar*, 982 S.W.2d at 854; *Miller v. Dilts*, 463 N.E.2d 257, 265 (Ind. 1984).
19. *Alcazar*, 982 S.W.2d at 854 (Tenn. 1998); *State Auto. Mut. Ins. Co. v. Youler*, 396 S.E.2d 737 (W. Va. 1990) (uninsured motorist case; courts also consider length of delay and reasons for it).
20. 984 F.2d 76 (2d Cir. 1993), *aff'g* 788 F. Supp. 214 (S.D.N.Y. 1992).
21. 984 F.2d at 77.
22. 879 A.2d 81 (Md. 2005).
23. *Id.* at 89.
24. *Id.* at 90.
25. *Id.* at 100.

26. *Id.*
27. 595 N.E.2d 1311 (Ill. App. 1992).
28. *Id.* at 1315.
29. *Id.* at 1316.
30. *Id.* at 1317.
31. 854 F.2d 94 (5th Cir. 1988).
32. *Id.* at 99.
33. *Id.* at 97
34. *Id.* at 98.
35. *Id.* at 99.
36. 815 F.2d 890 (3d Cir. 1987).
37. *Id.* at 895.
38. *Id.* at 896.
39. *Id.*
40. *Id.* at 897–98.

41. *Id.* at 899; *see also* Atlanta Int'l Ins. Co. v. Checker Taxi Co., 574 N.E.2d 22 (Ill. App. 1991) (no violations of notice provision where there were defenses to liability that affected valuation of claim; notice provisions “contemplate that the insured may exercise some discretion in evaluating the claim”); U.S. Fire Ins. Co. v. Vanderbilt Univ., 267 F.3d 465 (6th Cir. 2001) (Tennessee law) (insured university conducted unconsented, undisclosed experiment giving pregnant women radioactive iron isotopes in 1960s; it did not give timely notice of this occurrence in 1960s, nor in 1985, when information was requested by the U.S. Department of Energy for congressional hearings; it did give timely notice of 1994 claim by these women; late notice barred coverage where excess policy used “likely to involve” language); Am. States Ins. Co. v. Nat'l Cycle, Inc., 631 N.E.2d 1292 (Ill. App. Ct. 1994) (notice given after 17 months of discovery and four months after codefendant had settled out in a good faith settlement, cutting off contribution, established prejudice supporting denial).

42. *See* *Imparato Stevedoring Corp. v. Lloyd's Underwriters*, 27 A.D.2d 827 (N.Y. App. Div. 1967) (“The fact that the primary insurer duly attended to the defense of the third-party action against plaintiff constitutes no excuse for plaintiff's failure to comply with the condition of the policies as to notice.”); *but see* *Am. Centennial Ins. Co. v. Warner-Lambert Co.*, 681 A.2d 1241, 1245–47 (N.J. Super. Ct. Law Div. 1995) (“When a primary carrier/excess carrier relationship is involved, proper notice entails the primary carrier, not the insured, advising the excess carrier of the existence of the claim. To ensure proper notice is given, the primary carrier must also notify the excess carrier on an ongoing basis of any settlement discussions or pending litigation.”).

43. 681 A.2d 1241 (N.J. Super. Ct. Law Div. 1995).

44. *Id.* at 1246; *see also* *Pasker v. Harleysville Mut. Ins. Co.*, 469 A.2d 41 (N.J. Super. Ct. App. Div. 1983) (holding the court should consider the insurance industry promulgated guiding principles when fashioning a remedy for a situation described therein).