CASE STUDIES ON AGENTS DUTIES, STANDARD OF CARE AND OTHER ISSUES

(Comprehensive E&O risk management information and guidance is available on the BIG I and Swiss Re website E&O Happens)

Course Description: Learn how you can prevent many types of errors and omissions involving commercial liability insurance. When you successfully complete this course, you'll be able to recognize and prevent many of the problems associated with selling and servicing such as: commercial auto insurance, workers' compensation and employers' liability, and commercial excess umbrella policies.

DUTY AND STANDARD OF CARE CASES

a) **Rodriguez v. Charlton Manley Insurance agency et. al.**
   - **i)** Insurance coverage – CM sold a policy to Kansas State High School Athletics Association – $5,000,000 excess accident insurance policy providing coverage for accidental injury to students participating in athletic and other events within the jurisdiction of the Association. The policy provided coverage for going to and coming from events in some instances.
   - **ii)** The accident occurred when a student soccer player hitched a ride to the soccer game with another player, even though a bus had been provided for transporting the players. The student rode in the bed of the pickup driven by the fellow player. The fellow player ran a stop sign, and was hit by an oncoming car. The rider was thrown from the back of the P/U. He suffered terrible injuries and was left in a permanent vegetative state.
   - **iii)** The year before the accident the policy had been replaced by a policy from another company because the former carrier decided to pull out of the market.
   - **iv)** The current carrier declined coverage because policy required transportation to or from an event be authorized and subject to compensation. The former policy would have arguably provided coverage
   - **v)** The injured student sued the carrier, school district and agent/agency. The agent/agency were sued for failing to provide the same coverage for going and returning from events that was in the former policy.
   - **vi)** Agent/agency was granted summary judgement

vii) Why did the agent/agency get summary judgment?

(1) In replacing coverage, the agency contacted every company that sold this type of coverage and requested a proposal. The agency documented requesting the proposals. Only three companies provided proposals.

(2) The agent submitted all three proposals to the Board of the Association even though the Mutual of Omaha proposal was clearly the best.

(3) The agent only recommended the Mutual of Omaha proposal when asked for his recommendation. He did not tell them which to take. This was documented in the board notes.

(4) The agent recognized the difference in the coverage for transportation to and from events and brought this to the attention of the Associations executive Director.

(5) At the request of the Executive Director the agent drafted a notice that was sent to all School Districts and Schools pointing out the change is coverage.

(6) In the notice the agent did not attempt to interpret the policy language just quoted it.

(7) Consequently, the agent did not expand the agent's duty to that of an insurance advisor.

viii) Lessons:

(1) You can do everything right and still get sued.

(2) But if you do everything right you reduce your chances of getting sued.

(3) If you do everything right, you greatly increase your chances of winning if the case is tried or being able to settle the case for a much smaller amount.

b) <u>Lyndon house case</u>

i) Facts of case:

(1) The insured's house was insured under a dwelling policy in connection with a farm policy.

(2) The insured made improvements to the house but did not advise the agent.

(3) This was a situation where a replacement cost calculator was not required and not used.

(3) The insured claimed the agent had a duty to ask about improvements and generally to make sure the home was properly valued and insured.

(4) The court entered a directed verdict in favor of the agent at the end of the evidence.

ii) Duty case:

(1) The court found the agent did not have a duty to ask about improvements or make sure the house was properly valued.

(2) Under Kansas law is the owner has the responsibility to know the value of his property.

iii) Lessons:

(1) There was no evidence the agent represented he was the insured's "insurance advisor" or that he would make sure the insured's property was "fully covered" or that he acted in any way other than making sure he obtained the insurance the customer requested.

(2) This case never went to the jury even though it was tried to a jury. Duty is a question of law decided by the Judge not the jury.

c) <u>Marshall v. Cohen</u>

i) Facts of the case:

(1) The insured was an oil field operator who asked the agent to cover his operation.

(2) The insured testified at trial he told the agent he couldn't afford to "to take a bath on this". The insured also testified the agent told him he would take care of him and he would make sure he was fully covered. The agent disputed this.

(3) An oil well fire occurred. These fires are very difficult and expensive to extinguish. The insured had to hire an expert (Red Adair) who was extremely expensive to extinguish the fire. The cost to extinguish the fire was excluded under the policy.

(4) There was a policy available that would have provided coverage, but it was extremely expensive, although far less than the cost of extinguishing the fire. The agent testified he did not quote the policy because the insured was very cost conscious, and he was sure the insured wouldn't buy it. The insured testified he would have bought the policy with the expanded coverage if the agent had quoted it.

(5) The judge ruled the agent had expanded his duty to essentially that of an insurance advisor and allowed the case to go to the jury on the question of whether the agent should have quoted the additional coverage.

(6) The jury ruled in favor of the insured.

ii) Lessons:

(1) The court expanded the duty to that of an insurance advisor because of representations by the agent

(2) The defense the customer would not have agreed to pay for additional coverage never works unless it is very well documented

(3) Producers should document all substantive conversations with the customer

(4) Check the E&S market to determine whether the coverage the insured wants is available. The defense the coverage is not available is also a defense that rarely works because some E&S carriers will write almost anything if you pay them enough.

d) <u>Builder's risk case</u>

i) Facts of the case

(1) A retired agent of the agency first wrote the insurance for the customer twenty or more years before the claim occurred.

(2) Customer was a contractor that builds man lifts often attached to the exterior of a structure.

(3) The agent that wrote the coverage initially did not include or quote for Builder's Risk coverage and agreed he probably should have

(4) The agency reviewed the customer's insurance coverages annually and did not pick up the fact there was no Builder's Risk coverage. The agency owner felt that should have been caught.

(5) The case was settled

ii) Standard of care issues:

(1) The insured asked for "insurance coverage" not specifically Builder's Risk coverage.

(2) A reasonably prudent insurance agent would probably at least quote Builder's Risk insurance. So, the fact the customer didn't specifically ask for it is probably irrelevant.

(3) Also, a reasonably prudent insurance agent would review coverage every year on this type of account and notice there was no Builder's Risk coverage.

iii) Lessons:

(1) Try as much as possible to anticipate the risks of the customer. Risk analysis software, like Reference Connect, Rough Notes, Virtual Risk Consultant and others can help.

(2) It is a good idea, particularly on large accounts like this one to annually review coverage. The review should include a risk analysis to determine whether there is coverage the customer may need but doesn't have.

e) <u>Shangri La airport case</u>

i) Facts of the case:

(1) A husband and wife owned a small business and the wife wanted to learn to fly. The company bought a small plane and the wife took pilot's training.

(2) While the wife was still in pilot's training the husband contacted his insurance agent to get coverage including passenger liability coverage. The agent checked with his standard admitted carriers and found the highest limits he could get was $50,000 per seat. The agent quoted this to the husband who purchased it.

(3) The wife ultimately obtained her pilot's license. She crashed when she landed short of the runway while flying with her daughter-in-law to the Shangri La resort airport. The daughter-in-law was permanently injured and disfigured in the accident.

(4) There was evidence to show that while none of the agency's standard markets would write for more than $50,000 per seat, even after the wife obtained her license, additional coverage was available in the E&S market.

(5) The agent testified in his deposition the husband was very insurance cost conscious and would never have agreed to pay the higher premium for the E&S coverage with higher limits. The Husband testified in his deposition he would have paid the higher premium for the higher limits.

(6) The case was settled for a substantial amount of money

ii) Duty- obtain passenger liability coverage

iii) Standard of care – limits – The opposing expert testified in his deposition a reasonably prudent agent would have tried to obtain more than 50K per seat.

iv) Lessons:

(1) An agent may have to quote E&S coverage. The defense that coverage is not available almost never works because if you pay Lloyds enough, they will insure almost anything.

(2) There was never any real discussion about limits. The agent just got 50K because that was the most the agent could get through the agency's standard markets

(3) This is another case where the defense the customer would never have agreed to pay the higher premium for additional coverage did not work.

(4) Our expert recommended a standard disclaimer he used in his agency to the effect, , "additional coverages and/or higher limits may be available. If you are interested in additional coverages or higher limits please contact us".

v) Disclaimers – not a silver bullet but may help. Worst disclaimer ever. "Not responsible for injury caused by operation of automatic door". Good disclaimer "This website contains links to third party websites. This agency is not responsible for the content of these websites"

f) <u>Party bus case</u>

i) Facts of case

(1) Landscape business owned a party bus

(2) When the bus was purchased it had 15 seats and a pole for dancing
(3) The owners took out the pole and added an additional seat, so it then had 16 seats. The agent was aware of the change.
(4) DOT regulations require liability limits of $5,000,000 for a passenger bus with 16 or more seats. The liability limit of the policy for the bus was only $1,500,000
(5) The added seat was installed in front of a door and was not installed correctly. A young pregnant women fell out of the bus and was killed.
(6) The bus owners brought an E&O case against the agent and agency. The agent (who was inexperienced in selling trucking insurance) told the E&O carrier he told the bus owners to check the DOT regs to see how much liability insurance was required but there was no documentation of that. At his deposition he testified he thought he told this to the owners but "couldn't swear to it. The bus owner testified the agent never asked him to do that.
(7) There was a link to the applicable regulations on the agency website.
(8) The case was settled for a substantial amount.

ii) Duty – obtain liability insurance

iii) Standard of care

(1) You have to take into account the type of business you are insuring. In this case a bus with DOT authority.
(2) A reasonably prudent insurance agent selling trucking insurance should know the limits required by DOT regs.

iv) Lessons:

(1) There was no documentation of any of the contacts between the agent and the customer.
(2) This agent wrote little or no trucking business. I would consider this specialty type business. Don't write specialty type business unless you understand what is required both legally and as a matter of best practices. Risk analysis software can be a big help here. So can checking with others that regularly write the specialty business.
(3) There was a link to the applicable regs on the agency website. Most agents do not know what is on their websites. Agency staff should review the website, so they know what it contains. In doing website reviews I've noticed a lot of agency websites have extraneous links. I would recommend taking those off the websites.
(4) There was also a lot of E&O inappropriate language on the website such as the staff were "experts", the staff would find the perfect policy, the customers would be fully protected, etc. This sort of language can not only expand the agency's duty but can also provide fodder for a plaintiff's attorney arguments in settlement negotiations or at trial.

g) <u>Baking Institute Case</u>

i) Facts of the case

(1) The Baking Institute carried out a variety of operations concerning baking. One of these was to conduct inspections of food processing plants. During one policy year, the Institute did, among others, inspections of a sugar refinery and peanut butter processing plant. Subsequently there was an explosion and fire at the sugar refinery, and a salmonella contamination of peanut butter from the processing plant. There were multiple deaths and injuries from the sugar refinery explosion and fire and multiple deaths and illnesses from the peanut butter contamination.

(2) The Institute had a CGL policy with a professional services exclusion and a professional liability policy with a bodily injury exclusion. Both the CGL and the professional liability carriers denied coverage; the CGL carrier because of the professional services exclusion and the professional liability carrier because of the bodily injury exclusion.

(3) The Institute sued both carriers and the insurance agency. The plaintiff's petition against the agency included several quotes from the agency's website with E&O inappropriate language arguing these representations expanded the duty of the agency. Generally, the Institute alleged the agency had a duty to obtain coverage that would cover the Institute for bodily injury claims resulting from its inspections.

(4) After the carriers declined coverage the Institute was able to find a professional liability policy in the E&S market that covered bodily injury from another agency. Interestingly this same agency had initially competed for the business and submitted a proposal with the same companies and same coverages.

(5) The case was settled.

ii) The case involved both duty and standard of care issues

(1) The duty issue was whether the agency's duty was expanded to that of an insurance advisor because of the representations on the agency's website.

(2) The standard of care issue was whether a reasonably prudent insurance agency would have obtained a special professional liability policy from the E&S market that covered bodily injury.

iii) Lessons:

(1) Sometimes agents must think outside the box to cover an unusual risk. Probably 99 out of 100 agencies would have insured the institute the way this agency did. Part of the problem was the Institute didn't inspect for safety. It inspected the customer's processing procedures. The Institute ultimately paid out little or nothing on liability, but the defense costs were enormous. Agents

and agencies must consider the potential for being sued even if there little or no liability risk.
(2) E&O inappropriate language on agency websites (or social media) has become a huge problem. It is currently Swiss Re's E&O insurance program's number 1 priority. Clean up the language on your websites.

h) <u>Hospital case south of Wichita</u>

i) Facts of the case
(1) A hospital in a small town south of Wichita decided to shop its insurance with another agency.
(2) In addition to the hospital buildings proper the hospital owned an old building, it acquired through a donation, it used as a wellness center, located in the business district, a few blocks from the hospital grounds.
(3) Its existing policy provided coverage based on the agreed value of each building. The agreed value was the limit for each of the buildings.
(4) The new agent got copies of the existing policy and previous applications from the hospital showing the seize of the downtown building as 1900 sq. ft. with a replacement cost value at $325,000. The agent used this information for the application to the new carrier. The agent did not get the application signed.
(5) The agent did not inspect or view the building and did not check county records or any other source to check the accuracy of the information.
(6) The size of the building was actually closer to 19,000 sq. ft.
(7) The building was insured on an ACV basis on the old policy. The new agent insured it on a replacement cost value. Had the agent accurately reported the seize and value of the building the carrier would probably never have insured it on a replacement cost value.
(8) The case was settled.

ii) Standard of care case
(1) Clearly the agent had a duty of obtain insurance for the building, so this is a standard of care case. It would have gone to a jury if it hadn't settled

iii) Lessons:
(1) Don't rely on someone else's work. Make sure the information on earlier policies and paperwork is accurate.
(2) Actually, look at the property on a risk like this or at the very least check the public records.
(3) Make sure you get a signed application.

i) <u>Oklahoma Convenience/liquor Store case.</u>

i) Facts of the case

(1) The insured was a convenience store owner. The store was in Oklahoma close to the Kansas border. It was insured through a Kansas agency.

(2) Unbeknownst to the agency the owner added a liquor store to the convenience store.

(3) Unlike Kansas, Oklahoma has a dram shop act.

(4) An underage boy bought liquor at the store, got drunk and crashed his car. He was killed in the accident.

(5) The parents of the boy sued the convenience/liquor store owner. The owner then sued the agency for failure to provide Liquor Liability coverage.

(6) There was conflicting deposition testimony whether the producer on the account knew or should have known the liquor store was added to the convenience store.

(7) The agency had the Trusted Choice Pledge posted on its website. One of the agency owners was grilled in his deposition on certain language in the Trusted Choice Pledge that implied the agency was acting as the insured's insurance advisor rather than just his insurance agent.

(8) The case was settled.

ii) Duty/standard of care case

(1) That analysis is kind of blurred, because the agency's duty depended on whether the producer knew or should have known the owner had added a liquor store. There was also a question of whether the duty of the agency's duty was expanded to an insurance advisor and if so what was the standard of care for an insurance advisor under these circumstances.

iii) Lessons:

(1) Probably do an annual review on a risk like this to determine whether there have been any change in operations

(2) Consider doing an inspection of the property depending on the risk

(3) Make sure the staff understands what the law of the state where operations are being conducted. In this case the fact Oklahoma had a dram shop act was critical.

(4) If the Trusted Choice Pledge is posted on your website or if there is a link to it, take it off the website. Check your website for other E&O inappropriate language.

j) <u>Prison renovation case</u>

i) Facts of the case

(1) The general contractor contracted to renovate one of the cell blocks at Leavenworth Penitentiary. This is a massive structure.

(2) Prior to starting the renovation another agency approached the contractor about writing its insurance. One of the recommendations of the agency was to replace the contractor's builders risk policy with a less expensive installation floater policy.

(3) Typically, the major difference between the policies is the builders risk remains in effect until the project is accepted by the owner while the installation floater terminates once the equipment is installed. The agency proposed to get an endorsement added to the installation floater policy extending coverage until the project was accepted.

(4) The contractor agreed to the proposal of the new agency.

(5) After the new policy went into effect the contractor installed and filled the a new refrigeration unit for air conditioning the cell block with water. It froze and ruined the unit. The contractor made a claim to the tune of several hundred thousand dollars for replacing the unit to the new carrier who denied it based on an exclusion in the installation floater for freezing. There was no freezing exclusion in the builders risk policy.

(6) The contractor made an E&O claim against the agency that was settled.

ii) Standard of care case. Would a reasonably prudent insurance agency check the exclusions in the policies before replacing coverage in this situation

iii) Lessons:

(1) If you are going to duplicate coverage make sure you really are duplicating coverage or at least point out coverages may not be identical and document it.

(2) If you are moving insurance to a different company review the policy forms to make sure the coverage is the same. This is especially important when moving coverage to a non-admitted carrier.

REPORTING LOSSES

KAR 40-1-34 REQUIRES AGENTS TO REPORT CLAIMS

k) Mulch case

i) Facts of the case

(1) A pallet manufacturer also made mulch from old pallets. The mulch piles could be as high as 60 feet.

(2) One of these started smoking from a fire deep in the mulch pile.

(3) The owner of the manufacturer talked with the agent and, according to the agent, decided he wanted to try and put out the fire before reporting a claim

(the owner disputed this). Accordingly, the agent did not report the claim at that time.
(4)These types of fires are very hard to extinguish.
(5) Sometime later the fire was still burning when a neighbor threatened to sue the manufacturer for smoke pollution. The manufacturer contacted the agent and told the agent to report the claim to the insurance company.
(5) The agent did so but the company denied the claim based on late reporting.
(6) The manufacturer sued the insurance carrier and the agent when the company denied the claim. In a somewhat confusing procedural setting the insurance company also sued the agent claiming indemnity if the company had to pay the claim.
(7) Ultimately the court ruled the carrier was not damaged by any late reporting because the company did everything anyone could have done to extinguish the fire. The court found for the agent on the company's claim against the agent because it ruled there was coverage and eventually ruled against the carrier on its indemnity claim against the agent because the company wasn't damaged by the agent's failure to report the claim initially.

ii) Lessons:

(1) Even though the carrier had to ultimately pay the manufacturer's claim all this could have been avoided if the agent had reported the claim initially.
(2) Regardless of customers wishes agents contractually and legally are required to report claims.
(3) On an occurrence based policy, carriers cannot deny claims based on late reporting unless they can show prejudice.

l) Nursing home case

i) Facts of case

(1) A resident of the nursing home chocked to death eating a sandwich. The family was upset but didn't make a claim at the time.
(2) The administrative nurse contacted the nursing home their agent to report the incident. The agent decided not to report the incident to the insurance company (a non-admitted carrier) as no claim had been made at that time. The policy was a claims made policy.
(3) The nursing home decided to shop the coverage with another agent. The nursing home decided to place coverage with the new agent with a different company. The new agent told the nursing home to be sure to report any existing or potential claims to the existing carrier before the policy expired.

The nursing home didn't report the chocking death because it had already reported the incident to the agent and the family had not made a claim.
(4) After expiration of the old policy the family made a claim against the nursing home. The agent reported the claim to the insurance carrier under the automatic extended reporting provision in the policy.
(5) The company denied the claim relying on the policy provision that the extended reporting provision only applied to actual and potential claims. The company also denied the claim arguing the policy required the insured to report any claim or potential claim directly to the company.
(6) The case was settled.

ii) Lessons:

(1) Report all claims and potential claims to the company as soon as possible. Had the agent done that here all of this would have been avoided. Also, under Kansas law you should report claims to the company as soon as possible so the company will have time to investigate and notify the insured within the required time period if it disclaims coverage.
(2) The above is especially important when dealing with claims made policies because there is a good argument the company does not have to show prejudice to deny a claim for late reporting.
(3) Be sure you understand the reporting requirements in the policy. This is especially important when dealing with non-admitted carriers.

DOCUMENTATION CASES

m) Work Comp LLC Case

i) Facts of case

(1) A producer set up an initial meeting with the customer's owner to inspect its operations. The customer had set up several LLCs as separate entities. All of them, however, were in one building where each LLC had a separate space. The owner of the LLCs showed the producer around and described what each LLC did.

(2) With respect to one of the LLCs the producer noticed there were several people working and explained the owner would need worker's comp insurance for the LLC. The owner, however, explained the people working there were all independent contractors and the LLC had no actual employees. Hence the LLC didn't need work comp coverage.

(3) None of this was documented by the agent who was also the owner of the agency.
(4) One of the LLC workers was very seriously injured in an automobile accident. He filed a worker's compensation claim as an employee of the LLC. During the work comp proceedings, it was determined the worker was an employee and not an independent contractor. The worker and the Worker's Compensation Fund filed a claim against the LLC. The LLC filed an E&O claim against the agency for failing to obtain work comp coverage
(5) The owner of the LLC denied there was any discussion with the agent on the status workers at the LLC.
(6) There was also E&O inappropriate language on the agency's website
(7) The case was settled

ii) Lessons:

(1) Document all substantive contacts with customer including initial contacts. This is particularly important for producers.
(2) Document what coverages were offered, and which were rejected. This can be done with checklists and/or proposals. If feasible get the customer to acknowledge this is writing.
(3) Swiss Re suggests setting up AMS files for prospective customers.
(4) Any time anyone says their workers are independent contractors and not employees it should raise a big red flag.
(5) Clean up the website language

n) <u>Sterling college case</u>

i) Facts of the case.
(1) Sterling college contracted to restore and renovate, with an addition, a historic building on campus. The agent for the college wanted to insure both the old building and new addition to the building during the renovation.
(2) The agent contacted the college's insurer on how to insure the building during the renovation.
(3) The company basically manuscripted a policy using forms from three different polices, the existing property coverage policy on the building, an inland marine policy and a builders risk policy. The result was a very convoluted manuscripted policy with some conflicting provisions.
(4) The building collapsed during construction. At least four engineers inspected the building to determine the cause of the collapse. Although there was some speculation none could definitively determine the cause.

(5) The company denied the claim based on certain exclusions and provisions in the policy.
(6) Before denying coverage the company took a recorded statement from the agent.
(7) Ultimately the college sued the company and the agent.
(8) The company and the agent's E&O carrier agreed to each pay half the cost to settle with the college and litigate which would be responsible. The loser would reimburse the winner.
(9) The court held a bench trial and ruled there was coverage under the policy. The company then reimbursed the agent's E&O carrier its half of the settlement

ii) Lessons:
(1) The agent kept meticulous notes of all conversations with the company. These were extremely helpful in defending the case.
(2) If there are conflicting provisions in an insurance policy they will be construed in favor of the insured.
(3) The insured has the burden of proving it generally comes within the policy coverage and the insurance company has the burden of proving an exclusion applies. Here the company relied primarily on an exclusion for wind causing the collapse, but the court found the engineers could not determine the cause of the collapse hence the exclusion did not apply.
(4) There was probably a very good case for reformation of the policy based on the agents notes of his conversations with the company, but the court didn't need to decide the reformation issue because it found there was coverage under the policy.
(5) Do not give recorded statements or depositions in any situations where there is any possibility of a coverage dispute without notifying your E&O carrier and getting their approval.

o) <u>The General Agency case</u>

i) Facts of the case
(1) The agent was a general agent for the insurance company.
(2) The customer was a religious youth group with a camp in Colorado
(3) The youth group's employees used their private vehicles to transport kids to the Colorado camp. The youth group wanted liability insurance covering the group and their employees while transporting the kids.
(4) The company had provided the agent with underwriting guidelines on a computer disk. The agent could not get the disk to work on its computer system. Instead of trying to solve this problem with the company computer

disk the agency's staff would just call the company's underwriters to get authorization to bind coverage on a particular risk.
(5) The underwriting guidelines made it pretty clear this was not an acceptable risk.
(6) Because the underwriting guidelines were not available one of the agency staff called an underwriter and got a quote for the coverage. She wrote down the premium for $1,000,000 of coverage on a telephone message slip.
(7) The underwriter testified at trial the agency CSR was just asking for information on an auto liability policy and did not explain the risk the CSR wanted coverage for, nor did she ask to bind coverage. The underwriter said the premium figure she gave the CSR was the minimum premium for the $1,000,000 of liability coverage.
(8) The general agency collected the premium and issued the policy.
(9) Shortly afterwards there was a bad accident on the way to the Colorado camp very seriously injuring one of the children. The child's injuries and damages far exceeded the $1,000,000 limit. The company paid the $1,000,000 limit and sued the agency for indemnity.
(10) The case was tried and in a very close decision the jury held for the insurance company.

ii) Lessons:
(1) Document all substantive contacts with underwriters or other company representatives.
(2) Make sure the documentation is complete and understandable.
(3) If the company issues underwriting guidelines or other rules the staff is supposed to follow, make sure this is available to all staff and they follow the guidelines or rules.

ADDITIONAL ISSUES
(To be covered if time permits)

TORT CLAIMS ACT (ZISK CASE)

IMPORTANCE OF EPL COVERAGE

WHEN IN DOUBT QUOTE THE COVERAGE

CHECKLISTS AND REJECTIONS DOCUMENTATION

IMPORTANCE OF RETRO DATES AND REPORTING WHEN REPLACING CLAIMS MADE COVERAGE