Claims-made, Claims-made and Reported, Wrongful Act, and Occurrence Policies

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The following is an excerpt from a paper on "E&O and Professional Liability Insurance" by Walter E. Brock, Jr.

Professional liability policies are often "claims-made" or "claims-made and reported" policies rather than occurrence-based policies. Under a claims-made policy, a claim must be made during the policy period in order for there to be coverage. Under a claims-made and reported policy, both a claim must be made and that claim must also be reported during the policy period. A grace period may apply for claims made late in a policy period. Coverage may also apply for claims reported during an extended reporting period.

Note that in this context the term "claim" generally refers to the demand of a third party against an insured for money or, in some instances, the existence of facts creating a reasonable expectation that such a demand will be made. The term "claim" does not refer to a request by the insured that it be indemnified by the insurer. This request (or an indication that such a request may need to be made) is instead referred to as making a "report" to the insurer or as giving "notice" to the insurer. An occurrence-based policy, on the other hand, typically covers bodily injury or property damage that occurs during the policy period, regardless of when a claim is made or the claim is reported to the insurer.

When a claim occurs depends upon the policy language, though some policies may not include a definition for what constitutes a "claim". Those that do include a definition are likely to include actual demands for money (whether in the form of a lawsuit or not). Some may include actions indicating a demand is likely, even if a specific demand is not made.

In American Continental Ins. Co. v. PHICO Ins. Co., 132 N.C. App 430, 512 S.E.2d 490 (1999), the Court of Appeals examined whether a request for medical records by an attorney was a claim. The request for records, by itself, was of course not a demand for money. Id. at 432, 512 S.E.2d at 493. However, the policy at issue defined claim to also include "an act or omission which the insured reasonably believes will result in an express demand for damages ... ." Id. at 433, 512 S.E.2d at 492. Because the hospital's risk manager "reasonably anticipated an express demand for damages" once the attorney's request for medical records was made, that constituted a "claim" under the policy. Id. at 435-36.

The court similarly held in Gaston Memorial Hosp. Inc. v. Virginia Ins. Reciprocal, 80 F. Supp. 2d 549, 554 (W.D.N.C. 1999), that a request for medical records by itself is not a claim in the sense that it is not a demand for money. However, a report by the hospital to the insurer that a birth with complications had occurred, coupled with a letter from an attorney requesting medical records, was sufficient to find that a claim had been made. Id. at 557.

In this same vein, the date upon which the underlying injury occurred is typically irrelevant for purposes of determining when a "claim" or "report" was made. However, such date may be important when a policy includes a retroactive date or a prior acts limitation.

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