# Agenda
## St. Clair Shores City Council Special Meeting
## Monday, June 22, 2009
**27600 Jefferson Circle Drive, St. Clair Shores, MI 48081 (586) 447-3303**

There will be a City Council Special Meeting on **Monday, June 22, 2009 immediately following the 7:00 p.m. Study Session** in the Municipal Building, 27600 Jefferson Circle Drive, St. Clair Shores, Michigan.

The agenda will be as follows:

1. Consideration of Insurance Proposals for the fiscal year beginning July 1, 2009
2. Audience Participation

ST. CLAIR SHORES CITY OFFICES

MARY A. KOTOWSKI
City Clerk

Posted: June 18, 2009

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Council Meeting
June 22, 2009

AGENDA ITEM #1. Consideration of Insurance Proposals for the fiscal year beginning July 1, 2009

BACKGROUND: Insurance coverage through the Michigan Municipal Risk management Authority expires at 12 am July 1 2009. We have received proposals from Michigan Municipal Risk Management Authority and Arthur J. Gallagher Risk Management Services, Inc.

ENCLOSURES: Insurance quote comparison
Memo from Timothy P. Haney

RECOMMENDED ACTION: Select insurance renewal for the year beginning July 1, 2009.

SUBMITTED BY: Timothy P. Haney, Director of Finance / Treasurer

MOTION BY:_____ SUPPORTED BY: _____

VOTE: AYES: _____

NAYES: _____

ABSTAIN: _____

ABSENT: _____

City of St. Clair Shores
Insurance quote comparison

| | IBEX Insurance Agency - Keith Potter | Arthur J. Gallagher Risk Management Services Inc. - Jack Tallerico & Mike Miller |
|---|---|---|
| | Michigan Municipal Risk Management Authority | Travelers / Chubb |
| | | |
| Insurance company? | No | Yes |
| We have interest | Yes | No |
| Claim with maximum expected exposure (self insured retention) of up to $200,000 | We designate attorney with their concurrence. Settlements over $10,000 with Council concurrence | We designate attorney they reserve the right to settle claim. (1) |
| Claim with maximum expected exposure (self insured retention) over $200,000 | We may or may not be able to designate attorney. They have right to settle claim. | They designate co-counsel and reserve the right to settle claim. (1) |
| Price | $399,563 | $348,986 |
| Price with extended reporting periods | $399,563 | $361,829 |
| Year 2 maximum increase | 3% | ? |
| Surplus distribution program | Yes ($429,246 over last 3 years) | No |
| Self Insured Retention "SIR" | $200,000 | $200,000 |
| Aggregate liability limit | $600,000 | $500,000 |
| Sewer backup | $250,000 SIR to $500,000 limit | $200,000 SIR to $1,000,000 limit negligence only |
| Coverage | Occurrence | Occurrence & claims made mix |
| Risk avoidance program (grants) | Yes ($36,401 over last 4 years) | No |
| Michigan no fault personal injury protection and property protection self insured retention | $0 No self insured retention | $200,000 SIR |
| Eminent Domain, inverse condemnation | $200,000 SIR | No coverage |
| Sexual Abuse limit | $15,000,000 | $15,000,000 (1) |

(1) based on letter from Gallagher not consistent with plan documents

**City of St. Clair Shores**

# Memo

**To:** Honorable Mayor Hison and City Council

**From:** Timothy P Haney, Director of Finance and Treasurer

**CC:** Kenneth R. Podolski, City Manager

**Date:** June 11, 2009

**Re:** Insurance Renewal

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The City received two proposals for property, casualty and liability insurance for the year beginning July 1, 2009.

The current provider Michigan Municipal Risk Management Authority proposed to continue the current coverage including a $250,000 self insured retention at a price of $514,531. This is a 5% reduction in price from the current year. Subsequently they re-priced their quote to $399,563 with a self insured retention of $200,000 (sewer remains at $250,000). The aggregate liability limit was originally quoted at $703,000 and subsequently reduced to $600,000. They also bid a 2 year agreement with the second year rate increase limited to no more than 3%. The MMRMA has quoted insurance coverage on an *occurrence* basis which means we have coverage no matter when a claim is presented to us.

Arthur J Gallagher Risk Management Services, Inc. also gave us a proposal this year. The proposal is from Travelers, Ins. Companies for liability and crime and the Chubb Group for property. The proposed premium is $348,986. Subsequent to the original proposal the deductable was lowered from $250,000 to $200,000. The aggregate liability limit is $500,000.

Gallagher has proposed *occurrence* policies for public entity general liability, law enforcement liability (an umbrella over these two policies), property and vehicle coverage.

Gallagher proposed *claims made* coverage for employment practices liability, public entity management liability, employee benefit plans liability and excess errors and omissions liability. *Claims made* coverage means that a claim has to be made while the policy is in force. Gallagher originally proposed indefinite extended reporting periods on all of the *claims made* policies at a cost of 75% of the original premiums. Subsequently, they amended the

proposal to limit extended reporting periods to 3 years on the employment practices and public entity management liability policies for 75% additional premium. The other two can be extended indefinitely for an additional 75% premium. The *claims made* proposals from Gallagher are not apples to apples with the MMRMA *occurrence* based proposal. If we want to make it closer to an apples to apples comparison we have to include the 75% additional premium that total cost is $361,829.

The potential savings is large however; it is my recommendation to stay with full *occurrence* coverage. One claim made under the *claims made* polices after the policies expire could expose the City to great liability. If a claim was pending from a minor we have exposure until one (1) year after they reach 18 years old. The first year of a *claims made* policy is usually very economical because there are no "tail" claims from previous years. Subsequent years tend to increase in cost because you need to insure the tail claims back to the date you started with a *claims made* policy

Another factor to consider is that it is very expensive to convert back to an *occurrence* based policy from a *claims made* policy. This year we have been quoted 75% of premium. Normal premium for tail coverage is up to 200%. You have to purchase insurance on the tail claims if you can find it. If not, you go uninsured on any potential claims after the reporting period or extended reporting period.

The attached letter from Keith Potter details some of the benefits of remaining with the MMRMA. In that letter Mr. Potter refers to the surplus distribution program the MMRMA instituted three years ago. Over the past three years we have received on average $143,000 in refunds. In the current year we received $231,900. Unfortunately, because of recent investment performance, the MMRMA Board has decided to not make a distribution this coming year. If you consider the average refund the cost difference between the two quotes is $105,000 in favor of the MMRMA quote.

MMRMA has been a pleasure to deal with throughout the years. They pay claims promptly without contention and there coverage language is very broad. It is ultimately Council's decision as to which company we select to provide insurance and risk management services for the upcoming year.

Also enclosed are articles on *claims made* and *occurrence* insurance policies.

RISK Michigan Municipal MANAGEMENT AUTHORITY

May 21, 2009

Mr. Tim Haney
**City of St. Clair Shores**
27600 Jefferson Circle Drive
St. Clair Shores, MI 48081-2093

Dear Mr. Haney:

As you are aware the City of St. Clair Shores has been a Member of the Michigan Municipal Risk Management Authority (MMRMA) since 1985. The City joined the MMRMA when private sector insurance companies abandoned governmental entities during the mid-80's and decided it was not profitable to continue to do business with Cities, Counties and Townships. The MMRMA, formed under Public Act 138, is not an insurance company but a group of Michigan governments that came together to solve a problem.....to provide coverage and risk management services to themselves.

The MMRMA is operated by and for Michigan governmental entities only. The Board of Directors is made up solely of city managers, county administrators and other officials from its Members. All MMRMA committees are made up entirely from the Membership. Mr. Curtis Dumas currently participates on the DPW advisory committee on behalf of the City of St. Clair Shores. The MMRMA Loss Control staff only works on areas of concern to Michigan governmental entities and assists in implementing model policies and procedures in an attempt to minimize the frequency and severity of claims for all Members.

Over these many years the MMRMA has been able to provide a constant and stable insurance and risk management product for its Membership; stable coverages and pricing. They have always been in a position to offer occurrence form of coverage for all liability lines while; generally speaking, kept the pricing stable with minimum increases. This program has managed to operate on a "break-even" basis from an underwriting standpoint; i.e. they have paid out claim dollars that match the premiums collected.

While holding those premiums until they have to be paid out, there has been an investment return which has been a great benefit to the Members. For over ten years the MMRMA has paid out million of dollars under the Risk Avoidance Program (RAP) so that Members can make positive changes in an attempt to avoid and/or minimize claims against themselves. Over the past 4 years the City of St. Clair Shores has received $36,401 under this program.

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The MMRMA has also enhanced coverages with these funds. An example would be; the Member deductibles and Self Insured Retentions do not apply to Personal Protection Insurance and Property Protection benefits under Michigan automobile No-Fault coverages or uninsured or underinsured motor vehicle coverage.

As you are aware, the greatest benefit to the Membership recently has been the excess surplus distribution program. Due to the fact that the City of St. Clair Shores has been a long standing Member of the MMRMA, you have received $429,246.00 during the past three (3) year under this program. Unfortunately due to the overall decline in the market during the past year there will be no distribution, but hopefully as the stock market recovers the Board of Directors of the MMRMA will once again be in a position to distribute excess surplus. The three most important factors in the calculation process are; a) length of current continuous membership, b) current premium and c) loss history for the most recent five (5) years.

I hope that the City will seriously consider this while making the difficult decision they are confronted with.

Sincerely,

Keith L. Potter
Regional Risk Manager

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Massachusetts Medical Society

## Claims-Made vs Occurence Coverage

### The Difference Between Claims-Made and Occurrence Coverage

| | Claims-Made | Occurrence |
|---|---|---|
| **Limits of Coverage** | Coverage will respond to incidents arising on or after the policy retroactive date and which are reported during the term of the policy. | Coverage will respond to incidents arising from the coverage period - regardless of when those claims are reported. |
| **Prior Acts-or Retroactive Coverage** | Policy may be endorsed to respond to incidents which occurred before the policy start date. also referred to as policy retroactive date. | No Prior Acts coverage is needed. |
| **Extended Reporting or Tail Coverage** | Tail coverage responds to cover incidents that have not been reported to the company during the policy term. Some companies will offer a free tail at retirement, subject to certain conditions. | No Tail coverage is needed because incidents that occurred during the policy period are covered no matter how much later they are reported. |
| **Cost** | Claims made coverage involves a step process with premium increases over the first five years of coverage in increments proportional to the claims reporting for that experience. The initial premium and subsequent years' premium are substantially lower than an occurrence policy. By the fourth or fifth year the claims made premium reaches a mature level and premium adjustments are based on annual rate changes only. | Occurrence coverage tends to be very expensive because the insured is prepaying for tail costs whether the tail gets used or not. |

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# Who's Afraid of Claims Made?

The insurance industry experienced a liability crisis during the mid-1980s that changed the industry forever. Insurance companies received decades-old claims for asbestosis and pollution damages, while the courts introduced new legal theories to ensure that policyholders had coverage and victims were compensated. Concurrently, insurance companies had record general- and specialty-liability losses causing the revision of underwriting guidelines and premium charges. The industry cancelled or nonrenewed thousands of policyholders, rewrote all of the commercial insurance policies using simplified language, and introduced a claims-made liability policy.

Prior to the 1980's crisis, the vast majority of liability policies (including professional liability) were written on an occurrence form. Coverage under an occurrence policy is triggered based upon when the accident or injury happened; thus, the policy in force on the date of the accident responded to the claim regardless of when the claim was presented to the insurance company. For example, if a child were harmed in 1985 but the injury didn't manifest itself until 2003, the 1985 policy would cover the loss. Most claims are reported promptly and don't involve a long time between the occurrence and the resolution of the claim. However, the advent of asbestos, pollution and other latent-injury claims created a crisis in determining when the injury occurred and which policy was to respond. The courts resolved the issue by expanding the definition of occurrence to include all policies in force from the first exposure to the harmful situation to the manifestation of the injury. The new interpretation of "occurrence" created a pricing problem for the insurance industry, since the companies had to calculate current premiums for losses that might not be submitted for 10 to 20 years. The effects of economic inflation combined with social inflation (the amounts rendered by juries that affect the amount offered by the insurance companies and the amount the plaintiffs expect to receive) were impossible to predict and, without change, would lead to substantial premium increases. The claims-made policy offered a solution to these problems. In a claims-made policy, coverage is triggered if the claim is made *during the policy period* for an injury or damage that occurred *after the policy's retroactive date.* The new insurance company is no longer responsible for any losses occurring prior to the retroactive date.

## Claims Made Concerns

A claims-made policy has certain provisions that if not understood can get a nonprofit into trouble. The potential problems involve the retroactive date and the extended reporting period.

### Retroactive Date

Claims-made policies didn't become common until the 1980s and were written for entities that previously had occurrence coverage. Any losses that occurred prior to the first claims-made policy were insured under the previous occurrence policies. The insurer, to avoid redundant coverage and prior exposures, added a retroactive date to the policy. The claims-made policy doesn't insure any incidents that occur before the retroactive date, which is usually the inception or start date of the first claims-made policy. For example, if the nonprofit purchased its first claims-made policy on January 1,

2000, with that as its retroactive date, the policy wouldn't cover any claims arising from an accident occurring prior to January 1, 2000, even if the claim is presented during the current policy term. The nonprofit's prior occurrence policies would cover that loss.

The rule is: Never change the retroactive date. Often when a nonprofit changes insurance companies, the new carrier wants to advance the retroactive date to the inception date of its policy. If the carrier does this, the nonprofit has no coverage for any losses that occur between the date of its first claims-made policy and the inception date of the new policy. This creates a huge gap in coverage that is expensive to address. The only exception to this rule is if the new policy is written with "full prior acts" coverage and a retroactive date doesn't apply.

**Extended Reporting Period**

A claims-made policy requires that the claim be presented to the insurance company during the policy period. If a nonprofit learns of a situation that could lead to a claim or receives a notice of a claim, it must notify the insurance company immediately and before the policy expires. This reporting provision is difficult to comply with if the nonprofit receives notice of the claim near the policy's expiration date. Be sure to have procedures in place to report a claim policy immediately — a delay in reporting can negate coverage. Some insurance companies provide a 30-day extension beyond the policy expiration to report claims for that policy period.

Several situations necessitate the purchase of an Extended Reporting Period (ERP). An ERP extends the claims-reporting provisions for a specific time period beyond the policy expiration date. A nonprofit should purchase the extended reporting period when:

1. The nonprofit ceases all operations and cancels or nonrenews its claims-made policy.
2. The insurance company cancels or nonrenews a claims-made policy and the nonprofit is unable to obtain new insurance coverage.
3. The nonprofit replaces a claims-made policy with an occurrence policy.

Under all three of these situations, the nonprofit wouldn't have insurance coverage for any losses that occurred after the retroactive date and weren't reported to the insurance company prior to the last policy's expiration date. The ERP extends the reporting provisions so that the nonprofit can report any claims received during the extended reporting period to the insurance company. The purchased extended reporting period can be for several months or up to three years. The cost depends upon the nature of the risk with the premium charge ranging from 50 percent to 200 percent or more of the expiring annual premium.

Each policy has very specific requirements for activating and purchasing the extended reporting period. The insured usually needs to notify the insurance company in writing of the desire to purchase the ERP, request the coverage within 30 days of the expiration date and pay the premium in full before the coverage is in force. Talk to an insurance advisor before ending any claims-made coverage.

## Occurrence Concerns

Occurrence policies tend to give policyholders a somewhat false sense of security with

the assumption that any injury occurring during the policy period is covered. However, injuries that may occur but not be reported for a long time can cause problems, such as inadequate limits from an older policy, an impaired aggregate and an accident arising from ceased operations.



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### Low Limits on Previous Policies

The limits of liability from previous policies may not be adequate for paying today's claims. If an incident occurred 20 years ago, the nonprofit may have had $50,000 or $100,000 per occurrence — very low limits by today's standards. These older limits don't meet today's insurance needs and place the nonprofit's assets at risk.

### Impaired Aggregate

Another issue involves the 1986 introduction of the "general aggregate" for the commercial general liability and many umbrella policies. When a policy has a general aggregate, any paid or reserved claims are charged against the general aggregate, reducing the funds available to pay future losses. When the remaining general aggregate limit falls below the occurrence limit, the nonprofit no longer has full policy limits available for future claims or loss payments. When this occurs, the aggregate becomes "impaired," leaving the nonprofit with a greatly reduced policy limit that may be inadequate to meet its needs.

### Discontinued Operations

If a nonprofit goes out of business or ceases certain operations, it may still have products or work in existence that can cause an injury but have no insurance coverage. Any injuries occurring after the last policy expires aren't insured since the injury occurred after the end of the policy term. The board members responsible for the dissolution of the nonprofit could be personally liable for any insured losses. To be protected, the nonprofit would have to purchase insurance coverage for "discontinued operations" and continue to pay for the coverage long after the nonprofit has closed its doors.

## Summary

Insurance is a complex issue requiring every nonprofit to have a trusted insurance professional to help it through this maze. The use of claims-made policies can complicate the handling of an insurance program but shouldn't be feared. The main factors to remember are to never advance the retroactive date, and once the coverage is written on a claims-made policy never convert to an occurrence policy without exploring the cost and need for an extended reporting period.

HARPER RISK Inc. etc.

Fri September 12, 2008



# CLAIMS MADE vs. OCCURRENCE

What follows is a description of the various issues relating to this topic.

Where a policy is written on a "claims-made" basis, this means that the policy in force at the time a claim against you is made will pay for losses, regardless of when they occurred in the past. (Assuming no retroactive inception date restriction).

With an "occurrence" based policy, even though the policy may have expired, provided the policy was in force at the time that the bodily injury or property damage occurred, a claim can still be made against it.

Both forms of coverage have advantages and drawbacks, depending on the circumstances. It is difficult to predict whether, in any particular instance, it will be advantageous to insure using one form or the other. Only in hindsight can a judgment be made.

## Advantages of "occurrence" policies

- "Occurrence" policies are sometimes like "money in the bank," in that you can go back to old policies, years after they have lapsed and put a claim against them for incidents that happened while they were in force. Old policies should never be thrown away. They should be kept in a place of safekeeping.
- You don't have to worry about canceling an "occurrence" policy and moving to a different insurer. Coverage remains locked in for incidents occurring while the policy was in force, so long as the insurer is in business. In contrast, once a "claims-made" policy is cancelled, it is possible that purchasing insurance for past events will become difficult, expensive or perhaps not possible.
- Sometimes courts will find occurrences in successive policies if there is continuing harm. This can have the effect of accumulating limits over a period of years. With "claims-made," only one limit applies; that in force when the claim is actually made.

## Disadvantages of "occurrence" policies

- Insurance companies who wrote policies in previous years may no longer be around. With "claims-made" policies, the insurer is much more likely to be around when a claim becomes payable. The length of time between an occurrence and resolution in court can be 20 or more years. An insurer in business 20 years ago may not be in business today. The only way to mitigate this risk with "occurrence" insurers is to change to a different one every few years so that you do not keep "all your eggs in one basket."
- The limits on an "occurrence" policy are likely to be inadequate if a claim is made twenty years after a policy has expired. With "claims-made" it is easier to arrange a limit which is adequate for today's exposures.

For malpractice exposures written on an "occurrence" basis it is important to arrange limits which are somewhat more than is necessary in order to meet tomorrow's exposures. On a "claims-made" basis, one does not need to project twenty years or more into the future when setting limits; 7 years is usually the longest time it takes for a case to go through the court system, so even though you still need to project into the future, the length of time is much less.

## Advantages of "claims-made" policies

- Limits can be predicated on today's exposures more accurately than with "occurrence" policies, so there is less likelihood of being underinsured.

There are advantages to some "claims-made" policies in addition to normal "claims-made" advantages as follows:

- Previous inadequate "occurrence" basis limits can be topped up retroactively.
- Previous inadequate coverage or more restrictive terms exceptions and conditions can be broadened out retroactively.
- The above two advantages can be made to apply whether the insured was previously on either "occurrence" or "claims-made" policies.

## Disadvantages of "claims-made" policies

- Coverage is triggered by an actual claim for damages, not a notice of an "occurrence" or "incident." However, the date of the occurrence or incident must be more recent than the retroactive date of the policy. This retroactive date determines the cut-off date for claims: if the incident occurred before the retroactive date, the insurer has no obligation and the insured no coverage. While the claim has to be made during the policy period, the occurrence which gave rise to the claim has to fall after the retroactive date of the policy. A "claims-made" policy wording covers as follows:

> *This insurance does not apply to "bodily injury" or "property damage" which occurred before the retroactive date, if any, shown in the Declarations.*

A "claims-made" policy can have:

- No retroactive date (the broadest coverage).
- A retroactive date that pre-dates the policy inception date (this may range from days to years). Ideally, it should go back at least to the expiration date of your last "occurrence" policy. If it goes back further it can be designed to provide top-up cover in the case of different limits.
- A retroactive date that is the same as the policy inception date - this is the most limited coverage and excludes any claim for damages that occurred prior to the policy inception. It is acceptable only if prior to this policy "occurrence" coverage was in force or full "tail" coverage has been purchased on any previous "claims-made" policy.

Ideally, you want no retroactive date or one that includes the entire period that you have had "claims-made" coverage. Anything less makes you self-insured for any claims for injuries or damage that occurred during prior claims-made policy periods which you have not reported to your insurer at the time of the occurrence (unless such claims are covered by supplemental "tail" coverage).

- The first claim for damages determines which policy applies. If a person first makes a claim for medical payments in 1986, then files for additional damages in 1988, both claims activate the 1986 claims-made policy.
- With "claims-made" basis of coverage, should the policy ever be allowed to lapse or be cancelled, the insured is generally given the option of purchasing coverage, for a period of limited to 36 months following expiry of the policy (extended reporting period). Any "claims-made" during this 36 month period would then be covered. With "occurrence" policies you don't have to worry about past incidents when lapsing coverage or changing insurers.
- If coverage terms ever become more restrictive on subsequent renewal of a "claims-made" policy, the new terms apply retroactively to the original retroactive or inception date.

## Limits of Liability and need to project into the future

For "occurrence" based coverage, I suggest buying much higher limits than with claims made, bearing in mind that an incident today may not be ruled upon in court for, at the low end, a few years, and at the high end, for over twenty years. It is difficult to predict what the amount of the awards will be at some time in the future. It is therefore advisable to choose a limit that is somewhat in excess of the amounts being awarded for single injury cases today. For "claims-made" coverage a lower limit is more likely to be adequate.

## Changing Policies

When arranging coverage, consider:

If you switch from "occurrence" to "claims-made" coverage. If you switch from "occurrence" coverage to a "claims-made" policy with a retroactive date being the same as the date of the change, and then 1 year later you buy another "claims-made" policy from another insurer, be sure that it picks up coverage dating back to the date when you first changed from "occurrence" to "claims-made." Otherwise, you will need full "tail" coverage on the expiring "claims-made" policy to protect you from future claims that occurred during this period but were not reported as occurrences. Ideally, the retroactive date of any new "claims-made" policy should be the expiration date of the last "occurrence" policy.

**Switching "claims-made" policies and carriers.** When a "claims-made" policy expires, so does its coverage, even for injuries that occurred during the policy year(s), but were not reported. The Extended Reporting Period ("tail" coverage) provided by the policy, extends the reporting time for occurrences during the policy period.

Once an Insured is hooked on a "claims-made" policy it is difficult to get off. The Insured is given a 90 day "tail" coverage extension which can sometimes be extended to 1 / 5 years, and even this is at the option of the Insurer, and is not under the control of the Insured.

90 days, or even 1 year, is simply not enough on "long "tail" business, to catch all the claims, which may be made at a future date; particularly when claims may be forthcoming twenty years or more after the occurrence takes place.

The only effective answer to the problem is to either leave the cover with the "claims-made" carrier, who will likely maintain retroactive cover back to the date when the first change over from "occurrence" took place, or purchase prior acts coverage from the replacement "occurrence" basis insurance company.

To purchase "tail" coverage from the existing "claims-made" insurer, might only provide the insured with 5 years coverage which is not enough. 5 years may not even be available, and if it is, it may be expensive.

**Notifying the insurer of an occurrence** does not trigger coverage; an actual claim for damages must be made. The question whether you have coverage for a claim will depend on many and often complex factors, such as

1. the retroactive date of your present policy;
2. the "other insurance" clause of your present policy - if the incident was reported under a previous policy, your present policy may not cover at all or only on an excess basis,
3. "tail" coverage,
4. the status of the aggregate limit of the policy that applies.

## "Tail" coverage

Claims made policies usually only provide a 90-day extended reporting period beyond the expiration of the policy during which claims that occurred during the policy period can be reported.

"Claims-made" policies can sometimes be broadened to provide the following extensions to the standard 90 days "tail" coverage

### Basic "tail"

(Extended Reporting Period) extends for five years after the policy expiration date. It does not restore the policy limit and is quite limited in scope; it only covers claims due to occurrences (1) that the insured reported during the policy period or 60/90 days thereafter, (2) that occurred after the retroactive date in the policy to which the "tail" coverage is attached, (3) that are not covered by any other policy when the claim is made, and (4) if the aggregate limit of the policy is not yet exhausted.

The purpose of the basic "tail" (also called Extended Reporting Period) is to fill gaps in coverage when, for example:

1. the insurer cancels a claims-made policy and the insured cannot find a replacement;
2. the insured retires from business or from a certain operation;
3. the insured changes carriers or switches from a claims-made policy to an "occurrence" policy -- and vice versa;
4. the claims-made policy is renewed subject to a later retroactive date;
5. a renewal claims-made policy is modified with a "laser" endorsement. ("laser" endorsements added to claims-made policies that exclude specific accidents, products, or locations. Because the exclusions are very narrow, they were thought to resemble a laser.)

### Full (Supplemental) "tail"

A policy with full "tail" coverage comes close to an "occurrence" policy. It excludes incidents that occur after the policy to which the "tail" is attached has expired or that occurred prior to the retroactive date of that policy. For claims arising from reported occurrences, coverage begins five years after the policy period when the basic "tail" ends; for all other claims, sixty/ninety days after the policy period (to prevent overlapping with the Basic "tail").

The cost for full "tail" coverage is usually 200% of annual premium. The "tail" premium will restore the original general and the products-completed operations aggregate limits of the policy. The option to purchase full "tail" coverage is guaranteed, even if the policy is canceled.

Full "tail" coverage is essential (1) when an insured retires from business, or (2) when the insured changes insurers or policies and the new policy has a later retroactive date. When changing insurers, the insured must carefully weigh the new insurer's promise of cheaper coverage (due to its limited exposure) against the cost of purchasing "tail" coverage from the old carrier.

The policy provision for "tail" coverage usually reads:

We will provide one or more Extended Reporting Periods ... if:

1. This Coverage Part is cancelled or not renewed; or
2. We renew or replace this Coverage Part with other insurance that:

i. Has a retroactive date later than the date shown in the Declarations of this Coverage Part; or

ii. Does not apply to "bodily injury" or "property damage" on a claims-made basis.

## Limitations of "tail" Coverage

The five-year or basic "tail" is sometimes free of charge but covers only those claims that have been reported during the policy period or 60/90 days thereafter and while the original limit is not yet exhausted. Supplemental "tail" coverage must be purchased to cover claims that were not reported during this period.

Both "tail" coverages apply only to claims stemming from injuries or damage that occurred during the policy period back to the retroactive date. It does not cover claims that occurred prior to such date, nor after the policy expires.

"Tail" coverage is considered excess if any other policy (whether primary, excess or contingent) applies.