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D&O POLICY COMMENTARY

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The material in this outline is not intended to provide legal advise as to any of the subjects mentioned but is presented for general information only. Readers should consult knowledgeable legal counsel as to any legal questions they may have.

Directors and officers (“D&Os”) generally have two sources of financial protection in the event claims are made against them for alleged wrongdoing: indemnification from their company and insurance.

A company usually can indemnify its directors and officers for defense costs, settlements, judgments and other loss incurred by the D&Os in claims alleging wrongdoing in their capacity as directors or officers. However, indemnification by the company is generally considered, by itself, inadequate protection because, among other reasons, indemnification may not be available for the following reasons:

- The company may become insolvent or may not have sufficient resources to pay the losses and expenses incurred by the D&O.
- Because of public policy considerations and statutory limitations, some claims may not be indemnifiable. For example, settlements and judgments in lawsuits brought by or on behalf of the company are not indemnifiable in most states and loss arising from violation of the federal securities laws may not be indemnifiable, although such loss may be insured.
- Either the applicable law or the company’s internal indemnification provisions may be modified to limit or prohibit the expected indemnification.
- The composition or attitude of the company’s board of directors may change so that the board is no longer sympathetic to protecting prior directors and officers.

In light of these potential gaps in indemnification protection, D&O insurance has developed as a second source for D&O financial protection. D&O insurance is generally viewed as the ultimate backstop protection for directors and officers, affording coverage (subject to its terms and conditions) for loss which is otherwise not covered by other types of insurance purchased by the company and which may not be indemnifiable by the company.

D&O insurance policies are somewhat unique in nature and create complex legal, underwriting and management issues which are difficult to identify and analyze without the assistance of knowledgeable experts. The insurance is not written on a common policy form; rather, each D&O Insurer has developed its own form. The policy should not be viewed as a commodity which can be purchased from different Insurers each year depending upon who offers the lowest premium. Rather, the insurance coverage should be viewed as a long-term relationship between the Insurer and the Insureds.

The following discussion generally describes the purpose and intent of the more important provisions in typical D&O insurance policies and summarizes many of the important variations among different D&O insurance policies available in today’s market.

I. INSURING CLAUSES

Types of Coverages. Traditional D&O insurance coverage is actually two distinct coverages within one policy. The first coverage, referred to as the personal or direct coverage,

reimburses the individual directors and officers for losses which are not indemnified by the company. The second coverage, referred to as the corporate reimbursement coverage, reimburses the company for its indemnification of loss incurred by the D&Os. Both of these coverages apply only to loss incurred by the directors and officers in claims against the directors and officers. Neither of these two coverages insure loss incurred by the company for claims against the company. Although both of these coverages are contained in the same insurance policy, each will be set forth in a separate Insuring Clause and each will be subject to different retentions, co-insurance and perhaps exclusions.

Many D&O policies issued to non-profit and private for-profit companies include a third coverage, which insures loss incurred by the company resulting from claims against the company even if directors and officers are not also named as defendants. This “entity” coverage is typically not available to publicly-held for-profit companies (other than with respect to securities claims) and is frequently subject to several additional exclusions.

Claims-Made Coverage. Virtually all D&O policies are “claims made” policies, covering claims that are first made during the policy period even if the underlying alleged wrongdoing occurs prior to the policy period. Stated differently, the existence of coverage is determined based upon the policy in force when the claim is made, not the policy in force when the alleged wrongdoing occurs. This type of coverage allows the Insurers to estimate with reasonable accuracy soon after the end of a policy the amount of losses likely to be paid under that policy and protects Insurers against surprising claims first made years after the policy expires.

In light of this claims-made coverage, it is imperative that companies continue to renew their D&O insurance policy. Claims are frequently made against D&Os several years after the alleged wrongdoing occurred. If the policy was purchased only for the year in which the alleged wrongdoing occurred and was not renewed for subsequent years, a claim made in a subsequent year alleging that prior wrongdoing would not be covered.

Conversely, if the D&O policy was in force when the claim against the D&Os is first made but was not in force when the alleged wrongdoing occurred, coverage under the policy would apply unless a “prior acts” exclusion is added to the policy. Typically, D&O policies do not contain such an exclusion and afford coverage for alleged wrongdoing which takes place before the policy incept if the wrongdoing results in a claim during the term of the policy.

All Risk Coverage. D&O policies generally afford coverage for claims against directors and officers resulting from any wrongful act or omission committed by the directors or officers in their capacity as such, unless the wrongdoing is specifically excluded from coverage. Unlike some other types of insurance coverage, D&O insurance policies do not limit their coverage only to certain specifically listed perils, but instead afford so-called “all risk” coverage (i.e., any claim first made during the policy period resulting from any type of alleged wrongdoing is covered unless specifically excluded).

Pay-On-Behalf-Of Coverage. The Insuring Clauses of D&O insurance policies typically require the Insurer to pay covered loss on behalf of the Insured. A “pay on behalf of” type of coverage is broader than an “indemnity” coverage which merely requires the Insurer to indemnify or reimburse the Insureds for covered loss. Technically, under an indemnity coverage,

the Insurer can require the Insureds to first pay the loss and then seek reimbursement from the Insurer. However, under the preferred “pay on behalf of” coverage, the Insurer is obligated to pay the covered loss once the Insured is legally obligated to pay that loss, even though the Insured has not yet actually paid the loss.

Outside Position Coverage. Many, but not all, D&O policies cover claims against Insured Persons not only for alleged wrongful acts in their capacity as such, but also for alleged wrongful acts in their capacity as a director or officer of certain other organizations (“Outside Entity”) if the Insured Person’s service with that Outside Entity is at the request of or with the consent of the Insured Company. This “Outside Position” coverage typically applies to all Outside Positions held by Insured Persons in any non-profit Outside Entity, even if the Outside Positions are not specifically listed in the Policy (i.e., “blanket” non-profit Outside Position coverage). However, coverage for Outside Positions in for-profit Outside Entities usually applies only if the Outside Entity is specifically listed in the Policy and the Insurer has an opportunity to analyze that for-profit Outside Entity. Any coverage under the Policy for an Insured Person serving in such an Outside Position is excess of any indemnification available from or insurance maintained by the Outside Entity. Stated differently, the Policy affords coverage only if and to the extent loss incurred by the Insured Person in the Outside Position is not indemnified by the Outside Entity or the Outside Entity’s own D&O insurance.

II. DEFINITIONS

Claim. Most D&O policies today define what is a Claim and when is the Claim first made for coverage purposes. Typically, the definition is quite broad, and includes written demands, civil or criminal proceedings and, with respect to D&O coverage only, administrative, regulatory or investigative proceedings. A civil proceeding is typically defined to commence upon service of a complaint or similar pleading on the Insured, and a criminal proceeding is typically defined to commence upon the return of an indictment against an Insured. Administrative, regulatory or investigative proceedings are usually defined to commence by the filing of a notice of charges, formal investigative order, target letter or similar document. When the claim commences is important since the policy only covers claims first made during the policy term.

Although the expansion of this definition to include administrative, regulatory or investigative proceedings may appear attractive to Insureds, such a provision can ironically result in a loss of coverage if the Insureds do not timely report to the Insurer such a proceeding. D&O policies require Insureds to report a claim to the Insurer as soon as practicable. If the Insureds fail to report such a proceeding as soon as practicable but wait until a lawsuit is actually filed, the Insurer may contend the claim was not timely reported to the Insurer and therefore coverage may be jeopardized.

Insureds. D&O policies typically insure current and former directors, trustees and officers of the Insured company, as well as managers of limited liability companies. Privately-held for-profit company policies also insure employees, and non-profit organization policies also insure employees, committee members, volunteers and faculty. For publicly-held for-profit companies, the positions of general counsel, comptroller and risk manager, for example, may not

be considered officers and therefore may not be Insured under the Policy unless those positions are specifically listed as Insured.

The companies Insured under the Policy include not only the company named in the Policy's Declarations, but all subsidiaries (organizations which are more than 50% owned or controlled by the company). A few policies also include 50% or less owned organizations if the Insured Company is entitled to elect or designate the majority of the Board for that minority owned organization. Also, some D&O policies include as Insured Companies foundations, charitable trusts, political action committees and perhaps other types of Section 501(c)(3) organizations sponsored exclusively by an Insured Company.

In addition to covering claims against Insured Persons, D&O policies also cover claims against spouses of Insured Persons if a claim is made against the spouse by reason of the spouse's status as such or by reason of the spouse's common ownership of property with the Insured Person. The Policy, though, does not cover claims against the spouse for alleged wrongdoing by the spouse, but only claims for alleged wrongdoing by Insured Persons.

Similarly, D&O policies also cover claims against the estate, heirs, legal representatives or assigns of any Insured Person who dies or is incompetent, insolvent or bankrupt. However, the Policy does not cover claims against such third parties for their own wrongful acts, but only claims against those third parties for wrongful acts of the Insured Persons.

Loss. D&O policies include within the definition of Loss any damages, settlements, judgments and defense costs incurred by the Insureds on account of a covered Claim. Importantly, the definition of Loss excludes from coverage certain types of Loss which are considered inappropriate for coverage in light of the nature of the Loss. For example, virtually all D&O policies exclude from the definition of Loss fines or penalties imposed by law or matters uninsurable under the law pursuant to which the policies are construed. Some, but not all, Policies also exclude from this definition amounts for which the Insureds are absolved from payment, taxes and the amount incurred by the Company to investigate possible claims on behalf of the Company (i.e., shareholder derivative demands).

Historically, this definition also has excluded punitive, exemplary or multiple damages. However, in recent years, many but not all D&O policies began including provisions which state that the definition of Loss does not exclude such damages. Such a provision does not necessarily mean that punitive, exemplary or multiple damages are covered, though, since the other exclusions in the Policy are still applicable (including the fraud or willful violation of statute exclusions). In addition, if such damages are uninsurable by law, no coverage will exist regardless of the Policy provisions. In order to maximize the likelihood that a covered punitive damage award will be insurable by law, some D&O policies contain a broad choice of law provision, which states that if any jurisdiction which has a substantial relationship to the Insureds, the Insurer, the Claim or the Policy allows the insurability of punitive damages, then that jurisdiction's law will apply to determine insurability. This type of broad choice of law provision also may state that the Insurer is prohibited from challenging the Insureds' determination as to the insurability of the punitive damage award.

Defense Costs. D&O policies typically define Defense Costs as reasonable costs (including attorneys' fees, expert fees and other costs) incurred in defending or investigating a covered Claim, including the premium for any appeal, attachment or similar bond. However, the definition frequently excludes from coverage any compensation or benefits of directors, officers or employees of the Company or other overhead costs of the Company.

III. EXCLUSIONS

Although many other provisions of a D&O policy are extremely important, the exclusions invariably receive the greatest attention by both Insureds and Insurers. The analysis of exclusions in a D&O policy cannot be limited to the "Exclusions" section of the policy. Coverage limitations tantamount to exclusions exist in several places within the policy form. For example, the definition of "Loss" typically states that Loss does not include fines or penalties imposed by law, taxes, or matters uninsurable under the law pursuant to which the policy is construed. Depending upon the policy form, this definition may also exclude punitive or exemplary damages, treble damages, amounts for which the directors and officers are not personally liable (i.e. non-recourse settlements), or the cost to comply with an injunction or other non-monetary relief, or amounts incurred by a special litigation committee in the investigation or evaluation of any claim by or on behalf of the corporation.

The "Other Insurance" clause may also operate as an exclusion. Although sometimes included within the policy exclusions, this clause is more typically a separate condition, stating that if Loss is Insured under any other valid policy, then no coverage exists under the D&O policy. Some policy forms apply this exclusion only to the extent of payment under the other policy, only to other "valid and collectible" insurance, or only up to the amount of such other insurance (thereby making the D&O insurance excess of the other insurance).

A. Types of Exclusions

There are generally four categories of exclusions in D&O policies. First, "conduct" exclusions seek to eliminate coverage for certain conduct which is deemed to be sufficiently self-serving or egregious that insurance protection is considered inappropriate. The personal profit and advantage, fraud, willful violation of law and illegal remuneration exclusions are examples.

Second, the "other insurance" category of exclusions implements the concept that the D&O policy is the ultimate "backstop" protection for directors and officers. If a corporation can purchase another type of insurance to cover a specific D&O risk, the D&O Insurer expects that other insurance to be purchased and therefore the D&O policy will not cover that risk. Examples of exclusions in this category include the exclusions for bodily injury/property damage, ERISA, libel and slander, notice under a prior policy and (at least historically) pollution.

Third, the "claimant" exclusions eliminate coverage for claims by certain types of claimants who for various reasons are viewed as presenting litigation risks which the Insurers do not want to cover. For example, claims by one Insured against another Insured are generally excluded (except for employment-related claims) and some policies may also exclude certain types of claims by regulators.

Finally, various “laser” exclusions are intended to address specific risks unique to the Insured which the Insurer has identified as inconsistent with its underwriting principles. For example, a private-company D&O policy may contain exclusions applicable to claims against the company for breach of contract, taxes, the costs to comply with non-monetary relief, a public offering of securities, or rendering or failing to render professional services.

It is critical to examine the introductory or preamble language at the beginning of each exclusion to determine the scope and effect of that exclusion. For example, the “bodily injury/property damage” exclusion (as well as numerous other exclusions) may eliminate coverage with respect to claims either “for bodily injury...” or “based upon or arising out of bodily injury...” The former is much narrower since it excludes only claims by a person who incurs the bodily injury, etc. The latter could also exclude, for example, a secondary derivative claim by shareholders seeking recovery from directors and officers for loss incurred by the corporation as a result of bodily injury, etc. suffered by third parties.

Another important provision relating to exclusions is the “severability” clause at the end of the exclusion section in the policy. This provision, if included in the policy, typically states that no fact pertaining to and no knowledge possessed by any Insured Person shall be imputed to another Insured Person. Thus, an exclusion applies to a particular Insured Person only if he/she committed the conduct or is otherwise subject to the matters described in the exclusion. An exclusion would not apply to one Insured Person simply because it applies to another Insured Person. These “severability” clauses frequently do not apply to any entity coverage (because the company is considered responsible for the conduct of its D&Os and employees), or alternatively imputes to the company for purposes of the exclusions only knowledge of executive officers of the company.

B. Selective Typical Exclusions

The following summarizes many of the more common exclusions to D&O policies:

1. Fraud/Willful Violation of Law. This exclusion has potential applicability in most D&O claims and therefore is frequently referenced in Insurers’ reservation of rights letters. The exclusion varies among policies in several respects.

First, the conduct falling within the exclusion varies among policies. Some policy forms exclude claims brought about or contributed to by the “dishonest” or the “fraudulent, dishonest or criminal” acts of the Insureds. Other forms exclude “deliberately fraudulent” or “deliberately dishonest” conduct or a “willful violation of law” or an “intent to cause injury.” If entity coverage is afforded, this exclusion is frequently amended to clarify whose knowledge or intent is used to determine the applicability of the exclusion. For example, the exclusion may apply to the entity coverage only if certain executive officer’s conduct satisfies the exclusion.

Second, various policy forms apply different triggering conditions to the applicability of this exclusion. Some forms require a judgment or other

final adjudication which establishes that the requisite conduct actually occurred. Other forms simply require the requisite conduct to have occurred “in fact,” while other forms have no express triggering condition. For those forms which require a final adjudication, courts have consistently held that the adjudication must occur in the underlying D&O proceeding (not in coverage litigation) and therefore the exclusion is inapplicable if the claim against the D&Os is settled. However, if the exclusion does not expressly require an adjudication, the exclusion can apply to settlements. Some newer D&O policy forms adopt a third type of trigger, invoking the exclusion if there is a finding in any judicial or other proceeding or an admission or statement by the Insured that establishes the requisite conduct occurred. This approach requires more proof than the “in fact” trigger, but allows the Insureds to invoke the exclusion even if the underlying claim is settled.

2. Personal Profit or Advantage Exclusion. Most D&O policies exclude claims against D&Os based upon or attributable to such directors or officers gaining in fact any personal profit, advantage or remuneration to which they were not legally entitled. Various forms either include or delete one or more of the underlying phrases. If the word “such” or a similar word is in the exclusion, then the exclusion applies only to the person who receives the illegal profit or advantage. If “such” is not included, the exclusion applies even to directors who failed to prevent the person from gaining the illegal profit. Typically, this exclusion applies to settlements and does not require a final adjudication in the underlying D&O litigation, although if the “in fact” language appears the exclusion is not triggered merely by unsubstantiated allegations.
3. Bodily Injury/Property Damage Exclusion. All D&O policies exclude coverage with respect to claims for bodily injury, sickness, disease or death, or damage to or destruction of tangible property including loss of use thereof. Some forms also include within this exclusion reference to emotional or mental distress, violation of a person’s right of privacy, wrongful entry, eviction, false arrest, assault, battery, etc. In addition, some policy forms include either within this exclusion or a separate exclusion reference to libel, slander or defamation. In addition, some non-profit D&O policies apply the property damage exclusion to loss of use of tangible property whether or not the property is damaged or destroyed.
4. Insured v. Insured Exclusion. Historically, the D&O policy form did not exclude claims by one Insured against another. However, because of several suits in the 1980s brought by corporations against their directors and officers under circumstances which created an appearance that the corporation was simply trying to convert its D&O policy to cash by suing its own directors and officers, virtually all policy forms now exclude claims brought by one Insured Person or Company against another.

The primary differences among policies with respect to this exclusion relate to which claims are excepted from the exclusion and therefore covered. Virtually all policies except (i.e. cover) derivative lawsuits brought on behalf of the Insured Company by shareholders without the solicitation, assistance or participation of an Insured. Other exceptions to the exclusion in many forms include claims for wrongful employment practices, claims by bankruptcy trustees or receivers, claims by former D&Os who have not served as such for at least 3 or 4 years, claims brought outside the US or Canada, and claims for contribution or indemnity.

5. Pending and Prior Litigation Exclusion. When an Insurer first issues a D&O policy to a corporation, an exclusion is frequently included which eliminates coverage for claims arising from pending or prior litigation or from any facts or circumstances involved in such litigation. The Insurers' intent is to avoid exposure for the "burning building" (i.e., claims which the Insured knew about or should expect when they purchased the policy). This exclusion will reference a date (frequently the inception date of the policy) which is used to determine whether the litigation is "pending or prior."

The primary differences between forms of this exclusion involve (i) against whom the pending or prior proceeding must be made, and (ii) what type of prior proceeding must exist. Some forms of the exclusion limit its scope only to proceedings against the corporation and/or its directors and officers. Other forms apply the exclusion to any pending or prior proceeding, whether or not an Insured is a party or even knows of the proceeding. Also, some forms of the exclusion limit its scope only to prior or pending litigation, while other forms apply the exclusion to prior or pending litigation, claims, demands, causes of action or proceedings.

This exclusion can be deceptively broad and may create inadvertent coverage gaps. For example, if the prior litigation asserts claims only against the corporation (or under the broad type of exclusion, against only a third party) and Insured D&Os are subsequently brought into the litigation or are subsequently subject to separate litigation based upon the same matters as alleged in the prior litigation, no coverage will exist under the newly issued policy. Unless a notice of circumstance referencing the matters alleged in the prior litigation was given to the prior D&O Insurer, if any, the defendant D&Os will be without any D&O coverage for such new claim.

6. Pollution Exclusion. Virtually every D&O insurance policy contains a broad pollution exclusion, although substantial variation in wording exists among Insurers. The intent of most Insurers is to exclude coverage for any type of direct or indirect pollution or environmental exposure, but

some exclusions are more comprehensive than others. By negotiation, Insureds may under some circumstances obtain an exception to this exclusion (and thus coverage) for (i) shareholder suits against D&Os arising out of environmental-related loss incurred by the corporation, (ii) D&O claims not indemnifiable by the corporation, (iii) “whistleblower” employment claims, or (iv) claims brought outside the U.S. or Canada. Also, occasionally the exclusion may not apply to defense costs or apply only to claims “for” pollution.

7. Miscellaneous Other Exclusions. The following lists various other exclusions which are either routinely or at least frequently included within D&O policies and which are generally self-explanatory:

- ERISA exclusion;
- Circumstances noticed to prior carrier exclusion;
- Broad form nuclear energy exclusion;
- Various exclusions applicable only to claims against the corporation, such as:
 - “bump-up” of purchase price where the company paid inadequate consideration for the re-purchase of its securities;
 - breach of contract or liability assumed under a contract;
 - intellectual property;
 - antitrust;
 - professional services; and
 - dividends or distributions of profit.

IV. MISCELLANEOUS TERMS

Limit of Liability. D&O policies are typically subject to an aggregate Limit of Liability, which is the maximum amount payable under the Policy for all Loss resulting from all Claims first made during the Policy Period. If the Policy Period is for two or more years, the Limit of Liability may apply separately to each year within that multi-year period, or may apply once to the entire multi-year period. If a single aggregate Limit of Liability applies to a multi-year Policy Period, many Policies contain a reinstatement provision whereby the Insureds can elect to purchase an additional Limit of Liability during the Policy Period if a Claim is made which may exhaust the available Limit.

Retention. D&O policies typically apply a retention only to coverage under Insuring Clause B (Corporate Reimbursement Coverage) and Insuring Clause C (Entity Coverage), but do not typically apply a retention under Insuring Clause A (Non-Indemnified D&O Coverage). Unlike the Limit of Liability, which applies to all loss in the aggregate, the Retention applies separately to each Claim. However, multiple claims arising out of the same or interrelated wrongful acts are generally treated as a single Claim for coverage purposes and therefore subject to only one Retention. Policies differently describe the requisite relationship between interrelated wrongful acts for purposes of determining whether multiple claims constitute a single Claim for purposes of the Retention. Some Policies define Interrelated Wrongful Acts as all “causally connected” acts, while other policies more broadly define Interrelated Wrongful Acts to include any acts which have as a common nexus any fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, events or transactions.

In order to discourage the company from wrongfully withholding indemnification to the Insured Persons, thereby avoiding the Insuring Clause B retention, many but not all D&O policies contain a “presumptive indemnification” provision. Such a provision generally states that if the company is legally permitted and financially able to indemnify the Insured Persons, then the company is presumed to afford such indemnification for coverage purposes, and thus the retention applicable to Insuring Clause B applies even if the company fails to provide such indemnification. Although this provision reasonably protects Insurers against a company’s efforts to circumvent the retention under the policy, this type of provision places the Insured Persons in a difficult position of having to personally fund the relatively large retention when the company wrongfully refuses indemnification. For that reason, a few D&O policies now delete this “presumptive indemnification” provision and instead allow the Insurer to subrogate against the Insured Company for payment of the wrongfully withheld indemnification, up to the amount of the Insuring Clause B Retention.

Some D&O policies now also contain a creative provision which applies the retention applicable to Securities Claims (or under a few policies, all claims other than Employment Claims) only to defense costs, not to any settlement or judgment. In addition, this type of provision frequently provides that the retention does not apply even as to defense costs if all defendant Insureds successfully defend the Claim without the payment of any settlement or judgment. This type of provision is intended to encourage the Insureds to define an exit strategy early in the D&O litigation. If the Insureds believe they must ultimately settle the case, this type of provision encourages an early settlement, thereby triggering coverage sooner, and thus avoiding needless defense costs which are otherwise payable by the Insureds within the retention. However, if the Insureds believe they can successfully defend the case, this type of provision rewards such success by waiving the retention entirely.

Co-Insurance. An increasing number of D&O policies contain a co-insurance provision which requires the Insured Company to pay a designated percentage of all loss otherwise covered under the policy. This co-insurance applies, if at all, only under Insuring Clause B (Corporate Reimbursement Coverage) and Insuring Clause C (Entity Coverage), but typically does not apply under Insuring Clause A (Non-Indemnified Personal Coverage).

Discovery Period. D&O policies allow Insureds to purchase a “Discovery Period” or “Extended Reporting Period” at the end of the policy’s Policy Period if the policy is not renewed or is canceled under certain circumstances. Some D&O policies make this election available if either the Insureds or the Insurer terminate or refuse to renew the Policy (other than for non-payment of premium). More frequently, though, D&O policies today make this election available only if the Insurer cancels or non-renews the policy. If the Discovery Period is elected, the Insureds must pay a designated additional premium and coverage under the Policy continues for the length of the Discovery Period, but only with respect to Claims made during the Discovery Period for wrongful acts occurring prior to commencement of the Discovery Period.

Defense and Settlement. For-profit D&O insurance policies (unlike some non-profit D&O policies) require the Insureds to defend covered Claims. Although the Insurer is obligated to pay covered Defense Costs, the Insurer does not have a duty to defend the Claim. Thus, the Insureds select defense counsel, subject to the Insurer’s consent. Defense costs paid by the Insurer reduce the Limit of Liability available under the policy for settlements and judgments.

Although Insureds generally control the defense of covered Claims, the Insureds must cooperate with the Insurer in connection with that defense and must allow the Insurer to effectively associate with the Insureds in the defense of covered Claims. The Insureds must also obtain the prior written consent of the Insurer before agreeing to any settlement. The consent of the Insurer to any defense counsel or proposed settlement may not be unreasonably withheld.

Some D&O policies contain a provision which states that if the Insurer recommends to the Insureds a settlement of a Claim which is acceptable to the claimant, but the Insured refuses to consent to such a settlement, then the Insurer’s liability for all loss on account of that Claim shall not exceed the amount for which the Insurer could have settled the Claim plus defense costs accrued up to the date the settlement was recommended by the Insurer to the Insureds. This so-called “hammer” clause places upon the Insureds the risk of rejecting a settlement proposal that the Insurer believes to be reasonable.

Notice. The D&O policy generally requires Insureds to give notice of a Claim to the Insurer as soon as practicable. Some policies also require the notice of Claim be given no later than a defined number of days (e.g., 30 days) after the end of the Policy Period. Some D&O policies require the Insureds to give notice of a Claim both as soon as practicable and within the Policy Period. Because D&O policies are “claims made” (i.e. the Claim must be filed or otherwise first made during the Policy Period), Insureds have relatively narrow coverage if the Claim must be both made and reported to the Insurer during the Policy Period. The Insureds have broader coverage if they are allowed to report after the Policy Period any Claim first made during the Policy Period. Otherwise, Claims made towards the end of the Policy Period will likely not be covered because the Insureds will not have sufficient time to give notice to the Insurer of such Claim within the Policy Period.

If Insureds learn of alleged wrongful acts or circumstances which could reasonably give rise to a future Claim, D&O policies allow (but usually do not require) the Insureds to give notice of that potential Claim to the Insurer during the Policy Period. If that potential Claim is actually made against the Insureds at a later date, the policy will treat that subsequent Claim as having been first made at the time the notice of potential Claim is given to the Insurer, even if the

subsequent Claim is made after the end of the Policy Period. In other words, Insureds can “lock up” coverage for a potential future Claim by giving notice of that potential Claim during the Policy Period. However, the policy requires that the notice of potential Claim be rather specific and detailed.

Allocation. The term “allocation” refers to the process of determining the amount of defense costs, settlements or judgments which is properly attributable or “allocated” to covered Claims against covered persons, on the one hand, and uninsured claims against uninsured persons, on the other. In essence, allocation simply refers to the process of determining the amount of Insured loss when that loss is commingled with uninsured loss. The allocation process is one of the most troubling aspects of D&O insurance claims handling and can result in a contentious claims handling environment if the Insureds and Insurer are not adequately forewarned of the allocation issues or reasonable in their allocation expectations.

D&O policies frequently address allocation in two contexts. First, some policies contain a provision which predetermines the allocation in any Claim which otherwise requires an allocation, regardless of the facts of that Claim. The primary differences between available predetermined allocation provisions include the following:

- Some provisions predetermine only the allocation between covered and non-covered parties, whereas other provisions also predetermine the allocation between covered and non-covered allegations or matters. The latter approach eliminates allocation disputes when a portion but not all of a Claim is subject to a coverage defense. Insurers are still entitled under such a provision to deny a claim in full.
- Most predetermined provisions in D&O policies issued to public companies apply only with respect to Securities Claims since the range of potential allocation percentages in such Claims is relatively small in most cases and because Securities Claims usually create the most contentious allocation disputes. Allocation provisions in D&O policies issued to privately-held companies typically apply to any type of Claim.
- The predetermined percentage may apply only to defense costs, to both defense costs and indemnity, or may apply different percentages to defense costs and indemnity.
- Instead of predetermining the allocation, the Policy may establish a minimum allocation percentage and allow the parties to negotiate a potentially higher allocation percentage.

Second, instead of predetermining the allocation, some policies simply define how the allocation will be determined in a particular case. The alternative methodologies typically included within D&O policies include the following:

- One approach is to simply provide that the parties will commit their best efforts to agree upon a fair and reasonable allocation under the circumstances of each claim.

This approach leaves unresolved both what methodology should be used in determining the allocation as well as what the appropriate allocation is. In at least several jurisdictions, this approach will likely result in the pro-Insured “larger settlement rule” applying. That rule states that, under a D&O policy issued to a publicly-held company, a settlement of a Claim against both Insured D&Os and the uninsured company shall be entirely allocated to the Insured D&Os except and to the extent the settlement is larger as a result of the uninsured company being a defendant. However, this approach creates the greatest amount of uncertainty regarding allocation and thus will likely engender the most disputes between the Insureds and the Insurer under D&O policies issued to publicly-held companies.

- Another defined methodology is to allocate based upon the relative legal and financial exposures of and relative benefits to the parties. This methodology is generally viewed as most favorable to the Insurer and requires the parties to examine not only the factual and legal strengths and weaknesses of the case, but also the financial impact and collectability of the defendants and the benefits derived by each defendant from the settlement or defense. Several newer D&O policy forms are adopting this methodology.
- As somewhat of a compromise methodology between the pro-Insured “larger settlement rule” and the pro-Insurer relative benefits methodology, some Insurers provide in the policy that the allocation will be based upon the “relative legal exposures” of the parties. This type of methodology excludes as irrelevant any consideration of the relative benefits and financial implications of the defense or settlement.

Changes in Exposure. Typically, D&O policies automatically cover any subsidiary which is created or acquired during the Policy Period, provided that the total assets or employees of the new subsidiary do not exceed a defined threshold (e.g., 25% of the consolidated total assets or 10% of the total number of employees of the Parent Company and its other Subsidiaries). If that threshold is exceeded, the coverage for the new Subsidiary and its Insured Persons will exist only if the Insureds give notice to the Insurer of the new Subsidiary and agree to any additional terms and conditions and any additional premium required by the Insurer with respect to that new Subsidiary. In other words, Subsidiaries below the threshold are automatically covered and Subsidiaries in excess of that threshold are covered only if the parties agree upon the terms and conditions of such coverage.

In addition, D&O policies state that if the Parent Company is acquired or merges into another company, coverage under the policy with respect to Wrongful Acts after the date of the acquisition automatically terminates. Although the policy remains in effect after the acquisition until the end of the Policy Period, the policy will only cover claims for Wrongful Acts taking place prior to the acquisition.

Other Insurance. D&O policies state that coverage under the policy is excess of any coverage available under any other valid and collectable insurance. This provision is intended to

implement the concept that D&O insurance is the ultimate “back stop” insurance for D&Os and that the D&O policy should be depleted only by a loss which is not covered under any other type of policy.

Cancellation. D&O policies frequently are cancelable by the Parent Company at any time without prior notice, and cancelable by the Insurer only upon 60 or 90 days prior notice. Some policies may not allow the Insurer to cancel (except for non-payment of premium), and may provide that the Parent Company may not cancel the Policy after the Parent Company is acquired. This latter provision is intended to assure ongoing coverage for former D&Os in the event of a change in control. If the Policy Period is multi-year, the Policy will likely be non-cancelable by either the Insurer or the Insureds. If the Insurer makes a multi-year commitment, the Insureds are expected to make the same commitment.

V. APPLICATION

Because D&O insurance typically affords claims-made coverage for prior Wrongful Acts, the D&O insurance Application provides to underwriters an important safeguard against insuring known risks. During the soft insurance market of the 1990s, D&O underwriters frequently waived the requirement for an Application, thereby eliminating a potentially dangerous coverage limitation for Insureds. However, in today’s market, underwriters are not only again requiring Applications, but are strengthening the protections they obtain from the Application.

As a result, it is now critically important that both underwriters and Insureds understand the various types of Application provisions and how those provisions apply in a claims context. The following summarizes the more important information typically included within a D&O Application from a claims perspective, the Insurer’s remedies in the event of false information in the Application, and the effect of different types of severability provisions to protect Insureds.

Application Information. From a claims perspective, the two provisions in a D&O Application, which most frequently create coverage issues, are the so-called “warranty” statement and various information incorporated into the Application.

The “warranty” provision states that no Insured Person is aware of any matter which may give rise to a future claim. Such a warranty provision is generally included only within the Application for the initial D&O policy purchased by a Company from an Insurer, and usually is not included within a Renewal Application since in the renewal context, the Insurer is already on risk for the potential claim. However, if at renewal the Insurer increases its limit of liability or lowers its attachment point, the Insurer may require a warranty statement for the increased limit or lower attachment. In that event, Insureds should seek to have the warranty expressly apply only to the extent the limit is increased or the attachment is lowered.

These warranty provisions vary among Application forms in two primary respects. First, some provisions refer to known “facts, circumstances or situations,” whereas other provisions refer to known “acts or omissions.” The former approach is more encompassing since it does not require knowledge of specific conduct by Insured Persons which could give rise to a claim, but rather general circumstances (such as a restatement of financials) which could give rise to a claim even though no specific wrongdoing is then known. Second, the language describing the

likelihood of a future claim varies among Applications. Some provisions require disclosure of known information that “might” or “may” give rise to a future claim, whereas other Applications require disclosure of known information only if the information is “likely” or “reasonably likely” to give rise to a claim.

Courts interpreting these “warranty” provisions generally apply both a subjective and objective test to determine if the warranty statement was correct. The Insurer typically must prove that the Insured Person subjectively knew of the circumstance or wrongdoing which could give rise to a future claim, but need not show that the Insured Person actually realized that such information may give rise to a future claim. Rather, an objective analysis is usually applied to determine whether a reasonable person with actual knowledge of the circumstance or wrongdoing would believe that a future claim could be made as a result thereof.

The second type of Application information which most frequently creates coverage issues is the information incorporated into the Application. In addition to a signed Application form, D&O Insurers typically require the Insureds to submit other documentation, such as financial statements and certain SEC filings, as part of the underwriting process. Such attached documentation can be the basis for the Insurer’s rescission of coverage if the information in the attached documentation is false. As a result, it is important to clearly identify what information is attached or incorporated into the Application and to assure all such information is truthful. If the information is time sensitive, the date of the information should be clearly stated. Most Applications require the Applicant to update any information in the Application if the information materially changes prior to inception of coverage. Insureds should either expressly disclaim such an obligation to update attached documents or evaluate whether the attached documents should be updated to satisfy the Insurer’s requirements.

These attached documents may be identified in two different places. Most Application forms state in the form itself that the Insureds must attach certain documents and that such documents are incorporated into and are part of the Application. In addition, to make the Application process easier, many D&O policy forms today define the Application to include certain public filings by the Applicant, thereby avoiding the need to physically attach those filings to the Application. These incorporated documents need to be carefully considered by both underwriters and Insureds. If underwriters wish to raise as a coverage defense false statements in such documents, underwriters should carefully review such documents in the context of their underwriting analysis and should document such review and their reliance on such documents. Absent proof of actual reliance, it is doubtful such incorporated documents can support a coverage defense. From the Insureds’ perspective, legitimate concerns arise if the plaintiffs in a subsequent claim against the Insureds allege that the incorporated documents (such as SEC filings or financial statements) contained materially false information. In that situation, the Insurer may contend that no coverage exists to the extent the plaintiffs successfully prove the existence of such false information in documents that are deemed to be included within the Application. However, appropriate severability language in the Policy should greatly minimize this risk in many situations.

Rescission Issues. If information submitted to the Insurer during the underwriting process is false, the Insurer’s primary remedy is potential rescission of some or all coverage

under the Policy. If successful, such rescission voids the coverage *ab initio* (i.e., “from the beginning”), and thus the coverage is deemed to never have existed. The theoretical justification for this remedy is that the Insurer would not have agreed to issue the Policy at the agreed upon terms if the true facts had been disclosed to the Insurer, and therefore the Insurer should not be required to provide the coverage which was obtained under false pretenses.

The elements required for rescission vary from state to state, and are typically set forth in statutory and/or common law. As a result, important choice of law issues can arise as to which state’s law should govern rescission of a policy. In general, choice of law concepts provide that the law of the state in which the policy was formed governs that policy. Thus, the law of the state where the Insured is headquartered usually applies. However, some insurance policies contain explicit choice of law provisions, which are almost universally upheld by the courts as long as the selected state has a substantial relationship to the parties or the dispute.

Although the specific requirements for rescission differ from state to state, generally an Insurer must prove some or all of the following five elements: (1) the making of a representation; (2) the falsity of the representation; (3) the materiality of the misrepresentation; (4) the Insurer’s reliance on the misrepresentation; and (5) the Insured’s knowledge of the representation’s falsity (i.e., scienter). Virtually all states require the first four of these elements, but only some states require the fifth element. Each of these elements of rescission is briefly discussed below.

Making of a False Representation. The first two elements of rescission are common to all states: the Insurer must establish that the Insured made a representation, and that the representation was false. Usually, these elements are not in dispute if the Insurer can establish that the Insured’s answer to a question in a signed Application is false. Issues most frequently arise with respect to these two elements where the Insured submits an unsigned Application, where no written Application is submitted, or where the Insured fails to disclose to the Insurer material information even though such information was not requested by the Insurer.

Failure of the Insureds to sign an Application does not necessarily bar a successful rescission action. Where the Application is unsigned, the Insurer may still be entitled to rescind the policy if the Insurer can otherwise establish that the representations in the unsigned Application were made by the Insureds. For example, in one case, the court allowed the Insurer to rely on misrepresentations in an unsigned Application where the evidence showed that an Insured orally provided the answers in the unsigned Application to the Insured’s agent with the intent such information would be conveyed to the Insurer. Family Fund Life Ins. Co. v. Rogers, 90 Ga. App. 278 (1954).

Even in the absence of a written Application, the Insurer may still be able to argue that an Insured made misrepresentations which entitle the Insurer to rescind coverage. Although there is little case law directly on this point, a few cases recognize the possibility that oral representations made to an Insurer outside an insurance Application can be the basis for a rescission action. E.g., Lane v. The Travelers Indemn. Co., 391 S.W.2d 399 (Tex. 1965); Merchants Indemn. Corp. v. Eggleston, 68 N.J. Super. 235 (1961). As a result, Insureds should carefully evaluate the accuracy of all written or oral information provided to the Insurer either by the Insureds or their broker and should document for future reference all such information. Any

information conveyed to the Insurer by the Insureds or broker during the underwriting process can potentially give rise to allegations of misrepresentation even if the information is technically not part of the Application.

Omission of material information not specifically requested by the Insurer typically is not a basis for rescission in the United States. As a general rule, in the United States (unlike United Kingdom law) Insureds are not required to furnish information to the Insurer unless the information is specifically requested by the Insurer. Therefore, even if the omitted facts are material to the risk being insured, the omission cannot be the basis of rescission unless the information was specifically requested by the Insurer. Some courts recognize a narrow exception to this rule and allow a material omission to be the basis of rescission if the omission constitutes intentional fraud by the Insured (i.e., a deliberate intent to withhold information in order to mislead the Insurer). E.g., First State Bank v. New Amsterdam Casualty Co., 83 F.2d 992 (5th Cir. 1936).

Materiality. Almost every state requires that the Insured's misrepresentation be material in order to justify rescission of the policy. In a majority of states, a misrepresentation is deemed material if it influenced the Insurer's acceptance of the risk, calculation of the premium charged, or estimation of the risk involved. In other words, the Insurer must prove it would not have issued the policy, or at least would have required different terms or premium, if the Insurer had known the true information. However, a minority of states requires the Insurer to establish that it would not have issued the policy at all had it known the truth of the matter misrepresented. If knowledge of the truth would have merely caused the Insurer to increase the premium charged or change the conditions and terms of the policy, the Insurer would not be permitted to rescind in these states.

Regardless of which standard of materiality is employed, evidence for this element is usually provided by testimony from the underwriter(s) as to how knowledge of the truth would have changed the underwriting analysis. Materiality can also be shown through the Insurer's practice of accepting or rejecting similar risks, written underwriting standards or guidelines adopted by the Insurer, or other written documentation of the underwriting process.

To determine materiality, most courts focus on whether knowledge of the truth would have reasonably influenced the decision of the underwriter. The testimony of the underwriter is frequently the only evidence presented on this issue. However, in a recent New York case, Chicago Ins. Co v. Kreitzer & Vogelman, 210 F. Supp. 2d 407 (S.D.N.Y. 2002), the court refused to grant summary judgment for an Insurer on the materiality element where the Insurer only presented the subjective testimony of its underwriter and did not produce objective evidence of its underwriting practices and criteria, such as written underwriting manuals or rules. This decision may create difficulties for Insurers, and suggests that Insurers should have written guidelines relating to acceptable and unacceptable underwriting criteria.

Reliance. In addition to the materiality of the misrepresentation, most states require an Insurer prove that it relied on the Insured's misrepresentation in its underwriting of the policy. Reliance is usually considered closely related to materiality, and some courts interchange these two elements.

Under most states' laws, the Insurer must merely establish through the testimony of its underwriters that the Insurer reasonably relied on the information furnished by the Insured in connection with the underwriting of the policy. In addition, almost all states provide that the Insurer is under no obligation to independently investigate the statements contained in an Application beyond its regular underwriting practices. The Insurer is only under a duty to investigate if it has knowledge of information that warns of the falsity of answers in the Application.

If the underwriter did not review and consider certain information, that information cannot be a basis for rescission by the Insurer, even if the information is expressly included within the Application. For example, if the Policy defines the Application to include certain SEC filings or an application submitted to another insurer, the Insurer can later rescind coverage based on misrepresentations in those documents only if the Insurer can prove its underwriter read and relied upon such misrepresentation.

Scienter or Intent. A majority of states (including New York and California) require only that an Insurer establish that a material misrepresentation was made by the Insured and was relied on by the Insurer in order to rescind the policy. However, a significant minority of states also requires proof of some sort of intent to deceive by the Insured in order to rescind. The specific requirements of this scienter element vary from state to state. For example, some states require the Insurer to establish that the Insureds specifically intended to deceive the Insurer in connection with the underwriting and issuance of the policy. In contrast, other states merely require the Insurer to show that the Insured either knew the information was false when published or acted in bad faith, such as by making a false statement without any knowledge as to its truth or signing the Application without reviewing the contents to ensure they are correct. For this reason, persons completing and signing the Application should undertake and document reasonable efforts to determine the truth of information contained in the Application, including the polling of directors and officers to the extent feasible.

Under the latter version of this intent element, the Insured need not intend to specifically deceive the Insurer, and in fact need not even know what was disclosed to the Insurer. Instead, knowledge of a false publication to third parties generally is sufficient. Thus, Insureds who are not involved in the Application process may satisfy this intent requirement and lose coverage. Many D&O policies expressly confirm this result by stating that for purposes of rescission, an Insured need only know the facts that were not truthfully disclosed to the Insurer, and need not know that the facts were misrepresented to the Insurer. Thus, coverage may be rescinded as to an Insured whether or not the Insured was involved in the Application process.

Attached to Policy. As a condition to rescission based upon false statements in an Application, a few states require the Application be physically attached to the policy. A statement in the policy or Application that the Application is deemed to be attached and incorporated into the policy is probably not sufficient to satisfy this requirement. The Insurer and Insureds should therefore check relevant state law to determine whether actual attachment of these materials to the policy is a required element for a successful rescission action.

Representation vs. Warranties. The elements of rescission summarized above apply to rescission based on misrepresentations to the Insurer. Some states recognize a distinction in the

insurance context between misrepresentations and breach of warranties made by the Insured. In contrast to a misrepresentation, breach of a warranty can entitle an Insurer to rescind a policy without proving materiality, reliance or scienter because the mere falsity of the warranted information is sufficient to void the policy *ab initio*. This means that it is much simpler for an Insurer to rescind a policy due to an Insured's breach of warranty as opposed to a misrepresentation.

Because breach of warranty requires a lesser standard of proof than a misrepresentations, courts are often reluctant to construe statements by Insureds as warranties, and statutory or common law in many states provides that statements in an insurance Application either constitute or are presumed to constitute representations and not warranties. Although not determinative, the label used in the Application to describe the information as either a "warranty" or a "representation" can be important and should conform to the intent of the parties.

Severability. As a general rule, courts have held that absent special policy language, the misrepresentations of any one Insured in an Application can void the policy as to all Insureds, provided the Insurer can establish the requisite elements for rescission with respect to any one Insured. However, D&O policies can, and usually do, include a "severability" provision which protects the coverage for so-called innocent Insureds even if one or more other Insureds misrepresented information to the Insurer.

There are several different types of severability provision which are commonly included in D&O policies and/or Applications. A "full" severability provision states that the Application is deemed to be a separate Application by each Insured and that no knowledge of one Insured is imputed to any other Insured. If the policy includes entity coverage, this full severability provision may state that only the knowledge of certain executive officers is imputed to the company for purposes of determining coverage. In the current hard market, some Insurers are including within the D&O policy a more limited form of severability. For example, some provisions except from the severability any knowledge either by the signer of the Application or, alternatively, by any Executive Officer. Under such a provision, coverage for all Insureds could be rescinded if the signer of the Application or any Executive Officer knew of the false information which was not properly disclosed to the Insurer. If Insureds other than the signer or an Executive Officer knew such information, severability would apply and the Insurer would be able to rescind only with respect to that Insured who knew of the misrepresentation.

Warranty Exclusion. In some situations, an Insurer may have an option of excluding coverage rather than rescinding coverage based upon a misrepresentation in the Application. For example, many Applications include an exclusion as part of the warranty statement, which states that if circumstances or wrongdoing which could give rise to a future claim exists prior to inception of coverage, any subsequent Claim arising from such circumstances or wrongdoing is excluded from coverage.

The consequences to the Insurer and the Insured vary significantly depending upon whether the Insurer elects to rescind or exclude coverage. If coverage is rescinded, the Insurer must return to the Insured the premium paid for the policy, and the policy is deemed to have never existed for any claim. On the other hand, if coverage is excluded, the policy remains in

full effect for non-excluded claims and no premium is returned to the Insured. In addition, it is usually easier for an Insurer to invoke the exclusion rather than rescind coverage, since the elements of rescission summarized above do not apply to an exclusion from coverage.

As a result, some Insurers are endorsing to the D&O policy a warranty exclusion in lieu of or in addition to a warranty statement in the Application. Such an approach not only raises fewer questions in the claims context, but also avoids the necessity for a senior officer of the insured company signing the warranty statement. However, if such a warranty exclusion is utilized, the parties should confirm the intended applicability and the appropriate type of severability provision for such an exclusion. For example, a limited severability provision which does not apply to knowledge of the signer of the Application may not be appropriate for a warranty exclusion where no Application is signed.

Restated Financial Statements. Both original and renewal Applications typically require submission to the Insurer of the company's current financial statements. Those financial statements usually are considered a part of the Application and incorporated into the policy when issued. If those financial statements are later restated, the Insurer may argue that the Application contained material misrepresentations which may allow the Insurer to either exclude claims relating to the restatement or to rescind the policy as void *ab initio*. Like the plaintiff shareholders in the underlying claim, the Insurer can persuasively argue that it relied to its detriment upon the erroneous financial statements. In essence, the Insurer would argue that the company the Insurer thought it was insuring was far different (from a financial standpoint) than the company it in fact insured.

In states where Insurers need not prove scienter to rescind an insurance policy, virtually any restatement of financial information included within the Application arguably gives rise to a rescission of the entire D&O policy. In such a state, a severability provision which simply states that knowledge of one director or officer shall not be imputed to any other director and officer would have no relevance since knowledge of the Insureds is not an element of rescission.

To avoid this harsh result, Insureds may argue that the Insurer is required to prove intent or knowledge (notwithstanding applicable state insurance rescission law to the contrary) if the Application states that the person signing the Application declares to the best of his or her knowledge, after reasonable inquiry, that the statements contained in the Application are true. Under this language (which appears in some but not all D&O Applications), Insureds may argue that the Insurer must prove the falsity of this representation in addition to the falsity of the attached financial statements in order to rescind the policy or exclude coverage with respect to the restatement claim. In other words, coverage could be rescinded or excluded only for directors or officers who knew or should have known of the falsity of the financial statements. However, this declaration in the Application (if it exists at all) may be viewed by the Insurer and by a court or arbitration panel as applying only to the answers and statements of the Insureds in the Application form itself, and that misrepresentations in separate documents which must be submitted with the Application are not limited by the "best of knowledge" and "reasonable inquiry" provisions in the Application.

An alternative type of severability provision states that the Application shall be deemed to be a separate Application by each Insured director and officer. This type of provision likely

would provide no protection to the Insureds since the false financial statement would be deemed attached to each separate Application of each director or officer. Thus, the false financial statements would taint each director or officer's Application.

At least one policy form issued by CODA eliminates these risks to the Insureds by providing that the policy shall not be rescinded by the Insurer in whole or in part based upon the restatement of, or any misstatement or error in, any financial statements of the Company contained within the Application.