How Your Professional Liability Insurance Policy Works

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THE PROFESSIONAL liability policy arranged by your association is a contract between the insured member and the insurance company. As such, each party has obligations under the terms of the policy. The insurer agrees to provide a defence in the case of a lawsuit, pay legal, investigation and adjusting expenses and, most importantly, pay claims in the event that the surveyor was negligent and is found or would be found legally obligated to pay damages to a third party. For your part, you are entitled to the benefits of coverage providing you comply with the conditions of the policy and providing that the claim or suit is not excluded and is first presented during the policy period and further on condition that you did not have knowledge of the claim, or a potential claim that later developed into a claim, before the inception date of the policy.

The General Conditions of the policy require that notice be given to the adjuster, broker or insurer as well as your Association's Insurance Advisory Committee not only when a claim is made against you, say in the form of a statement of claim, a threatening letter from a lawyer or a complaint by a client but also when you become aware of "the occurrence of any fact or circumstance which may give rise to a claim". In other words, even if at that point you are the only one aware that a surveying error has been made, you have an obligation to report the matter. In some cases, you may question the appropriateness of doing so and fear that a claim will be provoked needlessly (it won't) but such concerns must be measured against the danger that by remaining silent you may end up depriving yourself of insurance protection that otherwise may have been available and also may unwittingly cause the claim to worsen by a delay in giving notice. It goes without saying that generally claims can be resolved more quickly and for less money before a lawyer enters the picture or before a lawsuit is started than after.

We now come to the question of what happens when a claim or potential claim is reported. The adjuster receives notice directly from you, usually by way of a telephone call or via the broker or insurer. F. C. Maltman & Co. Ltd. is a firm of independent insurance adjusters whose duty is to investigate and report to its principal, your insurer. When notice is received, we open a file at our office and, when necessary, contact you to discuss the matter. We then pass on notice to the insurance company by way of a Preliminary Notice of Claim report that gives a brief outline of the claim under various headings. Under these headings we identify the insured (the Association and the member), the claimant (a landowner or contractor), the date of the loss or error (when the mistake or alleged mistake was made) and the date the claim was made (when you first learned of the problem and gave notice). The report goes on to describe briefly the nature of the claim including reference to the surveying services provided and the nature and effect of any error. Finally, we recommend in the report a provisional reserve which is an amount based on the estimated potential claim set aside by the insurer to eventually pay the claim and associated costs and expenses.

For the adjuster to fully understand the matter and to prepare a report that will be informative and useful for the insurer, he or she will require certain basic details and documentation from the surveyor. The documentation required includes field notes and plans or sketches illustrating the property and the problem, any other notes prepared and any correspondence between the surveyor and any other interested party, such as the client, a lawyer or another surveyor. The information required includes not only a description of the error or suspected error but also an explanation of how the error was made. With this information, the adjuster can form an idea as to whether the surveyor was in fact negligent (remember it is possible to make an error without being careless or negligent) and also whether there is any other party, a subcontractor for example, that could be looked to to share responsibility for the loss.

As for your documents and, for that matter, any other information or material that you provide, please be assured that they are treated with strictest confidence and made available only to your insurance company or to defence counsel when the matter is in litigation. There are times, however, when your documentation ought to be produced to the claimant or the claimant's lawyer in an effort to defeat or reduce a claim. In those circumstances, the adjuster would request your permission before releasing any privileged material. It must be borne in mind that there would be such disclosure to the other side only if it advanced your position, that is if it could be used as evidence to support an argument that you were not negligent or that the damages are inflated or not causally related to the error.

We mentioned earlier that the insured member has certain obligations under the policy. Besides reporting promptly and in as much detail as possible, the member is required to "co-operate with the Insurer (and by extension the adjuster) whenever required for the purposes of obtaining information or settlement or defence." It is not enough simply to make a telephone call or send off a brief letter indicating that you are exposed to a claim. The obligation to co-operate is continuous until the matter is brought to a conclusion. We appreciate that frequent requests by the adjuster

for information can be annoying and time consuming to fulfil but, if it is any comfort, you should be aware that at his end the adjuster can be similarly besieged.

On one side the adjuster has to report regularly to the insurance company to keep it informed of the status of the claim and on the other he may be receiving calls and letters directly from builders, lawyers, etc. demanding action and/or money. Without your cooperation, we cannot take any steps to resolve the matter one way or the other. In these circumstances, an impatient claimant or lawyer may become frustrated and an opportunity to amicably resolve the dispute or claim could be lost. And, to make matters worse, at least from your point of view, a lack of co-operation so serious as to cause prejudice to the insurer can lead to a denial of coverage for breach of the policy condition quoted above.

A month after the preliminary notice of claim is submitted, the adjuster is expected to prepare a comprehensive report elaborating on the first report and enclosing copies of any relevant documentation such as surveys, letters, suit papers, invoices, etc. that has been obtained. In addition, the report must cover in detail the investigation conducted by the adjuster as well as comment on the issues of liability and coverage.

Under the liability heading in the follow-up report, the adjuster offers his opinion on whether or not the surveyor acted negligently or whether the surveyor was contributorily negligent along with another party. (In complicated cases, the adjuster may find it necessary to obtain a legal opinion or other expert advice to assist in determining the issue.) Under the coverage heading, the adjuster recommends to the insurer that the surveyor either be covered under the policy or not covered. If it is learned that there was knowledge of a claim or potential claim before the effective date of the policy, or if one of the policy exclusions applies, or if the surveyor is not co-operating, the adjuster may recommend that coverage be denied or that he proceed under a non-waiver agreement. (A non-waiver agreement is entered into by both insured and insurer and is taken when there is a question of whether the policy will apply. The non-waiver preserves the rights of both parties until a decision on the issue is made.)

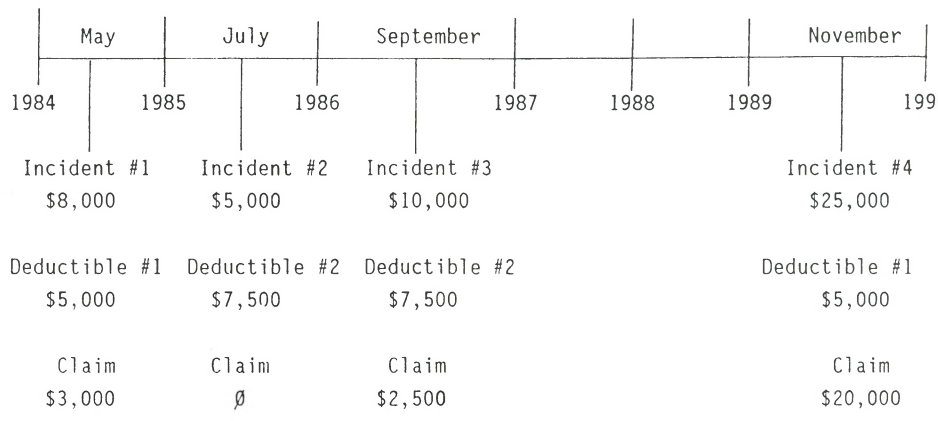
Finally, in the report, the adjuster comments on the potential value of the claim and again makes a recommendation as to the reserve to be set. By this time, depending on information developed respecting liability and damages, the adjuster may suggest that the reserve be revised upwards or downwards or simply be left unchanged. After the report is sent to the insurance company, the adjuster continues to report on a regular basis until the case is closed.

As stated, we as independent insurance adjusters investigate and report with recommendations to your insurance company. We act on instructions from the insurance company and receive authority to settle claims from the insurance company and from the member whose consent to any proposed settlement is required under the terms of the policy. We also consult regularly with the Insurance Advisory Committee of your association where all claims are discussed and expert assistance is provided to us in understanding the role of the surveyor in a certain situation. This assists us in making our recommendations to the insurer. The committee plays a very important role in the claims adjustment process and, thus, full cooperation by the members with the committee is imperative if the programme is to work properly. When and if the insurance company accepts our recommendations and extends settlement authority, we contact the member to obtain his or her consent and then proceed to attempt to negotiate a settlement of the claim, on a compromised basis if possible. Upon settlement, a cheque in full payment of the claim is requisitioned from the insurer and payment of the deductible is requested from the member. The deductible payment is forwarded to the insurance company and the insurance company's cheque is exchanged for a final release in our favour to conclude the settlement.

We now come to the subject of the deductible. There appears to be some confusion on how the deductible comes into play. As you know, the deductible increases with claims frequency. For example, the deductible for a first claim is $5,000.00, for a second it is $7,500.00, for a third is it $10,000.00 and for a fourth it is $25,000.00. The deductible does not apply to expenses such as adjusters' fees, lawyers' fees or experts' fees. It only applies to actual amounts paid to settle a claim. Therefore, if you report a claim and it is successfully defended (i.e. no claim payment) or the settlement is below your deductible, you are not considered to have incurred a claim. In that case, if you report a second incident, the deductible is still $5,000.00 and remains that way regardless of how many incidents or potential claims are reported, so long as no claim payment exceeds your deductible of $5,000.00. The same applies to the other deductible levels. With this in mind, you should not be afraid to report potential claims because of the increasing deductible.

The deductible level does not necessarily increase with a subsequent claim. The deductible automatically reverts to the previous level after three consecutive claims-free years. Therefore, if you incurred a claim of $10,000.00 (less your $5,000.00 deductible) on January 3, 1984 and did not have another claim (where the amount of the claim exceeded the deductible), on January 3, 1987, your deductible would revert to $5,000.00. If you incurred a claim of $10,000.00 and your deductible at the time was $7,500.00, three years later you would return to the $7,500.00 deductible level.

We have prepared a chart for you to illustrate how the deductible clause works:



A claim is deemed to have occurred on the date that you first had knowledge of the claim or potential claim, not the date it is reported or the date that the claim is settled. If you have more than one claim ongoing at any one time, the deductible applies as the claims are paid, not necessarily in the order in which they are reported. Therefore, if you reported an incident in 1984 which results in a claim being paid in 1986 and you also reported an incident in 1985 which was paid in 1985, the 1985 claim would be subject to the $5,000.00 deductible while the 1984 claim would be subject to a deductible of $7,500.00. Remember, a claim is not actually incurred until a payment is actually made.

It is not always possible or necessary to dispose of a claim by negotiation. Occasionally it happens that we can persuade a claimant or a claimant's lawyer to withdraw the claim on the basis that our investigation demonstrates that the surveyor was not negligent. It sometimes turns out that a claim that was threatened or perceived does not in fact materialize, in which case we simply close the file because of a lack of activity over a reasonable period of time. On the negative side, we also encounter claimants and lawyers who make unreasonable demands with the result that a negotiated settlement cannot be achieved and litigation ensues.

We hope that the above comments give you some insight into the role played by the adjuster in handling claims against a surveyor and how your deductible comes into play. It is important to realize that the adjuster must have your cooperation and all the relevant information available because otherwise he cannot do his job, which essentially is to protect your interest and the interest of the insurance company which, absent any question of coverage, ultimately are one and the same. By working together, the adjuster and the surveyor can resist many claims or, failing that, at least have them dealt with in a timely and cost efficient manner. ●