Missing Policies Proof – Turning Burden Into Opportunity

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I. INTRODUCTION

Latent injury claims involve situations where a party began to sustain continuing bodily injury or property damage years ago but did not discover and assert a claim for the injury until recently. Examples of such claims are those alleging groundwater contamination, or injury from asbestos or other hazardous substances, that first occurred as early as the 1950s or 1960s. These claims might be asserted against the company that manufactured, distributed, or used a defective product or hazardous substance or, if that company no longer exists, the successor company that merged with or acquired it.

In order to maximize insurance coverage for such claims (assuming a claims-made policy is unavailable or insufficient), the sued company typically must look to its or its predecessor’s occurrence-based liability insurance policies on the risk from the time of the first injurious exposure to the time the injury or damage was discovered. Often, however, a company finds that it long ago discarded those older insurance policies under the mistaken notion that they were no longer in effect. When faced with that problem, the sued company must promptly try to identify the insurers that potentially or actually sold comprehensive general and excess liability insurance to the company during the relevant years. Those insurers’ identities can usually be determined preliminarily through the retired comptroller who purchased the insurance, the agent who sold the insurance, the company’s financial records, or various other sources of evidence discussed below.

Once the sued company identifies any potential insurer that issued missing policies, it must notify the insurer of the latent injury claims as soon as practicable. At this point, both the insurer and the company have opportunities. The insurer has an opportunity to demonstrate its good faith by, for example:

- Asking the sued company for all information that might help the insurer find information, documents and data relating to the missing policies;
- Thoroughly disclosing and searching all potential sources of such information, documents, and data available to the insurer (including not just the “official” or usual databases, but also former employees, outside storage vendors, reinsurers’ records, and microfiche or other non-indexed caches of records);
- Producing and explaining all potentially helpful information it locates or knows (e.g., policy code numbers; standard pre-printed policy and endorsement forms; unexplored avenues that have yielded results in the past);
- Following up on additional ideas, leads, and requests from the sued company;
- Re-doing searches and retracing steps when helpful new information arises; and
- Any other efforts showing that the insurer truly wants to find information relating to the missing policies and to go the extra mile.
If the insurer refuses to fully cooperate with the sued company, however, the company has an opportunity to build a case against the insurer for bad faith or fraud – thereby potentially recovering not just proceeds due under the missing policies, but also coverage action attorney fees, penalties, heightened prejudgment interest, punitive damages, and other extra contractual remedies. What’s more, the missing policies investigation can provide the company with the opportunity to develop additional historical evidence that undercuts the insurer’s typical coverage defenses.

This paper discusses how to turn the burden of missing policies into the opportunities noted above. Section II explains the insured’s and insurer’s respective burdens of proof with regard to missing policies. Section III outlines the typical sources of evidence for proving missing policies. Section IV addresses the admissibility of that proof under the rules of evidence. And section V discusses proof of bad faith and fraud that might arise from a missing policies investigation.

II. BURDEN OF PROOF

A. Insured’s Burden.

The insured bears the burden of proving the existence and coverage terms of a missing insurance policy, according to most courts which have addressed the issue. See D. Leitner, R. Simpson, & J. Bjorkman, 3 Law and Prac. of Ins. Coverage Litig. §§ 40:9, 14 & 15 (2009). Although at first blush this sounds like a daunting task, as a practical matter it usually means that the insured need only prove, through testimony and exhibits:

1. The name of the insurer that issued comprehensive general or excess liability insurance to the insured during the period in question;

2. The unremarkable fact that the insurer issued its standard, pre-printed form policy to the insured (i.e., that the insured, like almost all commercial insureds since the 1940s, did not negotiate over the language of the basic insuring agreement); and

3. Depending on the jurisdiction, the coverage limits of the policy.

Courts are split on whether the insurer ought to bear the burden of proving the “per occurrence” coverage limits, or at least the aggregate limits (if any), of the policy, because they are, after all, called “limits of liability” in the contract. Compare, e.g., Emons Indus., Inc. v. Liberty Mut. Fire Ins. Co., 545 F. Supp. 185, 189 (S.D.N.Y. 1982); City of Tacoma v. Great Am. Ins. Cos., 897 F. Supp. 486, 487 (W.D. Wash. 1995).

Regardless of who bears the burden, though, it’s important to remember that there were at least minimum coverage limits on the missing policy. Since the 1940s, the insurance industry rating bureaus required that comprehensive general liability (“CGL”) insurance policies have “basic” (i.e., minimum) per accident or occurrence limits (e.g., $10,000 for bodily injury and $5,000 for property damage in earlier years). (See A027-34 & A043-
44.) What’s more, the standard CGL policies: (a) required the insurer to pay defense costs in addition to (i.e., outside) those limits; and (b) much of this period, did not necessarily contain aggregate limits or apply any such aggregates to all coverages in the policy. See, e.g., J. Stempel, Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute, 12 Conn. Ins. L. J. 349, 381-96 (2005-06); Mass. Electric Co. v. Travelers Cas. & Sur. Co., No. 990467B, 2002 WL 31677203, *1-2 (Sept. 2, 2002).

Thus, where there is no evidence of a missing policy’s coverage limits, the insured may be able to establish (through historical insurance industry information and expert testimony) a “default” inference that the policy had at least minimum limits and no aggregate. This point is especially significant in maximizing coverage in cases where the insured faces a multitude of bodily injury claims (e.g., asbestos claims), because each “per occurrence” settlement is typically for a relatively small dollar amount, yet the policy and its outside-the-limits defense duty are never exhausted.

B. Insurer’s Burden.

The insurer bears the burden of proving the existence and terms of policy provisions or endorsements that limit or exclude coverage, according to most courts which have addressed the issue. See D. Leitner, R. Simpson, & J. Bjorkman, 3 Law and Prac. of Ins. Coverage Litig. § 40:14 (2009).

As noted above, courts disagree as to whether this burden includes proof that there was an applicable aggregate limit on the policy – an issue that could significantly affect the insurer’s overall liability in cases involving multiple bodily injury claims from hazardous substances such as asbestos.

The insurer’s burden to prove exclusions is likewise significant in environmental contamination cases. In 1970 the insurance industry sought regulatory approval of the “polluter’s exclusion,” but the exclusion was not incorporated into the body of the standard CGL policy until 1973. Between 1970 and 1973, states had varying requirements as to when a polluter’s exclusion endorsement could be added to the CGL policy. (See, e.g., A053-55.) What’s more, many states require insurers to prove that they provided their insurers with separate and conspicuous written notice of any reduction in coverage of an existing and renewal policy; otherwise, the reduction is void. See, e.g., Hawkins Chem., Inc. v. Westchester Fire Ins. Co., 159 F.3d. 348, 350-54 (8th Cir. 1998); Thomas v. N.W. Nat’l Ins. Co., 973 P.2d 804, 808 (Mont. 1998). Thus, where an insurer issued or renewed missing policies to an insured during the early 1970s, it may bear a difficult burden in establishing whether and when: (a) those policies actually incorporated a polluter’s exclusion; and (b) it provided the required notice of any reduction in coverage.

1 “A___” refers to the pages in the Addendum of historical documents accompanying this paper.

2 The irony of this issue is notable. In the early 1970s insurers, though their rating bureaus, represented to state regulators that the polluter’s exclusion was not a reduction in coverage, yet today they are representing to courts around the country that the exclusion was a reduction in coverage. See Morton
C. Degree of Burden.

Some courts have held that the existence and terms of missing insurance policies, like lost deeds or wills, must be proved by a heightened “clear and convincing” standard. 52 Am. Jur. 2d, Lost and Destroyed Instruments §25. But the majority of courts that have carefully considered the issue hold that “preponderance of the evidence” is the appropriate standard for missing policies. Id., §25 n. 7. Under the “preponderance” standard, the insured need only show that it is more probable than not that the missing policy once existed and that its insuring agreement was the same as the basic insuring agreement in the insurer’s standard, pre-printed policy.

This “preponderance” standard is the better reasoned rule. Historically, courts applied the “clear and convincing” standard to lost instruments such as deeds, wills and non-standard contracts, because fraud was an overriding concern. Proof of missing insurance policies, however, typically is not vulnerable to fraud because the business records used to prove the policy’s existence and content (e.g., standard, pre-printed form policies; dailies; certificates of insurance; contemporaneous entries in accounting records) are inherently reliable. Moreover, modern discovery rules allow parties to ferret out and allege any fraud well before trial.

III. SOURCES OF PROOF

The hallmarks of an effective missing policies investigation are thoroughness, tenacity and perseverance. All potential sources of information should be identified and examined, all ideas, leads and follow-up should be pursued, and everything should be logged so that nothing is overlooked. A company with missing policies should consider hiring an insurance archeology firm to conduct or assist with its efforts to find information and reconstruct coverages.3 If in litigation, the company should also consider asking for appointment of a “special master” or magistrate to oversee discovery requested from the insurer. The judge assigned to the case often is too busy to enforce the insurer’s discovery obligations in any meaningful way, whereas a special master can be much more focused and knowledgeable about the tasks necessary for a thorough missing policies investigation.

Outlined below are the sources of evidence that may be available from the insured, insurer, non-parties, and expert witnesses.

A. Evidence Accessible to the Insured.

Int’l, Inc. v. Gen. Accident Ins. Co. of Am., 629 A.2d 831, 847-48 (N.J. 1993). This of course begs the question – if the exclusion was in fact a reduction in coverage, why is an insurer unable to produce any example of a separate and conspicuous written notice to its policyholders from the early 1970s that states this?

3 Such firms include: Insurance Archaeology Group (www.iag.com); PolicyFind (www.policyfind.com); and Risk International Services (www.riskinternational.com).
1. Memory of past and present employees.

When faced with a missing policies problem, a company should promptly identify and interview all of its and its predecessor’s past and present employees who potentially have knowledge of the following information from the relevant period:

a. The core elements on which the company must gather proof:

   (1) The name of the insurer that issued comprehensive general or excess liability insurance to the insured during the period in question;

   (2) That fact that company received only standard, pre-printed form policies from the insurer (i.e., the company didn’t negotiate over the language of the basic insuring agreement); and

   (3) The coverage limits of the policy.

b. The chronology of the company’s structure (e.g., departments, divisions, management, titles and functions) and significant changes over time (e.g., moves to new locations; shifts in management; growth; mergers and acquisitions).

c. Any of the company’s activities that may have involved insurance, including:

   (1) Purchasing, handling or reviewing any type of insurance;

   (2) Receiving or addressing claims against the company, or notifying insurers of such claims;

   (3) Handling or notifying insurers of property loss claims;

   (4) Handling or recording insurance premium or claim payments;

   (5) Handling property or business transactions implicating insurance, certificates (proof) of insurance, or additional insureds;

   (6) Requesting, sending or receiving certificates of insurance;

   (7) Participating in underwriting or loss prevention inspections by the insurer;
(8) The type of documents generated by the above activities, and their likely location now;

(9) The historical retention or destruction of records, both formally by the company and informally by individuals.

d. The name and location of past and current employees involved in any way in the above activities. Such employees might include officers, directors, comptrollers, treasurers, risk managers, in-house accountants and attorneys, assistants, secretaries, clerks, and plant managers.

e. The name and location past and current non-employees involved in any way in the above activities. Such persons might include insurance agents or brokers; outside accountants or attorneys; auditors, bankers, realtors, and consultants; customers, suppliers and governmental agencies; and document storage vendors.

2. Records.

The company should identify and search all potential locations of records and data that may have involved insurance, including copies of documents that may have been retained by individuals. The primary targets of the search are the missing policy itself; policies that are excess to or underlying the missing policy; policies issued before, during or after the period of the missing policy; or insurance schedules, declarations pages, or certificates of insurance identifying any of those policies. But the company should keep in mind that any information in the company’s records that could lead to identification of an insurer, the type or number of the policy it issued, or the policy’s limits, is helpful. (See, e.g., A001-A004.) Such information might be found in the company’s:

a. Insurance files;

b. Claims and litigation files, including workers compensation and automobile claims;

c. Ledger sheets, check registers, cancelled checks, invoices and similar accounting records;

d. Customer files;

e. Closing documents and other records relating to transactions;

f. Plant and safety records;

g. Minutes of meetings; or

h. Miscellaneous correspondence and memoranda.
B. Evidence Accessible to the Insurer.

Once a company identifies an insurer that potentially issued a missing policy, it should press the insurer thoroughly disclose and search all potential sources of such information, documents, and data available to the insurer, including the identity of all past and present employees who may have relevant information about the insured, or about the insurer’s records and search efforts.

The company should not assume that the insurer’s usual missing policy search “procedures” or databases are adequate, or have been adequately followed or searched. Nor should the company assume that any of the insurer’s official document retention manuals or policies are complete, or have actually been followed over time. The insurer may be well aware that those manuals have been modified by undisclosed document retention memoranda, or that certain former employees, collateral databases, outside storage vendors, reinsurer records, or non-indexed caches of microfiche might yield helpful information, documents, and data.

Again, the company should consider hiring an insurance archaeology firm to help it ask the right questions and request the right information and follow-up from the insurer. Otherwise, the insurer may exploit its advantage over the company and remain silent about information that a cooperative insurer would disclose.

The company should also keep in mind that it’s seeking two categories of historical records – those relating specifically to the company or its predecessor, and those relating generally to the type of coverage at issue. Both categories are discussed below.

1. Historical records specific to the insured.
   a. Dailies, declarations pages, policy index cards, and similar records.

   Historically, most insurers did not maintain copies of all the policies they sold to all insureds. Instead, they typically logged all the information they needed to reconstruct the policy on a few sheets of paper called a “daily,” or on a declarations page, policy index card, or similar record. (See A005-06 & A009-12.) These records usually identified the insured, producer, policy number, limits, form numbers of all the pre-printed forms comprising the policy, and any endorsements to the policy. Beginning in the 1950s, many insurers microfilmed these records or used other means to store the data they contained. (See A007-08 & A013-17.)

   b. Reinsurance records.

   The company should resist any contention by the insurer that reinsurance information is “irrelevant.” It’s probable that the insurer ceded a portion of its risk under the missing policy to a reinsurer, and that reinsurance-related records reference the policy’s named insured, number and limits.
It’s improbable that the insurer would ever destroy such information, because reinsurance reduces its liability. Even disclosure of just the reinsurer’s name helps, because the insured can then ask the reinsurer to search its records for pertinent missing policy information.

c. Any other information, documents or data referencing the name of the insured, any known policy numbers, or the producer or branch office that placed the policy. Such information may be located in records or databases relating to:

a. Claims (e.g., loss runs; litigation);
b. Underwriting (e.g., rating worksheets; reports);
c. Loss prevention (e.g., inspection reports – see A061-63);
d. Accounting (e.g., retrospective premium calculations);
e. Departments performing the above functions;
f. Regional or branch offices; or
g. Agents and brokers.

2. Historical documents relating to the coverage at issue.

a. Standard, pre-printed policy forms.

Insurers typically maintain a collection of the “specimen” pre-printed insurance policy forms and endorsement forms they used since the 1940s. Even if an insurer denies having such specimens, it should be able to produce pre-printed policies it actually issued to policyholders since the 1940s, with redactions to protect privacy. Many such policies have been produced in coverage litigation since the 1980s.

b. Manuals and guidelines.

Many insurers maintained copies of the department manuals and guidelines they used in past decades, including manuals and guidelines published by outside organizations. These documents often contain a wealth of information regarding: the terms of the standard pre-printed policies the insurer used; the de-coding of the numbers on policies issued to insureds; the underwriting and loss prevention standards the insurer followed before issuing or renewing a policy; the risks the insurer knew it was assuming for businesses in particular types of industries; how premiums are calculated; and the “strata” and rating of limits typically
placed on certain types or sizes of businesses; and other helpful information. (See, e.g., A043-52 & A056-60.)

The company should ask the insurer to produce all of the historical manuals and guidelines it used in performing the following functions:

(1) Underwriting and rating;

(2) Compiling standard-preprinted forms for policies;

(3) Recording policy information on dailies or similar documents;

(4) Loss prevention;

(5) Handling claims;

(6) Retaining records.

C. Evidence Accessible to Non-parties, or in the Public Domain.

A company should also request pertinent information, documents and data from sources other than the insurer who potentially issued the missing policy. Again, the company should search for insurance information relating specifically to the company or its predecessor, and generally to the type of coverage at issue.

1. Public or non-party sources of historical records specific to the insured:

   a. The company’s past or present insurance agents, brokers, attorneys, accountants, auditors, bankers, realtors, and consultants;

   b. The company’s potential certificate of insurance recipients (including customers, indemnitees, additional insureds, mortgagors, financial institutions, and governmental entities);

   c. The company’s other insurers;

   d. Potential reinsurers of the missing policy;

   e. Courts and governmental agencies the company may have dealt with;

   f. Insurance archeology firms (sometimes these firms find insurance information and documents relating to other companies during the course of an investigation for their client company);

   g. Governmental repositories (e.g., the National Archives maintains historical insurance records relating to numerous companies that conducted business with the U.S. Navy and other parts of the U.S.)
Defense Department; railroad commissions maintain similar records; the Minnesota Pollution Control Agency maintains historical insurance records relating to companies that may have contributed to the state’s landfills).

h. London brokers, syndicates and companies (these entities have significant caches of historical insurance and reinsurance records relating to U.S. insureds).

2. Historical documents relating to coverage at issue.

a. A number of entities have a trove of helpful records, manuals, sample policies and other historical materials relating to specific insurers and the insurance industry in general:

1. Law firms specializing in coverage disputes;

2. Insurance archeology firms;

3. Insurance experts;

4. Insurance industry organizations (e.g., Insurance Services Office; American Insurance Association; National Association of Insurance Commissioners; A.M. Best – see, e.g., A018, A043-44 & A052).

d. Governmental agencies (e.g., state Insurance Departments) and repositories (see above).

b. Historical periodicals and treatises relating to the insurance industry, and various other industries, contain a wealth of helpful information (see, e.g., A005-17 & A027-42). Many useful articles are indexed in the “Industrial Arts Periodicals Index” and “Business Periodicals Index,” located in public libraries.

c. Court records (e.g., the appendices to appellate briefs in past coverage cases) often contain copies of historical policies and other records issued by specific insurers.

D. **Expert Witness Testimony.**

Both insureds and insurers typically rely on expert testimony in cases involving missing policies. Qualified experts can help the jury understand, for example: historical insurance industry practices, the reason insurers nearly always used standard, pre-printed forms; the basic CGL or excess liability insuring agreement, and its evolution over time; the “evergreen nature of accident- or occurrence-based policies, and why insurers knew better than to destroy their records of those policies; the minimum CGL limits; the levels
of limits typically sold to businesses; the frequency with which insurers issued policies with no aggregate limits before the 1970s; the significance of the insurer’s underwriting and loss control standards; and the “coverage chart” depicting the insured’s known and likely insurance program from beginning to end.

IV. ADMISSIBILITY OF PROOF

A. Relevance (FRE 401 to 403, and 406).

1. All relevant evidence is presumed to be admissible. FRE 402. Relevant evidence means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence. FRE 401.

2. In the missing policies context, any testimony or document that tends to make the existence of any of the following facts more probable or less probable is therefore relevant and admissible:
   a. The alleged insurer issued the alleged type of insurance to the insured for the alleged period;
   b. The insurer issued its standard, pre-printed policy for that type of insurance (i.e., the insured did not negotiate over the language of the basic insuring agreement); and
   c. The insurer issued at least the minimum GGL limits, but more likely the higher limits alleged by the insured.

3. Evidence of an organization’s routine practice is relevant to prove that the organization’s conduct on a particular occasion was in conformity with the routine practice. FRE 406. This rule is pertinent, e.g., to the insurer’s issuance of standard, pre-printed policies and at least minimum CGL limits.

B. Best Evidence (FRE 1001 to 1004, 1007, and 1008).

1. The principal hurdle to the admissibility of missing policies proof is usually the “best evidence” rule, which historically required parties to produce the original of certain documents to prove their existence and contents. The federal rules of evidence, and many states, have substantially eroded this rule.

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4 This paper’s discussion of admissibility focuses on the Federal Rules of Evidence (“FRE”). For specific state courts’ application of their evidentiary rules relating to missing policies, see cases organized under Westlaw Key Numbers Lost Instruments (246) kn 23, and Evidence (157) kn 165 & 174.5. See also cases discussed in D. Leitner, R. Simpson, & J. Bjorkman, 3 Law and Prac. of Ins. Coverage Litig. Ch. 40 (2009).
2. Under FRE 1004, secondary evidence tending to show the probable contents of a missing insurance policy is admissible, and the original of the document is not required, if the proponent of the secondary evidence shows any of the following circumstances:

   a. The original has been lost or destroyed, unless the proponent lost or destroyed them in bad faith; or

   b. No original can be obtained by any available judicial process or procedure; or

   c. At a time when the original was under control of the party against whom it was offered, that party was put on notice, by the pleadings or otherwise, that the contents would be a subject of proof at the hearing, and the party does not produce the original at the hearing; or

   d. The secondary evidence is related to a collateral matter (i.e., not closely related to a controlling issue).

3. Notably, the same rule should apply to the originals of dailies, declarations pages, policy index cards, or other documents the insurer used to keep track of what the policy itself contained. Under FRE 1001(3), the “original” of a document includes “any counterpart intended to have the same effect by a person executing or issuing it.” Insurers used dailies and similar records to reconstruct policies when necessary. Those records should be considered “counterparts” to the original policy, because they were intended by the insurer to have the same effect as the policy itself. As discussed below, this point may be helpful when addressing bad faith issues associated with the insurer’s destruction of records.

4. The probable contents of a missing insurance policy, daily, or declarations page may also be proved by the testimony or written admission of the party against whom such evidence is offered, without accounting for nonproduction of the original. FRE 1007. The memory of a comptroller, secretary, insurance agent or other witness regarding the policy limits, or the receipt of pre-printed forms, is admissible.

5. In the typical missing policies case the insurer denies that: (a) the insurance policy and its corresponding daily, declarations page or policy index card ever existed, and (b) the policyholder’s proffered secondary evidence correctly reflects the contents of those missing documents. These denials are important, because under these circumstances FRE 1008 requires that the jury hear and determine the evidence establishing the factual conditions, described above, in FRE 1001, 1004 and 1007.

   a. FRE 1008 states: “[W]hen an issue is raised … whether the asserted writing ever existed, or … whether other evidence of contents correctly
reflects the contents, the issue is for the trier of fact to determine as in the case of other issues of fact.”

b. This rule, if followed, allows the insured the opportunity to present evidence to the jury as to whether the insurer’s daily, declarations page or policy index card have in fact been lost or destroyed, including all evidence relating to inadequacies and omissions in the insurer’s missing policies search. (See discussion at Section V.A.3., below.)

C. Authenticity (FRE 901 to 903).

1. A document tending to show the probable contents of a missing insurance policy must be authenticated to be admitted. This requirement is satisfied by evidence sufficient to support a finding that the document “is what its proponent claims.” FRE 901(a).

2. For documents relating to missing policies, pertinent examples of valid authentication include:
   a. Testimony from a witness with knowledge that the document is what the proponent claims it to be (FRE 901(b)(1));
   b. The jury’s or expert witnesses’ comparison of the document with specimens which have been authenticated (FRE 901(b)(3));
   c. Distinctive characteristics (including appearance, contents, substance, and internal patterns), taken in conjunction with circumstances (FRE 901(b)(4)); or
   d. Evidence that the document has been in existence twenty years or more at the time it is offered, and: (a) is in such condition as to create no suspicion concerning its authenticity, and (b) was in a place where it, if authentic, would likely be (FRE 901(b)(8)).

3. Extrinsic evidence of authenticity is not required for certain documents, including:
   a. Printed newspapers and periodicals. FRE 902(6).
   b. A document accompanied by a “certificate of acknowledgement.” FRE 902(8). The certificate must be executed in a manner provided by law by a notary public or other officer authorized by law to take such acknowledgements.
   c. A record of regularly conducted activity that would be admissible under FRE 803(6) (the “business records” hearsay exception), accompanied by
a written declaration of the record’s custodian or other qualified person. FRE 902(11). The declaration must certify that:

1. The record was made at or near the time of the occurrence of the matters set forth in the record;

2. The matters in the record were set forth by a person with knowledge of the matters, or from information transmitted by a person with such knowledge;

3. The record was kept in the course of the regularly conducted activity; and

4. The record was made by the regularly conducted activity as a regular practice.

However, it is important to remember the special notice requirement accompanying FRE 902(11). A party intending to offer a record of regularly conducted activity into evidence must provide written notice to all adverse parties of its intent to do so, and produce the record and declaration sufficiently in advance of the offer to provide those parties a fair opportunity to challenge the record and declaration.

D. Hearsay (FRE 801 to 803).

1. Before evidence tending to show the probable contents of a missing insurance policy may be admitted, its proponent must overcome any hearsay objections by showing that the evidence is not hearsay or falls within a hearsay exception.

2. “Hearsay” is an out-of-court statement offered in evidence to prove the truth of the matter asserted. FRE 801(c).

   a. An out-of-court statement is not hearsay if it is not offered for the truth of the matter asserted.

   b. An out-of-court statement is not hearsay if the statement is offered against a party and is:

      1. The party’s own statement, in either an individual or representative capacity; or

      2. A statement of which the party has manifested an adoption or belief in its truth; or

      3. A statement by a person authorized by the party to make a statement concerning the subject; or
(4) A statement by the party’s agent or employee concerning a matter within the scope of the agency or employment, made during the existence of the relationship.

As to (3) and (4), however, the contents of the statement alone are not sufficient to establish the declarant’s authority, agency, or employment relationship; the proponent of the statement must show these facts with additional evidence.

3. Several hearsay exceptions are pertinent to proof of missing policies. The following types of out-of-court statements are not excluded by the bar on hearsay evidence:

   a. Records of regularly conducted activity (FRE 803(6)) – Statements in a record of a regularly conducted business activity are admissible if the custodian of the record or other qualified witness testifies (or certifies in compliance with FRE 902(11)):

      (1) The record was made at or near the time of the acts or events set forth in the record;

      (2) The acts or events in the record were set forth by a person with knowledge of them, or from information transmitted by a person with such knowledge;

      (3) The record was kept in the course of the regularly conducted business activity; and

      (4) It was the regular practice of that business activity to make the record.

   “Business” includes any business, institution, association, profession, occupation, or calling of any kind. This hearsay exception does not apply, however, if the source of information or the method or circumstances of preparation indicate lack of trustworthiness.

   b. Absence of entry in records of regularly conducted activities (FRE 803(7)) – Evidence that a matter is not included in the statements in a record kept in accordance with the provisions of FRE 803(6) is admissible to prove the nonoccurrence or nonexistence of the matter, if the matter was of a kind of which a record was regularly made and preserved. This hearsay exception does not apply, however, if the source of information or other circumstances indicate lack of trustworthiness.

   c. Ancient documents (FRE 803(16)) – Statements in a document in existence twenty years or more are admissible if the document’s authenticity is established. (See FRE 901(b)(8).)
d. Market reports and commercial publications (FRE 803(17)) – Statements in published commercial compilations, tabulations, lists and directories are admissible if the publications are generally used and relied upon by the public or persons in particular occupations.

e. Learned treatises (FRE 803(18)) – Statements in published treatises or periodicals on a subject of history, science or art are admissible if:

(1) Expert witness testimony or judicial notice establishes that the publication is a reliable authority; and

(2) The statements are called to the attention of an expert witness in cross-examination or relied upon by an expert witness in direct examination.

If admitted, such statements are read into evidence but not received as exhibits.

f. Recorded recollection (FRE 803(5)) – Statements in a record concerning a matter about which a witness once had knowledge are admissible if:

(1) The witness now has insufficient recollection to enable the witness to testify fully and accurately;

(2) The record was made or adopted by the witness when the matter was fresh in the witness’ memory; and

(3) The record reflects the witness’ knowledge correctly.

If admitted, the record is read into evidence but not received as an exhibit, unless offered by an adverse party.

E. Expert Opinions (FRE 702).

1. Under FRE 702, expert witness testimony tending to show the probable contents of a missing insurance policy is admissible if the proponent of the testimony establishes that:

a. The witness is qualified as an expert by knowledge, skill, experience, training or education;

b. The expert’s scientific, technical, or other specialized knowledge will assist the jury to understand the evidence or to determine a fact in issue;

c. The expert’s testimony is based upon sufficient facts or data;
d. The expert’s testimony is the product of reliable principles and methods; and

e. The expert has applied the principles and methods reliably to the facts of the case.

2. Insurers sometimes try to introduce “lay opinions” through in-house employees who have not been identified, qualified or deposed as FRE 702 experts, and have not provided the disclosures and report required by Fed. R. Civ. P. 26(a)(2). FRE 701 prohibits this practice, however, by disallowing lay opinions based on “scientific, technical, or other specialized knowledge within the scope of Rule 702.”

V. PROOF OF BAD FAITH AND FRAUD

An effective missing policies investigation can provide an insured with opportunities to build a bad faith and fraud case against the insurer, while also undercutting an insurer’s coverage defenses. Several opportunities are discussed below.

A. Concealment or destruction of evidence.

1. “Is not finding evidence the insurer’s true aim?”

An insured should immediately begin to build a bad faith or fraud case against an insurer that refuses to cooperate fully in the insured’s missing policies investigation. The insured should:

a. Marshal evidence showing that the insurer has access to sources of information, documents and data that could potentially lead to proof of the probable existence and terms of a missing policy, but has refused to disclose or investigate those sources thoroughly;

b. Send letters to the insurer memorializing all of its requests and follow-up requests to the insurer for cooperation, information, and pursuit of potential sources of information, documents and data; and

c. Memorialize all representations made by the insurer, and push for precise clarity on those representations, to build an unequivocal record in the event future investigation or discovery reveals those representations to be false or misleading.

2. “What did the insurer know when it decided to destroy the evidence?”

The insured should also marshal evidence showing that the insurer destroyed records or data documenting the existence and terms of the missing policy, at a time (e.g., since at least the 1960s) when the insurer knew the importance of
preserving that information indefinitely for accident- or occurrence-based insurance policies.

a. There is ample evidence that, by the late 1950s, insurers knew the accident- or occurrence-based insurance policies they historically issued could be called upon at any time in the future to defend against and pay latent injury claims. See, e.g., J. Stempel, *Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute*, 12 Conn. Ins. L. J. 349, 353 & 363-75 (2005-06); S. Bradbury, *Original Intent, Revisionism, and the Meaning of the CGL Policies*, 1 Environmental Claims J. 279, 290-92 (Spring 1989); *Am. Home Products Corp. v. Liberty Mut. Ins. Co.*, 565 F. Supp. 1485, 1500-03 (S.D.N.Y. ‘1983). What’s more, by that time, insurers were preserving records and data evidencing the existence and terms of those policies on microfiche and through other efficient means. (See A005-17.) See also R. Sayler & W. Skinner, *The Mother of All Battles: The Quest for Asbestos Insurance Coverage*, 27 Litigation 45 (Fall 2000). Where are these historically preserved records now and, if they were destroyed, when and why?

b. By at least the latter 1970s, insurers knew that claims for latent bodily injuries from asbestos were increasingly being asserted against their insureds, who were tendering those claims under historical accident- and occurrence-based policies. (See, e.g., A018-22.) In fact, at the time some insurers distributed internal memoranda acknowledging that they should preserve records showing the existence and terms of such policies sold to their commercial insureds during the previous decades, in the event of future asbestos claims. (See, e.g., A023-26.) During or after the 1970s, did the insurer have records or data documenting the existence and terms of the accident- or occurrence based policies they issued in the previous decades, but nevertheless destroy that information in an effort to avoid future coverage claims? Did the insurer decide to destroy that evidence despite its previous recognition that it was not appropriate to do so?

3. Marshalling the above evidence serves a dual purpose.

a. If a court allows the insured to pursue a bad faith or fraud claim based on the insurer’s concealment or destruction of evidence, the insured will have the opportunity to recover extracontractual remedies allowed by state law – which may include tort damages, coverage action attorney fees, penalties, extra interest, and punitive damages.

b. But even if the court or state law disallows a bad faith or fraud claim, the insured may have the opportunity to sway the jury against the insurer on the credibility of not just its missing policy defense, but all its coverage defenses.
(1) As noted above, where the insurer denies the existence and terms of a missing policy or daily (or other records or data documenting the policy’s existence and terms), FRE 1008 requires that the jury hear and determine whether those original documents have been lost or destroyed; whether the proponent of secondary evidence lost or destroyed the original documents in bad faith; and whether the originals could not be obtained through available judicial process or procedure. FRE 1004.

(2) FRE 1008 thus allows the insured to present to the jury all the facts relating to its efforts to obtain information, records and data from the insurer, and the insurer’s response to those efforts, because those facts are relevant to whether the original documents could be obtained through available judicial process or procedure (e.g., through the insurer’s full compliance with formal discovery requests), whether the originals were truly “lost” (instead of the insurer just not wanting to find them), or whether the originals were in fact destroyed. Likewise, because the insurer is the proponent of secondary evidence on terms of limitation and exclusion, the facts regarding when and why the insurer lost or destroyed the original documents is relevant to whether the insurer lost or destroyed them in bad faith.

(3) Thus, while the evidence of the insurer’s concealment or destruction of evidence may not be relevant to a disallowed bad faith claim, it should get to the jury under FRE 1008. And depending on the egregiousness of the insurer’s concealment or destruction, the FRE 1008 evidence will beg this question regarding the insurer’s other coverage defenses: “Are there any limits to what this insurer will say or do to avoid coverage?”

B. Fabrication of coverage defenses relating to insured’s knowledge and intent.

A helpful by-product of a missing policy investigation is the discovery of historical documents relating to the insurer’s underwriting or loss prevention activities. These documents often undercut the insurer’s coverage defenses that: the insured “expected or intended” the injury alleged in the underlying claim; the injury was not “accidental” or a “known loss;” or the insured failed to notify the insurer of the injury in a timely manner. The insured can use historical underwriting and loss prevention documents to show that the insurer is fabricating its “knowledge” defenses in bad faith attempt to evade coverage and engage in “retroactive underwriting.”

Historical underwriting and loss prevention documents might relate specifically to the insured that was issued the missing policies, or generally to all insureds in a particular industry.
1. Insured-specific underwriting and loss prevention records often show, for example, that the insurer inspected the insured’s operations, products and premises, and found that the insured was a well-run and conscientious company that more than satisfied the insurer’s underwriting standards. (See, e.g., A061-63.)

2. Similarly, the historical underwriting and loss prevention manuals and guidelines used by the insurer typically set forth the insurer’s underwriting and loss prevention standards for types of companies, industries, operations and products. (See, e.g., A046-52 & A056-60.) These documents help to show that the insured must have met or exceeded those standards, because otherwise the insurer would not have issued insurance to the insured.

C. **Duplicate positions on meaning of policy language.**

A missing policy investigation also provides the opportunity to uncover historical documents relating to the insurer’s prior interpretations of its policy language. The insurer’s historical underwriting and claims manuals often explain the intended meaning and application of policy terms, and sometimes describe example scenarios that would be covered. See, e.g., J. Stempel, *Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute*, 12 Conn. Ins. L. J. 349, 371 & 390-91 (2005-06). Insured-specific claims records may similarly show how the insured previously interpreted or applied terms in practice. Examples of such terms might include “accident,” “occurrence,” “injury during the policy period,” “defend any suit,” “notice as soon as practicable,” policy limits and aggregates (if any), and the polluter’s exclusion.

When the insurer’s past interpretations are contrary to its present-day, coverage-defeating interpretations, the insured may be able not only to defeat the insurer’s coverage defenses, but also to raise the question of whether the insurer is presently engaging in duplicitous and bad faith claims handling.

VI. **CONCLUSION**

This paper’s message to companies facing potential or actual latent injury claims is that lost insurance policies do not necessarily mean that all is lost. With the right approach, the company should be able to prove the existence and coverage terms of some or all of the missing policies, secure a full defense of underlying claims triggering those policy years, and obtain full or partial indemnification from those policies. What’s more, the missing policies investigation may give the company an opportunity to recover extracontractual remedies against the insurer, if the insurer does not seize the opportunity to show its good faith by fully cooperating with its insured.