Unique Issues With Special Cases: Computer and Funds Transfer Fraud, Inventory Losses, and Loan Losses

John J. McDonald, Jr., Esq.
Daniel L. Payne, Esq.
Kerry M. Evensen, Esq.
Mr. Eric Emmette

I. Computer and Funds Transfer Fraud

Over the past few decades, the use of computers and other electronic technology in business has become more and more prevalent to the point now where it appears to be an absolute necessity. Today, a business cannot compete without the ability to conduct transactions electronically, and to provide that same convenience to its customers. Face-to-face transactions have long given way to a click of the mouse and instant credits or debits to the customer’s account that can be viewed in real-time.

But the necessary convenience also gives rise to new risks. Although the risk of on-premises fraud will always exist, from the defalcator’s perspective the possibility of achieving the same goal without having to be seen is proving to carry with it an allure difficult to resist. Further, the prospect of being able to swindle much larger amounts by simply entering instructions from a computer carries an obvious incentive as well. Although one is by no means completely invisible behind a computer screen, the concept is certainly proving to be empowering and providing many otherwise innocuous individuals with the confidence to act in ways they likely would never endeavor to undertake were they required to personally appear before their victim.

In light of the substantial increase in electronic transactions, it goes without saying that computer-related fraud is a growing concern to even the smallest businesses and banks. Computer crimes present real risks and the stakes are high to any business when, ultimately, a thief can access its entire portfolio with the touch of buttons. The threats of theft are far greater than the “on premises robbery.” With the right knowledge and equipment, a “hacker” can make off with millions in an instant without having to be anywhere near the premises of the business or bank, and still be somewhat confident that he or she will have sufficient time to make a “get-away” before the theft is even discovered. Having anticipated and seen these sophisticated risks for many years, the insurance industry has long offered protection two inter-related additions to the crime coverage: the Computer Fraud and Funds Transfer Fraud Insuring Agreements.

A. THE COMPUTER FRAUD COVERAGE INSURING AGREEMENT

The ISO Computer Fraud Coverage Form (Form F) in the commercial crime coverage has been around for nearly two decades. First appearing in 1983, the coverage has gone through a number of revisions to its current form. The coverage provided is as follows:

1 For a more detailed discussion of these types of coverages please see John J. McDonald, Jr., Joel T. Wiegert & Jason W. Glasgow, Computer Fraud and Funds Transfer Fraud Coverages, XIV Fid. L.J. 109 (2008).
A. Coverage – We will pay for loss of and loss from damage to Covered Property resulting directly from the Covered Cause of Loss.

1. **Covered Property:** “Money,” “Securities” and “Property Other Than Money and Securities.”

2. **Covered Cause of Loss:** “Computer Fraud.”

The additional definitions place the coverage into context, and most notably, “computer fraud” is itself defined as follows:

“**Computer Fraud**” means “theft” of property following and directly related to the use of any computer to fraudulently cause a transfer of that property from inside the “premises” or “banking premises” to a person (other than a “messenger”) outside those “premises” or to a place outside those “premises.”

Generally speaking, this insuring agreement is intended to protect an insured where a defalcator uses a computer to fraudulently and improperly gain access to an insured’s internal computer system by circumventing the insured’s computer security procedures, directly causing a loss. In other words, the coverage applies in situations where when a third-party uses a computer to “hack” into an insured’s computer system and cause funds to be transferred from the insured’s (or its bank’s) premises. Some combination of fraudulent key strokes and/or mouse clicks would need to directly cause the insured’s loss of funds. However, the specific insuring agreements, definitions, and exclusions utilized by a particular carrier would need to be analyzed in any situation where an insured is seeking coverage.

The standard coverage includes two additional exclusions to the Crime General Provisions: Acts of Employees, Directors, Trustees or Representatives; and Inventory Shortages. The Inventory Shortages exclusion is similar to the traditional exclusion that precludes a loss for which the proof of such is dependent on an inventory or profit and loss computation, which will be discussed in more detail later in this article. The more pertinent of these exclusions is the first, which precludes coverage for loss resulting directly from any dishonest or criminal acts committed by what could be referred to as an “inside” party, such as an employee, director, trustee, or authorized representative of the insured, whether acting alone or in collusion with other persons, or while performing services for the insured or otherwise.

The exclusion is broad, precluding coverage regardless of the employee’s intent, and regardless of when the employee acts. By precluding losses involving “inside” parties the exclusion makes clear that coverage is intended to protect against third-party access.

More recently, the market seems to have gone towards an insurer-specific form of coverage with respect to computer fraud. The risk has presented insurers with the opportunity to

---

2 ISO CR 00 07 (10 90) (Form F).
3 “Premises” itself is defined to mean “the interior of that portion of any building you occupy in conducting your business.”
address their insured’s needs through niche endorsements that depend on the insured’s particular business. However, the same general concept first found in the ISO form seems to have survived. The focus is on providing protection for the third-party theft of assets through the use of a computer.

Although the general concept behind the original coverage remains, the more recent policies have been refined to limit the scope of coverage due to the ever-evolving scope of risk. The limitation has been primarily confined to the exclusions that apply to the coverage grant. For example, most modern policies contain an exclusion precluding coverage for loss due to the giving or surrendering of covered property in any purchase or exchange, whether legitimate or fraudulent. Thus there is no coverage for loss of property that the insured gives up in connection with a fraudulent sale, transaction or exchange that involves the computer.

Another exclusion that is often relevant in the context of Computer Fraud coverage precludes coverage for loss resulting directly or indirectly from the input of “Electronic Data” by someone having the authority to enter the insured’s computer system. The pertinent issue with respect to this exclusion is understanding the scope of what is identified as “electronic data.” Electronic data generally includes those facts or information converted to a form that the computer system can utilize in performing its function. In other words, it is the data, not the program. As such, the exclusion does not preclude coverage for loss resulting from someone altering the computer program, but it does preclude coverage for loss resulting from someone entering incorrect or fraudulent data that does not allow the computer program to accurately perform its function.

Finally, another of the more relevant exclusions (and there can be many others depending on the coverage form utilized) makes clear that the extent of coverage applies only to the loss of covered property—most often money—and does not include intangible property or confidential information. Many policies will specifically identify “electronic data” and “computer programs” as falling within the scope of the exclusion. The intent behind this exclusion is to limit coverage to that which can be readily quantified, as valuating the data or program itself can often be a difficult assessment. The information can usually be replaced for a value much less than the value (and dependence) the insured places on it. Other property coverages may encompass this risk, but the crime coverage does not.

B. **The Funds Transfer Fraud Insuring Agreement**

The Funds Transfer Fraud Coverage is usually written as a direct corollary to the Computer Fraud coverage. Many times it may be added to the crime policy in the same endorsement. However, the two coverages are distinct and protect against separate risks. A typical example of the coverage afforded by the Funds Transfer Fraud coverage in today’s market is as follows:

---

Some policies, however, limit the application of this exclusion to those transactions with a party not in collusion with an Employee.
**Funds Transfer Fraud:** We will pay you for your direct loss of Money and Securities contained in your Transfer Account on deposit at a Financial Institution directly caused by Funds Transfer Fraud.

“Funds Transfer Fraud” means:

1. an electronic, telegraphic, cable, teletype or telephone instruction fraudulently transmitted to a Financial Institution directing such institution to debit you Transfer Account and to transfer, pay or deliver Money or Securities from your Transfer Account which instruction purports to have been transmitted by you, but was in fact fraudulently transmitted by someone other than you without your knowledge or consent;

2. a fraudulent written instruction, other than one covered under Insuring Agreement B., issued to a Financial Institution directing such Financial Institution to debit a Transfer Account and to transfer, pay or deliver Money or Securities from such Transfer Account by use of an electronic funds transfer system at specified intervals or under specified conditions which written instruction purports to have been issued by you but was in fact fraudulently issued, Forged or altered by someone other than you without your knowledge or consent; or

3. an electronic, telegraphic, cable, teletype, telefacsimile, telephone or written instruction initially received by you which purports to have been transmitted by an Employee, but which was in fact fraudulently transmitted by someone else without your or the Employee’s consent.

While the Computer Fraud Coverage Insuring Agreement and the Funds Transfer Fraud Insuring Agreement are similar, (so much so they have sometimes been combined into one insuring agreement), they obviously differ in the risks they cover. The Funds Transfer Fraud Insuring Agreement was intended to provide coverage to losses caused by fraudulent written, telephonic or teletype instructions, mirroring the way business was transacted before computers became ubiquitous. The policies containing both coverages generally are structured such that the two are mutually exclusive. For example, many will contain an exclusion that the computer fraud insuring agreement does not apply loss resulting from a fraudulent instruction directing a financial institution to transfer, pay or deliver funds form the insured’s transfer account. Similarly, they will also include an exclusion stating funds transfer fraud insuring agreement does not apply to loss resulting from the use of any computer to fraudulently cause a transfer of money, securities or other property.

**C. APPLICATION OF THE COMPUTER FRAUD AND FUNDS TRANSFER FRAUD COVERAGES**

Even though variations of Computer Fraud and Funds Transfer Fraud Coverages have been available for over 20 years, there is a surprisingly low number of reported decisions interpreting these coverages. However, the cases available provide good discussions of the issues relevant to the coverage. With respect to the Computer Fraud Coverage, *Brightpoint, Inc.*
v. Zurich American Insurance Co.,\(^5\) identifies several issues that often come up in the context of that coverage. With regard to the Funds Transfer Fraud Coverage, the limited cases provide insight into the common coverage issues as well. Each are discussed below.

1. **The Computer Fraud Insuring Agreement**

*Brightpoint, Inc. v. Zurich American Insurance Co.* involved the theft of nearly $1.5 million through a scam involving prepaid telephone cards.\(^6\) The insured sought coverage under a computer fraud insuring agreement arguing that the computer fraud was carried out by a fraudulent facsimile purchase order.

The insured distributed mobile telephone cards, and its customary practice was to receive a facsimile purchase order from one of its regular phone card dealers.\(^7\) Along with the purchase order, the insured would accept a post-dated check from the dealer and would require the dealer to provide a bank guarantee certifying the sufficiency of the funds in the dealer’s account and committing the bank to honor the post-dated check when it was presented on the maturity date. The dealer normally sent copies of the post-dated checks, guaranties, and purchase orders to the insured by facsimile. The insured would then purchase the phone cards from a telecom company and deliver them to the dealer in exchange for the original check, guaranty and purchase order.

On two occasions the insured went through the order process, and eventually met with a known employee of a dealer, who purported to deliver to the insured an original copy of a post dated-check and bank guarantee in exchange for the $1.5 million worth of prepaid phone cards.\(^8\) A few days after the exchange, the dealer met with the insured to advise that it had not authorized issuing the purchase order, denied authorizing the bank to issue the guaranties, and denied authorizing its employee to pick up the cards.\(^9\) Ultimately, the phone cards were never recovered and the insured never received payment for the stolen cards. The insured claimed a loss under the Computer Fraud/Wire Transfer insuring agreement, contending that the facsimile constituted the use of a computer. The insurer denied coverage, maintaining a computer was not used to fraudulently cause a transfer of the phone cards.\(^10\) On summary judgment the insurer set forth several defenses in support of its coverage denial, some of which are discussed below.

a. **“Covered Property”**

The insurer argued that the phone cards were not “covered property,” defined by the policy as “Money”, “Securities” or “Property Other Than Money or Securities.”\(^11\) The insurer’s position was based on its argument that the loss resulted only from the economic value attached to the phone cards and not the cards themselves. Therefore, the phone cards could not be considered “tangible” property. The court agreed that to fall under the “Property Other than

---

\(^6\) See id. at *1.
\(^7\) See id. at *2.
\(^8\) See id.
\(^9\) See id. at *3.
\(^10\) See id. However, this defense was not developed in the summary judgment motion.
\(^11\) See id.
Money and Securities” category, the property must be “tangible.”\textsuperscript{12} The court also recognized that the property must have “intrinsic value” and not be any property specifically excluded by the policy.\textsuperscript{13} However, the court held that the phone cards were tangible because they can be physically transferred.\textsuperscript{14} In addition, the court held that the cards had an intrinsic value because each had a specific value attached to them.\textsuperscript{15} Therefore, the court held that the stolen prepaid telephone cards did qualify as “covered property” under the policy.

b. “Premises”

Next, the insurer suggested that the theft of the phone cards was not covered under the policy because the phone cards were not transferred from inside the “premises” or “banking premises,” as required under the policy definition of “Computer Fraud.”\textsuperscript{16} “Premises” was defined as “the interior of that portion of any building you occupy in conducting your business.”\textsuperscript{17} However, the insured argued that the definition of “premises” should be interpreted broadly to include any location where one of its employees carries out the company’s interests, including the location where the phone cards were actually exchanged should be covered as a “premises” because they were places the insured’s employees conducted business.\textsuperscript{18}

The court adopted a narrower view of the “premises” concept, limiting its application to the context of the policy definition and holding that only the places that the insured occupies in conducting its business is included in the definition. Applying the relevant rules of contract interpretation, the court found that the limitation on coverage to property transferred out of the insured’s premises (or its bank’s) would be made meaningless by adopting the insured’s broad interpretation. As a result, because the phone cards were never inside an office building occupied by the insured, the loss did not result from a transfer from “inside the premises or banking premises” as required by the policy.\textsuperscript{19}

c. “Directly Caused by Computer Fraud”

Finally, the insurer focused on the direct loss requirement and contended that the facsimile transmission did not “fraudulently cause a transfer” of the phone cards, as required under the “Computer Fraud” definition.\textsuperscript{20} Rather, the insurer argued that the fraudulent facsimile simply alerted the insured to the fact the dealer, or someone purporting to be the dealer, wished to place the order.\textsuperscript{21} Indeed, based on the insured’s established practices, it would not have exchanged the phone cards simply on the basis of the facsimile itself. It was only after the insured received the physical documents that it would release the cards. Therefore, the insurer

\textsuperscript{12} See id.

\textsuperscript{13} See id.

\textsuperscript{14} See id. at *6.

\textsuperscript{15} See id.

\textsuperscript{16} See id.

\textsuperscript{17} See id.

\textsuperscript{18} See id.

\textsuperscript{19} See id.

\textsuperscript{20} See id. at *7.

\textsuperscript{21} See id.
argued, the fraud was carried out through the use of unauthorized checks and guaranties, and was not directly or proximately caused by the use of the facsimile machine, much less a computer.\textsuperscript{22}

On the other hand, the insured argued that the policy only required that the theft follow and be directly related to the use of a computer. Moreover, the insured argued that the policy did not contain a modifier such as “proximate cause”, “predominate cause” or the like.\textsuperscript{23} As such, the insured argued all that was required by the policy is the use of a computer followed by a theft that is in some way connected to that initial use of the computer.\textsuperscript{24}

The court rejected the insured’s interpretation of the term “directly related” and found that the insured’s loss did not flow immediately from the use of the facsimile machine.\textsuperscript{25} Rather, the court held that intervening events or circumstances became the direct, proximate, predominate, and immediate cause of the insured’s loss.\textsuperscript{26} Consequently, the court held that this was another ground for which the insurer was justified in denying coverage under the Computer Fraud policy.

\textbf{2. The Funds Transfer Fraud Insuring Agreement}

The following two cases raise issues unique to the coverage available under the Funds Transfer Fraud Coverage Insuring Agreement.

\textit{a. Northside Bank v. American Casualty Company of Reading}\textsuperscript{27}

In \textit{Northside Bank v. Am. Cas. Co. of Reading}, the insured opened an account for its client-merchant pursuant to a merchant services agreement.\textsuperscript{28} Pursuant to the agreement the client-merchant would accept orders for merchandise by debit and credit card payments. Upon receipt of electronically transmitted debit and credit card authorizations from the client-merchant, the insured would then transfer money into the client-merchant’s account. However, it turned out that the client-merchant never actually delivered the purchased merchandise to its customers. When the client-merchant’s customers exercised their rights under federal law to rescind their debit and credit card payments for the undelivered goods, the creditors refused to pay, or charged back the amounts they had paid, to the insured. When the insured similarly attempted to charge back the client-merchant’s account, it discovered that the account had been completely depleted.\textsuperscript{29}

\textsuperscript{22} See \textit{id.} A seemingly threshold issue presented in \textit{Brightpoint} was whether the facsimile machine itself was a “computer” for purposes of the policy. However, the insurer did not address the issue in the summary judgment motion.
\textsuperscript{23} See \textit{id.}
\textsuperscript{24} See \textit{id.}
\textsuperscript{25} See \textit{id.}
\textsuperscript{26} See \textit{id.}
\textsuperscript{28} See \textit{id.} at *96.
\textsuperscript{29} See \textit{id.}
The insured sought coverage under its financial institution bond for what it deemed to be fraudulent electronic fund transfers and computer crimes. The insured argued that the loss should be covered because the submission from the client-merchant was an electronic instruction, and the subsequent failure to ship the merchandise should be viewed as a ‘modification’ or ‘alteration’ of the electronic instruction with the intent to deceive.

Although the insured argued “modified or altered” was ambiguous, the court held that the insured was trying to “place a square peg in a round hole.” The electronic instructions sent from the client-merchant were never modified or altered, but were paid according to the intended instruction. In what is proving to be an encouraging pattern with respect to the decisions involving these coverages, the court, in affirming the denial of coverage under the Bond, found the insured’s claim to be at odds with the “obvious intent of the insurance policy.”

Viewing the policy as a whole, the court found that the purpose of the Electronic Funds Transfers and Computer Crime coverages was to protect the insured from someone breaking into the insured’s electronic fund transfer system and pretending to be an authorized representative or altering the electronic instructions to divert monies from the rightful recipient. The funds transfer instructions at issue in Northside Bank, whether fraudulent or not, were sent directly from the client-merchant to the bank unaltered. Therefore, the court agreed that this was not the type of risk that was contemplated by the coverage.


Morgan Stanley Dean Witter & Co. v. Chubb Group of Insurance Cos. involved the issue of whether coverage was available under an Electronic and Computer Crime Policy for fraudulent telephone-initiated funds transfers. Morgan Stanley sought indemnification for over $21 million it paid to defend and settle a lawsuit which stemmed from the fraudulent actions of one of its customers, London and Bishopsgate International (LBI).

Morgan Stanley had agreed to provide custodial services for property owned or held by LBI. According to the written custodial services agreement between them, Morgan Stanley was to be responsive to instructions from LBI, which could come from several specifically authorized persons. In order to facilitate the instructions, Morgan Stanley provided LBI with computer software allowing access to Morgan Stanley’s computer programs. LBI later entered into an investment management contract with First Tokyo Index Trust Limited (First Tokyo), allowing

---

30 See id. at *98.
31 See id. at *101. The definition of “fraudulent electronic instruction or advice”—to which both the Electronic Funds Transfers and Computer Crime coverages referred—involved two subparts: when someone other than a customer defrauded the insured; and when an electronic instruction or advice was “modified or altered with intent to deceive after being sent by another financial institution or automated clearing house or by a customer of the insured.” Id.
32 See id. at *101.
33 See id.
34 See id. at *101-102.
36 See id. at *1.
LBI to manage First Tokyo’s investments. To facilitate the management of First Tokyo’s investments, LBI opened an account with Morgan Stanley, which was subject to the custodial services agreement between the two parties.37

Two years later, the company owning the controlling share of LBI made a public offer to purchase First Tokyo. Once the offer became unconditional, the purchasing company requested that there be no changes to First Tokyo’s securities portfolio without its consent. As such, First Tokyo ordered LBI to cease all trading on its behalf; however, Morgan Stanley was not informed that LBI was no longer authorized to trade for First Tokyo.38 Despite the lack of authority, LBI later instructed Morgan Stanley to liquidate the bulk of First Tokyo’s portfolio through several transactions, and the sale proceeds were delivered to LBI-affiliated accounts.39 The transactions were accomplished through instructions sent by computer, fax, and voice to Morgan Stanley by persons who were specifically authorized by LBI.40

Morgan Stanley’s crime policy provided coverage for loss as a result of fraudulent instructions communicated by voice, fax, and computer. After settling the claim First Tokyo made against it, Morgan Stanley argued that its loss was covered by those insuring agreements, covering “computer systems,” “customer voice initiated transfers,” and “facsimile transfer instructions.”41

The court held there was no coverage under fraudulent facsimile transfer instruction agreement. The facsimile insuring agreement was recognized to limit coverage to situations “where an unauthorized person poses as a customer or other authorized person to issue the fraudulent transfer instructions.”42 As the instructions at issue had been made by persons authorized to act for LBI, they were not “imposters.” Consequently, the failure to satisfy this requirement precluded coverage.

With respect to the “computer systems” insuring agreement, the court held there was no coverage because any such coverage otherwise available was excluded. The applicable exclusion precluded coverage for “loss by reason of the input of Electronic Data at an authorized electronic terminal…or a Customer Communication System by a customer or other person who had authorized access to the customer’s authentication mechanism.”43 The court held this exclusion also unambiguously excluded coverage for fraud committed by customers or other authorized persons.44 Again, there was no dispute that the fraudulent instructions were made by authorized employees of LBI, but Morgan Stanley tried to argue that LBI was not a customer. Citing the custodial agreement, the court dismissed this argument and held there was no “computer systems” coverage.45

37 See id.
38 See id.
39 See id. at *2.
40 See id.
41 See id.
42 Id. at *3.
43 Id.
44 See id. at *3.
45 See id.
However, the court held the “customer voice initiated transfers” agreement was not as limited as the others. Contrary to the lower court, the appeals court found the voice initiated transfer agreement was not limited to “imposters or hackers.”\textsuperscript{46} Rather, this agreement covered voice transfer instructions that:

\begin{itemize}
\item [1] fraudulently purport to have been made by a person authorized and appointed by a Customer to request by telephone the transfer of such funds but which instructions were not made by said Customer or by any officer, director, partner or employee of said Customer or
\item [2] were fraudulently made by an officer, director, partner or employee of said Customer whose duty, responsibility or authority did not permit him to make, initiate, authorize, validate or authenticate customer voice initiated funds transfer instructions.\textsuperscript{47}
\end{itemize}

The insurers first argued that coverage was limited to the transfer of “funds,” and therefore did not include securities.\textsuperscript{48} “Funds” was not defined in the policy, and the court held the concept was ambiguous and could be more broadly interpreted to include assets other than money.\textsuperscript{49} The insurers also contended the agreement, like the other coverages, was limited to “imposter or hacker” coverage. The court interpreted the insurers’ position regarding the scope of the agreement as one conceding ambiguity.\textsuperscript{50} Nonetheless, the court found there was no ambiguity with respect to the second provision and held the voice initiated transfer agreement covered the losses attributed to the transactions made by telephone because when the LBI employees issued the telephone instructions, they were no longer authorized by First Tokyo to do so.\textsuperscript{51} Thus, it became a matter of exceeding authority, and therefore, coverage was held to be available under this coverage part.\textsuperscript{52}

### D. Issues Involved in Recent Cases

One of the most basic issues with regard to Computer Fraud coverage is what qualifies as a “computer.” Most insuring agreements do not include a policy definition for “computer.” As a result, it is not clear how broadly the term “computer” is interpreted. For the most part, this term is unaddressed by courts interpreting coverage under Computer Fraud policies. One exception is \textit{Brightpoint}, wherein the insured claimed that the fraudulent use of a facsimile machine constituted the use of a computer for purposes of its Computer Fraud policy.\textsuperscript{53} While the insurer abandoned at summary judgment its argument that the facsimile was not a “computer,” the court’s decision included a footnote disagreeing with the insured’s expert’s position that it did constitute a “computer.” Although it did not explicitly decide the question, the court opined that that the common and ordinary meaning of “computer,” as used and understood in our society and around the world, would be stretched too far by including the use of a facsimile machine.\textsuperscript{54}

\textsuperscript{46} See id. at *4.
\textsuperscript{47} Id.
\textsuperscript{48} See id.
\textsuperscript{49} See id.
\textsuperscript{50} See id. at *5.
\textsuperscript{51} See id.
\textsuperscript{52} See id.
\textsuperscript{53} See Brightpoint, Inc., 2006 WL 693377 at *7 n. 5.
\textsuperscript{54} Id.
Another issue becoming more prevalent in computer fraud claims is that of to what extent must the use of a computer be involved to trigger coverage? For example, does the use of a computer to create and print fraudulent documents that are submitted to the insured in paper form constitute Computer Fraud? An insured asserted this claim in Milwaukee Area Technical College v. Frontier Adjusters of Milwaukee. There, the wrongdoer fashioned fake check ledgers using standard accounting software. By submitting the fake check ledgers to the insured, the wrongdoer received reimbursements for payments that were never made. The court, however, did not reach the issue of whether this action constituted computer fraud because coverage was excluded as the fraud was carried out by an authorized representative.

A similar claim was asserted by an insured in Great Am. Ins. Co. v. AFS/IBEX Fin. Servs., Inc. In that case, the defalcator was an insurance agent who obtained insurance premium finance checks from the insured by submitting premium financing applications from fictitious insureds. The agent purportedly used a computer to fill out an application online, enter the information from the fictitious application into the insured’s online processing system, which would generate a premium finance agreement. The agent would then print and sign the finance agreement, and fax it and the signed application to the insured. Upon receipt of these documents, the insured would then issue the checks.

The insurer argued that the losses sustained by the insured did not bear a direct enough loss to the use of a computer to fall within the coverage available under its policy’s computer fraud provision. It asserted that there were several intervening acts before the insured’s loss occurred, including its receipt of the signed applications and finance agreement, its issuing of the finance checks, and the agent’s endorsement and deposit of the checks. The court granted the insurer’s motion for summary judgment related to computer fraud coverage, finding that the insured failed to raise a fact issue as to whether the use of a computer directly caused the transfer of any funds from the insured’s bank.

The issue of whether an insured suffered a direct loss due to the use of a computer may also become more prevalent in the Ponzi scheme cases that have recently made headlines. In those cases, insureds who lost money by investing in a Ponzi scheme may assert that the defalcator’s use of a computer to facilitate the scheme, such as by generating false income statements or bogus trading slips, fell within the Computer Fraud insuring agreement of the commercial crime policy. The insureds in these cases will necessarily need to establish that money or other covered property was fraudulently transferred from inside the insured’s premises or banking premises to a person or place outside those premises. Further, like in the AFS/IBEX

---

56 See id. at 366.
57 Id. at 373.
59 Id. at *2.
60 See Great Am. Ins. Co.’s Br. in Supp. of Mot. for Summ. J., pp. 11-12 (on file with the authors).
61 Id.
63 Id. (noting that insured did not present any evidence or arguments opposing insurer’s summary judgment motion with respect to computer fraud provisions).
and *Frontier Adjusters* cases, the direct loss analysis likely will be one of the most crucial issues. Direct loss means direct, and consequently, the computer must be used to directly cause the insured’s loss, not merely be a passive instrument that happened to be used in facilitating the fraud.

**E. CONCLUSION**

The Computer Fraud and Funds Transfer Fraud coverages will continue to present issues that one can not even imagine at this point. The schemes are constantly evolving and the coverage responding. Although there is surprisingly little case law on the coverages, it is most certain that that will change in the near future as more and more insureds are suffering losses, as well as larger losses, as a result of computer crimes. Although the vast majority of decisions are unreported, the cases are positive in that courts’ analyses, particularly with the application of exclusions, has indicated an unwillingness to interpret the language out of context as to what the coverage is intended to provide. Coverage is available for third-party access to computer systems for the purpose of theft. The coverage grant, and the exclusions, make this intent clear and unambiguous. Thus far, the courts have agreed.

**II. Loan Loss Exclusion**

For several years, one of the most heavily disputed issues relating to coverages available under a Financial Institution Bond is the extent to which coverage is available for so-called “loan loss” claims. The Financial Institution Bond is not intended to provide a life-line to the insured bank when it makes an ill-advised loan decision. The rationale behind this theory is that after the bond is issued, an insurer has no influence or input related to loan decisions made by a bank’s loan officers and committee. Banks develop relationships with their customers, and in the course of those relationships, often relax certain requirements pertinent to a loan. Banks may also be interested in obtaining new business, and in doing so, decide to take a risk they otherwise would not to accommodate the customer. There simply is no analytical schematic that any bank will follow in determining whether to issue credit or enter into a loan transaction. Each loan requires individual attention and decisions, and the bank is certainly entitled to base its decision on whatever criteria it is comfortable with, and the insurer has no basis to interfere with that process.

The trade-off between the insurer’s involvement and the bank’s autonomy is simple—the loan loss exclusion. That particular exclusion provides the allocation between the business risk maintained by the insured and the insurable risk the insurer agrees to undertake in the bond. The bond will not provide coverage for any loss resulting directly or indirectly from a Loan or other transaction or extension of credit, whether that loss is the result of a legitimate loan gone bad or a thief duping the bank through a fraudulent transaction, unless the loss falls within one of several explicit exceptions. Courts have generally recognized this limitation and allocation of risk by applying the loan loss exclusion where appropriate.

---

A. THE FINANCIAL INSTITUTION BOND’S LOAN LOSS EXCLUSION

The first American standard form bond (Standard Form 24) was produced in 1916 by the Surety Association of America (“SAA”) and the American Bankers Association. Over the last 90 years, the standard form bond has undergone numerous revisions, including renaming the bond from a Bankers Blanket Bond to a Financial Institution Bond to deter courts from interpreting coverage as broader than intended by the parties. The first loan exclusion clause appeared in the Standard Form 24 around 1920. The “loan loss” exclusion, as it has come to be known, has been revised numerous times since its original introduction, the most comprehensive revisions to the exclusion taking place in 1969, 1980, and 1986.

The most recent version of the Standard Form 24, as revised in 2004, contains a loan loss exclusion which provides that the bond does not cover:

(e) loss resulting directly or indirectly from the complete or partial non-payment of, or default upon, any Loan or transaction involving the Insured as a lender or borrower, or extension of credit, including the purchase, discounting or other acquisition of false or genuine accounts, invoices, notes, agreements or Evidences of Debt, whether such Loan, transaction or extension was procured in good faith or through trick, artifice, fraud or false pretenses, except when covered under Insuring Agreements (A), (E) or (G).

Moreover, the 2004 version of the Standard Form 24 defines the term “Loan” as “all extensions of credit by the Insured and all transactions creating a creditor relationship in favor of the Insured and all transactions by which the Insured assumes an existing creditor relationship.”

One of the more prevalent issues with respect to the loan loss exclusion is the exceptions contained within the exclusion. Every version of the loan loss exclusion has contained three general exceptions: Insuring Agreement (A), covering a loss resulting from the dishonest acts of an employee; Insuring Agreement (D), covering certain activities which involve forged or altered instruments; and Insuring Agreement (E), covering certain transactions involving forged, altered, lost, stolen or counterfeit securities. If any of these exceptions apply, the loan loss exclusion does not.

66 See Broeman, supra note 65 at 444.
68 Id.
69 FINANCIAL INSTITUTION BOND, Standard Form No. 24 (revised April 1, 2004), reprinted in LOAN LOSS COVERAGE UNDER FINANCIAL INSTITUTION BONDS, supra note 64, Master App’x at 667.
70 Id.
B. PURPOSE AND INTENT OF THE FINANCIAL INSTITUTION BOND AND LOAN LOSS EXCLUSION

1. The Financial Institution Bond is Not Credit Insurance

The evolution of the loan loss exclusion evinces the intent of insurers to avoid becoming guarantors of bad loans made by banks. Lending is the business of banks and a part of its business risk permitting insureds to an interest on the loans made. The modern day Financial Institution Bond is not “credit insurance.”\(^{71}\) It is not intended to “protect the bank when it simply makes a bad business deal.”\(^{72}\) Again, the primary provision in the bond exemplifying this objective is the loan loss exclusion. The exclusion is quite broad, encompassing all extensions and transactions creating a debtor/creditor relationship, in addition to those transactions falling within the scope of the bond’s definition of Loan.

The rationale behind the loan loss exclusion is that making loans is the financial institution’s business and part of its business risk.\(^{73}\) “The Bond’s language attempts to distinguish between risks against which the banks could reasonably protect themselves through, for example, diligence in screening and approving loans, and risks which commercial realities indicate that the banks should not assume.”\(^{74}\) The exclusion “clearly allocates the risk of entering into a bad credit transaction on the insured rather than the insurer.”\(^{75}\) Quite simply, “[t]he rationale underlying this exclusion is to deny coverage for poor loan underwriting.”\(^{76}\)

2. Allocating the Business and Insurable Risks Between Insured and Insurer

The insured is certainly entitled to make loan decisions based upon the comfort level it maintains with the borrower. But this is a business practice only the bank can control and demonstrates why it is not an insurable risk. Insureds cannot pass the consequences of their business decisions and practices onto the insurer. That is not the purpose of the bond. The bond is designed to protect banks “against risks of dishonesty, both external and internal, but does not insure good management nor against the risk or loss inherent in the banking operations.”\(^{77}\) “The failure to follow sound business practices and verify authenticity is a business risk taken by banks and not an insured risk covered by the Bond.”\(^{78}\)

The primary mechanism for enforcing this distinction actually arises out of the exceptions—the identified Insuring Agreements—and their direct loss requirements. The interplay between the exclusion and stated exceptions vis-à-vis the direct loss requirements distinguishes “between the ‘risk of authentication’ (forgery and counterfeiting) against which the [insured] could not reasonably protect itself and the credit risk” maintained by the insured, such as the risk of not verifying collateral securing a loan.\(^{79}\) There is no coverage for the credit risk

\(^{74}\) Id.
\(^{78}\) Id.
\(^{79}\) See Liberty Nat’l Bank, 568 F. Supp. at 863.
because the insured can “investigate the assertions made therein through credit checks, appraisals, title searches, financial statements and the like.”

The expectation that banks will protect themselves through their own credit evaluation procedures is not only derived from common sense, as the bank is in the best position to make such judgment calls based upon its market, but also carries a preemptive element with respect to loss management. Indeed, requiring the insurer to underwrite the business risk would bind the carrier to a contract that it did not enter into and “transform the bond into a credit insurance policy.”

But some restraint is required when distinguishing the insured’s business risk. Placing the loss within the insured’s business risk is not akin to arguing the insured has been negligent in its evaluation and therefore, no coverage is available. “Ample authority supports the conclusion that, in the absence of policy language to the contrary, mere negligence of the insured does not defeat coverage under a fidelity bond.”

The issue presented is not that the insured was negligent in its credit evaluation procedures, but rather, the insured’s negligence demonstrates why the matter is not an insurable risk to begin with. While every bank, for example, has a loan policy, exceptions are made on a daily basis. Those exceptions are based on the bank personnel’s comfort level and knowledge with respect to the borrower. A bank is certainly entitled to make those decisions, however, it does so at its own risk. A bank simply does not have the luxury to disregard verifying collateral or signatures simply with the hope of getting insurance coverage for such an ill-fated decision. An insurer has no means of underwriting such acts. In light of that, by virtue of the loan loss exclusion, the bond provides that the insurer will not cover losses that arise out of a loan, whether such losses were “procured in good faith or through trick, artifice, fraud or false pretenses.”

3. Loan Loss Exclusion Is “Clear and Unambiguous”

Numerous courts have interpreted and applied the loan loss exclusion. When interpreting the scope of the exclusion, courts have found “there is no dispute as to the meaning.” The language of the clause is clear and unambiguous.

That fraudulent loan losses (absent an exception) are not covered is often a difficult concept for insureds to accept. Arguably, fraud is present in no other area of the financial institution’s business more than that involving loans and other extensions of credit. The lack of coverage for fraudulent loans is particularly tough to swallow for the insured when it reads through the bond and notes various references to coverage for dishonest or fraudulent acts by an employee, false pretenses committed by a person on the insured’s premise, forgery or alteration of negotiable instruments and securities and other coverages to the like. The presence of such language often leads to the insured’s argument that fraud is sufficient to establish coverage.

---

80 Id.; see also Nat’l City Bank, 447 N.W.2d at 177.
81 KW Bancshares, 965 F. Supp. at 1055; see also Flagstar, 2006 WL 3343765, at *13.
84 Id.; see also, Lyons Fed. Sav. & Loan, 863 F. Supp. at 1448.
The concept of no coverage for fraudulent loans can also be difficult for many courts, and the practitioner must often place emphasis on the underlying rationale of the loan loss exclusion, as well as noting the situations for which the bond is intended to provide coverage. Explaining the application of the bond as a whole often alleviates the apprehension carried by some courts when analyzing a loan loss issue. The loan loss exclusion in particular is not a novel issue. It is a veteran among the exclusions to the bond and has survived the numerous revisions to arrive at its current state. It should not take any insured by surprise.

C. Recent Cases Involving the Loan Loss Exclusion

There are relatively few recent cases that actually rely on the loan loss exclusion to preclude coverage. In the majority of reported decisions, the loan loss exclusion is addressed in the context of Insuring Agreements (A), (D) or (E) claims. When the loss involves Insuring Agreements (A), (D) or (E), the exclusion essentially takes a back seat—the primary issue is whether the Insuring Agreement applies. If it does, the exclusion does not and need not be addressed. It is only when a non-excepted Insuring Agreement is triggered, most commonly Insuring Agreement (B), that the exclusion carries weight.


The Court of Appeals of Kansas recently considered whether a bank’s payment of insufficient funds checks on behalf of its customers constituted a “Loan” for the purpose of applying a financial institution bond’s loan loss exclusion. In Nat’l Bank of Andover v. Kan. Bankers Sur. Co., the head accounting clerk for an insured bank honored insufficient funds checks drawn on the accounts of three of the insured’s customers, rather than recording overdrafts in the customers’ account records. The clerk did not receive any financial reward for honoring these checks, which totaled over $900,000, nor does it appear that she was working in collusion with any of the customers. Rather, she claimed that she was having problems keeping up with her work, and that she believed those customers ultimately would repay the honored overdrafts.

At trial, the insurer sought summary judgment on the issue that the loss was excluded by application of the bond’s loan loss exclusion, asserting that the payment of insufficient funds checks constituted loans. The trial court denied this motion, finding that the loan exclusion did not apply to those transactions because “although they were loans, they had not been approved by the bank’s management.” At trial, the court refused to permit the insurer to present evidence that the loan loss exclusion applied, apparently based on its earlier ruling denying summary judgment.

In remanding the case for trial, the court of appeals ruled that the insurer should have been permitted to present evidence at trial to establish that the loan loss exclusion precluded

---

86 Id. at *1.
87 Id.
88 Id. at * 5.
89 Id. at *10.
The court noted that the payment of insufficient funds checks created a debtor-creditor relationship between the bank and its customers, and that the bank was entitled to reimbursement for the advances made. "The transaction…cannot be characterized as anything other than a consummated extension of credit, i.e., a loan from the bank.”

The court of appeals did not overturn the trial court’s denial of summary judgment on this issue because the insurer failed to provide undisputed evidence that Insuring Agreement (A) of the bond did not apply:

For [the insurer] to obtain summary judgment, it must establish through uncontroverted evidence not only that the honoring of insufficient funds checks constituted loans to the customer on whose account the checks were drawn, but also that the provisions of Insuring Agreement (A) do not apply. Insuring Agreement (A) includes the provision that “if some or all of the Insured’s loss results directly from Loans, that portion of the loss is not covered unless the Employee was in collusion with one or more parties to the transactions . . . .” For the purposes of summary judgment, [the insurer] had to demonstrate that [the accounting clerk] did not act in collusion with [the customers]. In its statement of uncontroverted facts, [the insurer] makes no such assertion.

This finding provides a good example of how the application of the loan exclusion can be dependent on first determining whether coverage may be available under Insuring Agreements (A), (D), or (E).

2. **First New England Federal Credit Union v. Cuna Mutual Group**

A 2005 decision from a Connecticut state court addressed a financial institution bond’s definition of the term “Loan” in the context of a transaction extending of a line of credit on a home equity consumer revolving loan agreement. *First New Eng. Fed. Credit Union v. Cuna Mutual Group* involved a series of transactions by a borrower on a line of equity previously intended to be paid off and closed. Despite the banks’ intent to close the line, the borrower continued to take advances and make payments on the line of credit. A dispute developed and the borrower ultimately declared bankruptcy.

The insured bank sought coverage under its bond, claiming that the transaction in question was not a loan because the funds were advanced in error. The insured further argued that even if the loss were found to arise out of a loan, the loss would still be covered under the bond because the proceeds were obtained by fraud, deceit, or theft within the meaning of the bond.
The court began its analysis by noting the case law interpreting and applying the loan loss exclusion:

The cases dealing with the loan exclusion language of insurance policies all virtually identical to that in the present case do not focus on questions of whether the financial institution would have lent money if aware of the lender’s actual situation, or whether there was a meeting of the minds that a loan be made, or even whether the intent was to make a loan. The cases which have confronted this issue are basically in agreement that a loan exists in any situation wherein a bank expects that a customer will repay monies.\(^{98}\)

The court followed that reasoning and held the language of the bond was not ambiguous and the immediate cause of the loss was nonpayment.\(^{99}\) The court dismissed the insured’s claim that there was never a creditor/lender relationship established and that no Loan ever existed within the meaning of the policy. To support this, the insured relied on the dictionary definition of the term “loan” and contract law to establish there was no meeting of the minds. Relying on the doctrine of construction for insurance policies, the court held it was bound by the definition provided in the bond.\(^{100}\)

The court further noted that although the “plaintiff vehemently denies that any ‘loan’ was ever made, the record show[ed] that plaintiff has characterized itself as a ‘creditor’ in its filings in bankruptcy court, and referred to the funds as a loan in other documents.”\(^{101}\) The court found these statements to be an admission. But even beyond this, the court relied on the language of the bond and case law in reaching its conclusions, finding that the insured, through the computer error, “assumed” a creditor relationship with the borrower. In concluding the loss was not covered, the court focused on the purpose of the exclusion, which is to avoid the risk of writing credit insurance, and noted “common sense” dictates that it would be actuarially unsound for insurers to assume the risk of an “unknown, and perhaps infinite, number of bad debts.”\(^{102}\)

3. **Humboldt Bank v. Gulf Insurance Company**

*Humboldt Bank v. Gulf Ins. Co.*\(^{103}\) analyzed the applicability of a Financial Institution Bond to losses resulting from the theft of the insured’s cash that was loaned to the owner of automated teller machines pursuant to a contract with the insured bank. In doing so, the court focused on the bond definition of Loan.

In this case, the owner of several ATMs was permitted to use its own armored truck service to transport cash from the insured bank to the machines.\(^{104}\) After the bank experienced a change in ownership, it was determined, not surprisingly, that the current procedure and direct access to the cash by the owner was unacceptable. The owner of the ATMs was then given 120 days notice that the contract to supply the ATM cash was terminated unless he agreed to use a third-party armored truck service. After receiving the notice and before the expiration of the 120

---

\(^{98}\) Id.

\(^{99}\) Id. at *3.

\(^{100}\) Id.

\(^{101}\) Id.

\(^{102}\) Id.

\(^{103}\) 323 F. Supp. 2d 1027 (N.D. Cal. 2004).

\(^{104}\) Id.
days, the owner stole $5.25 million, disappeared, and was later found dead in Florida. An investigation by the FBI recovered approximately $3.7 million of the money, and the insured made a claim under its bond for the remaining $1.3 million. The claim was denied on the basis of the loan loss exclusion.

In subsequent suit on the matter, the Northern District of California court, looking at the loan loss exclusion “through the eyes of a reasonable lay person,” concluded that the money given to the owner which formed the basis for the action was “in the nature of a loan” or an “extension of credit.” The court dismissed the insured’s claim that a review of its internal accounting and financial reporting procedures demonstrated that it did not view or ever treat the transactions as loans. To circumvent the application of the loan loss exclusion, the insured also argued the transactions could not be considered loans because the insured always maintained, pursuant to the contract, exclusive ownership and control of the subject funds. The court stated, “[w]hile it is true that the [Cash Agreement] grants [the insured] title and control over the money, this element does not preclude the Court from finding that this transaction was ‘in the nature of a loan.’”

In dismissing the insured’s arguments, the court noted that under the contract to provide cash to the ATM owner, the insured received a fixed rate on the amount of money used in addition to other set fees and charges. The owner was also required to fill out an application requesting the same information and materials requested in traditional loan applications. Upon termination of the agreement, the insured would receive an immediate return on the full amount of advances outstanding or receive interest at a rate of 18% on such amounts. The court found it “commonsensical” to conclude that this money was “in the nature of a loan” or an “extension of credit.” The court’s decision is consistent with the intent of the loan loss exclusion:

As one commentator has stated, financial bonds in general allocate the risks of loss between an insurer and the financial institution: It is a compromise between insuring against certain risks and providing that coverage at a reasonable premium. To achieve this, credit risks (a natural result of lending money) stay with the financial institution. The loan exclusion accomplishes this goal by sweeping away all loan losses caused by fraud, no matter how pervasive the fraud, unless the loss falls within one of the narrow exceptions to the loan exclusion.

The court also recognized that the loan loss exclusion is written broadly to include much more than just a “loan” as defined by banking industry standards. Applying the economic substance of the transactions, the court declined to “rewrite the terms of the Bond” and enforced the loan loss exclusion, precluding coverage for Humboldt’s claim.

105 Id.
106 Id. at 1033.
107 Id.
108 Id.
109 Id.
110 Id.
D. CONCLUSION

The courts continue to express a willingness to look to the design of the Financial Institution Bond as a whole and recognize the intent of the loan loss exclusion—preclude coverage under the bond for unfortunate loan decisions. The underwriter has no ability to properly assess the likelihood of such decisions and base a premium thereon. Consequently, the business risk that arises in any credit transaction stays with the insured, and that allocation is made through the loan loss exclusion. The trade-off is simple: less interference by the insurer with respect to the insured’s daily activities in exchange for a lower premium.

III. Inventory Loss Exclusion

A common way insured entities will confirm or discover an employee dishonesty act or other fidelity loss is by conducting an inventory analysis or a profit and loss statement.111 These methods are often used to gauge the scope of an insured’s loss when it suspects an employee of theft or dishonesty. In other circumstances, the insured’s use of these procedures in its normal business practices can reveal a shortage in income that could be explained by intentional wrongful acts of the insured’s employees.112 When fidelity losses are revealed or confirmed by inventory count or the preparation of a profit and loss statement, the insured often will based the amount of its claim on these types of analyses.

An insured’s reliance on an inventory analysis or a profit and loss statement to support a fidelity claim is problematic to the insurer for several reasons. First, even if there is some other evidence of an otherwise covered claim, the use of these procedures to determine the scope of the loss often is not accurate. There can be several other factors reflecting the amount of “loss” shown in an inventory count or profit and loss statement that would not be covered by a commercial crime or similar fidelity policy, including but not limited to as non-intentional accounting mistakes, market factors, and losses covered under a first-party property or business income insurance policy. Accordingly, commercial crime policies have long excluded or limited coverage for fidelity or commercial crime claims that are based solely or substantially on inventory analysis or profit and loss statements.113 As one court noted, those provisions “reflected a belief that proof of an inventory shortage does not establish either that there has been actual loss of goods or, in case of an actual loss, that it is due to employee dishonesty. The [inventory exclusion] clause is designed to protect the insurer against claims based on erroneous or falsified computations.”114

A. THE LANGUAGE OF INVENTORY LOSS EXCLUSIONS

For over 50 years, commercial crime and other similar policies have included exclusions precluding coverage for losses that are substantiated solely by the use of inventory counts or

112 Id.
113 Id. at 268-69.
profit and loss statements. The most recent versions of these inventory exclusions include language identical or substantially similar to the following, which excludes coverage for:

b. Inventory Shortages: loss, or that part of any loss, the proof of which as to its existence or amount is dependent upon:

(1) An inventory computation; or
(2) A profit and loss computation.

However, some inventory exclusions, such as that contained in ISO’s Commercial Crime Policy (Loss Sustained Form), include a provision that permits an insured to utilize an inventory count only – and not a profit and loss computation – to establish the amount of a covered loss if that insured is able to prove that a covered loss occurred wholly independent of the inventory analysis. That exclusion precludes coverage for

b. Inventory Shortages
Loss, or that part of any loss, the proof of which as to its existence or amount is dependent upon:

(1) An inventory computation; or
(2) A profit and loss computation.

However, where you establish wholly apart from such computations that you have sustained a loss, then you may offer your inventory records and actual physical count of inventory in support of the amount of loss claimed.

Insurers utilizing this provision require insureds to compare their inventory records with an actual physical count of the inventory. Use of a loss of profit calculation will be unacceptable to establish loss under this provision.

B. Application of the Exclusion

Courts have generally enforced the intent of inventory exclusion in those policies, both for the policies that include a provision permitting the use of an inventory calculation to establishing the amount of loss and those that do not. In Sec. Ins. Co. of Hartford v.
Wilson, an insured restaurant owner submitted a claim under an employee dishonesty endorsement to its business liability policy based for a loss related to cash stolen by the insured’s business manager. The insured apparently was able to provide independent evidence of the business manager’s theft, but relied solely upon a profit and loss computation to establish the amount of its claimed loss. The insurer denied coverage based on an inventory exclusion that did not permit use of a physical inventory calculation to establish the amount of loss. The court upheld this denial:

The language of section 2(b) [the inventory exclusion] is clear and unambiguous: a claim footed on alleged employee dishonesty must be supported by more than profit and loss computations . . . . In opposing a motion for summary judgment, the [insured] had the burden to come forward with other evidence of the amount as well as the existence of the alleged loss to raise a genuine issue of material fact for trial on those essential elements of their claim. Their failure to do so – their admitted inability to do so – amply supports the district court’s summary judgment against them on that issue.

It is important to note that, while courts typically enforce the provisions as written, some are hesitant to apply the exclusion broadly with respect to what constitutes an “inventory computation” or a “profit and loss computation.” In Stings & Things in Memphis, Inc. v. State Auto Ins. Cos., an insured musical instrument seller submitted a claim under its employee dishonest coverage for approximately $30,000 in missing inventory. In support of its loss, the insured submitted invoices, packing lists, sales receipts and other documents showing that it had purchased and financed the missing instruments and equipment, but that they had not been sold in the ordinary course of business. It also testified that a visual inspection of its inventory indicated that certain items were missing. The insurer denied coverage relying on the inventory loss exclusion, asserting that the documentation submitted by the insured constituted an “inventory computation.” The Court disagreed with the insurer, finding that the evidence provided by the insured did not constitute an “inventory computation”:

The language in the policy in this case refers to an “inventory computation,” which denotes some type of mathematical calculation. Considering the language used, we feel that … the policy exclusion [does] not apply[] to a physical count of individually identifiable units of inventory. When dealing with individual identifiable units, there is no computation involved; the unit is simply present and accounted for, or it is missing. We think it is significant that the policy language

---

800 F. 2d 232 (10th Cir. 1986).
122

Id. at 233.
123

124

920 S.W.2d 652 (Tenn. Ct. App. 1995).
125

Id. at 654.
126

Id. at 656.
127
excludes loss based on an inventory computation rather than on an enumeration of missing items.\textsuperscript{128} Other courts have taken similar positions regarding what does or does not constitute an “inventory computation” or a “profit and loss computation.”\textsuperscript{129}

C. RECENT DECISIONS INVOLVING THE INVENTORY LOSS EXCLUSION

Although the inventory loss exclusion is an issue that insureds and insurers alike need to be aware, there are no notable recent decisions interpreting this provision in commercial crime or employee dishonesty claims. There are, however, recent cases involving a similar exclusion that can be found in first-party commercial property policies. That exclusion precludes coverage for tangible property that is missing, where the only evidence of the loss or damage is a shortage disclosed on taking inventory, or other instances where there is no physical evidence to show what happened to the property.\textsuperscript{130}

The application of an inventory exclusion was a major issue in \textit{HCA, Inc. v. Am. Protection Ins. Co.}\textsuperscript{131} There, an insured hospital system (HCA) sought coverage under a first-party property policy for the loss of several million dollars worth of linen stock that purportedly was caused by the negligence or intentional misconduct of the hospital’s linen management company (FDR).\textsuperscript{132} Approximately two and a half years after HCA first began using FDR, the hospital system conducted a physical inventory of linen stocks at each of its medical facilities. Based on this inventory, HCA determined that it had suffered a loss of linen stock valued at between $8 million and $12 million. After conducting this analysis, HCA submitted claims to different insurers under various “all-risk” property policies the carriers issued.\textsuperscript{133}

The carriers denied coverage for several reasons, including the application of an inventory exclusion, which in relevant part precluded coverage for “loss or shortage disclosed on taking inventory, except this exclusion does not prohibit proving the amount of any loss otherwise provable by inventory.”\textsuperscript{134} The trial court granted summary judgment to the carriers, finding that the inventory exclusion precluded coverage.\textsuperscript{135} On appeal, the Tennessee Court of Appeals reversed the summary judgment ruling. After an exhaustive discussion of case law relating to similar inventory exclusions, the court found that there was a factual dispute as to whether the inventory exclusion applied.\textsuperscript{136} The court determined that HCA had presented evidence that it was aware that it had suffered substantial losses of its linen stock under FDR’s

\textsuperscript{128} Id. at 657.
\textsuperscript{129} See, e.g., \textit{Fid. & Dep. Co. of Md. v. S. Util., Inc.}, 726 F.2d 692, 695 (11th Cir. 1984) (finding that purchase orders, invoices for good delivered incorrectly or not delivered, monthly statements, cancelled checks, building plans, job specifications, bid estimates, and expert and lay testimony supporting loss was evidence “independent of any inventory or profit and loss computation.”).
\textsuperscript{131} 174 S.W.3d 184.
\textsuperscript{132} Id. at 188.
\textsuperscript{133} Id.
\textsuperscript{134} Id. at 187.
\textsuperscript{135} Id. at 190.
\textsuperscript{136} Id. at 195-210, 215.
care and had reported these losses to FDR more than a year before it conducted the inventory that preceded its insurance claim. While the court acknowledged that the fact finder may not accept the hospital’s “evidence establishing a loss independent of the inventory, or indeed, whether or not the September 1998 inventory quantifies any such loss,” the evidence was sufficient to preclude summary judgment on the issue.

In *Westcom Corp. v. Greater N.Y. Mut. Ins. Co.*, an insured telecommunications company sought coverage under a first-party property policy for the loss of several digital line interface cards (“DLICs”) from an off-site storage facility.139 While visiting the off-site storage facility one day, an insured’s employee discovered that the padlock securing the unit had a key broken off in the keyhole. At the insured’s request, the owner of the storage facility cut off the padlock, and the insured placed a new padlock on the unit. However, the insured did not check the inside of the unit at this time. Two days later, another employee of the insured visited the storage unit and discovered that none of the DLICs were there. Moreover, no one had physically observed the inside of the storage unit form approximately two months before the discovery of the missing DLICs.141

The insured submitted a claim of loss with its insurer. The insurer denied coverage on the ground that the claimed loss fell within the policy’s exclusion for “[p]roperty that is missing, but there is no physical evidence to show what happened to it, such as shortage disclosed on taking inventory.”142 The court agreed with this denial, acknowledging that while the loss was not disclosed upon taking an inventory, there still was “no evidence at all, much less any ‘physical’ evidence, to show ‘what happened to’ the DLICs.”143 In so finding, the court disagreed with the insured’s claim that the broken off key in the padlock was physical evidence of what happened, because the unit remained secured and there was no evidence that any attempt to gain access to the unit had been successful.144

While these cases do not address inventory exclusions contained in commercial crime or employee dishonesty coverages, they do demonstrate both that courts continue to enforce the intent behind inventory exclusions, but generally will not take a broad view of what constitutes an inventory or profit and loss computation in determining whether there is evidence of a loss wholly independent of such calculations.

7138753.1

---

137 *Id.* at 210-213.
138 *Id.* at 214.
140 *Id.* at 21.
141 *Id.*
142 *Id.*
143 *Id.* at 22.
144 *Id.*