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Quicksand!:Ethical Pitfalls in Eroding Limits Professional Liability Policies

Defense Within Limits

Professional liability policies can be either defense within limits or defense outside limits. Defense within limits means the stated policy limit includes the amount available for defense costs. Such policies should encourage efficient defense handling and motivate the claimant to resolve the case sooner. But the insured could be left with little to no insurance available to actually settle the case. Defense expenses can accelerate as discovery multiplies with document review and multiple depositions, investigations and motions, especially as settlement dates approach. The insurer, insured and even the law firm may not know the cost of the next bill as they negotiate a settlement. Even the cost of the bill may have questionable charges (some in good faith, others unnecessary, some improper) that will need to be resolved. The effect is that the insured and the insurer are trying to negotiate a settlement with an available limit that has eroded more than they know.

Where the law firm is retained by the insured, either due to a conflict and the jurisdiction allows the insured to select the attorney, or because the insurer leaves the defense obligation to the insured, the burden of expense control is on the insured, with the insurer merely paying the bills up to the limit. Insurers and the law firms may then have cross-claims for unpaid bills and malpractice against the other. Where the defense expenses is not within the limit of liability (thus unlimited), then billing disputes arise about over-billing, fraudulent billing, etc.

Where the insurer retains the law firm because it has the duty to defend, conflicts can erupt, though presumably the long-standing working relationship and understanding of claims handling guidelines will make this infrequent. The insurer's limit is capped by the liability limit, therefore the insured will be liable for amounts beyond the policy limit both to the lawyer and the claimant. This means the lawyer's work and billings might be questioned for overzealousness. These cross-currents offer openings for the insured to criticize the insurer for mishandling or bad faith, and the insurer to criticize the firm for self-dealing or malpractice. The insurer might have claims for fraudulent billing and malpractice against the law firm. The law firm might have claims for misrepresentation as to defense commitments made but not paid, and the firm itself may be torn between zealous representation, and inoculation against malpractice because the case might actually go to trial. Who pays the indemnity or defense bills after the limits are exhausted is ripe for dispute, especially where the claimant finds its settlement unfunded.

Other situations where these conflicts can arise are where the insured has a high deductible or self-insured retention. Under the deductible, the insurer controls the defense and expenses and the insured must either pay the bills directly or reimburse the insurer. The insured might, where limits are in jeopardy, contend the insurer spent the insured's money loosely and then ran out of money when it came to the insurer's need to balance defense against indemnity choices. With an SIR, the insured is entirely in control of the defense until the SIR is exhausted, thus leaving the insurer clear of any handling until then.

A high deductible or high SIR policy with low limits (relative to the insured's potential exposure or this particular claim) is a brew of trouble. Alternative fee arrangements are one consideration to avoid such trouble.

Law firm expenses are further complicated, or enlarged, where two law firms are engaged, such as with national (coordinating) counsel and local counsel, or local counsel is retained to allow the national counsel to appear pro hac vice, or where claims are so diverse that expertise of two firms is appropriate, or where separate defenses are owed to several insureds under the severability clause, all further grinding down the available limits at double speed.

Attorney Ethics When Dealing With Defense Within Limits Policies

ABA Rules of Professional Conduct, which are adopted in whole or in part in many states, provide a little guidance for these circumstances with the following rules:

> PREAMBLE: A LAWYER'S RESPONSIBILITIES
> [1] A lawyer, as a member of the legal profession, is a representative of clients, an officer of the legal system and a public citizen having special responsibility for the quality of justice.
> [2] As a representative of clients, a lawyer performs various functions. As advisor, a lawyer provides a client with an informed understanding of the client's legal rights and obligations and explains their practical implications. As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system. As negotiator, a lawyer seeks a result advantageous to the client but consistent with requirements of honest dealings with others. As an evaluator, a lawyer acts by examining a client's legal affairs and reporting about them to the client or to others.
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> Rule 1.3 Diligence
> A lawyer shall act with reasonable diligence and promptness in representing a client.
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> Rule 3.1 Meritorious Claims And Contentions
> A lawyer shall not bring or defend a proceeding, or assert or controvert an issue therein, unless there is a basis in law and fact for doing so that is not frivolous, which includes a good faith argument for an extension, modification or reversal of existing

law. A lawyer for the defendant in a criminal proceeding, or the respondent in a proceeding that could result in incarceration, may nevertheless so defend the proceeding as to require that every element of the case be established.

Rule 3.2 Expediting Litigation
A lawyer shall make reasonable efforts to expedite litigation consistent with the interests of the client.

California has its own rules, relevant ones to this issue being:

Rule 3-300 Avoiding Interests Adverse to A Client
A member shall not enter into a business transaction with a client; or knowingly acquire an ownership, possessory, security, or other pecuniary interest adverse to a client, unless each of the following requirements has been satisfied:
(A) The transaction or acquisition and its terms are fair and reasonable to the client and are fully disclosed and transmitted in writing to the client in a manner which should reasonably have been understood by the client; and
(B) The client is advised in writing that the client may seek the advice of an independent lawyer of the client's choice and is given a reasonable opportunity to seek that advice; and
(C) The client thereafter consents in writing to the terms of the transaction or the terms of the acquisition.

Rule 3-310. Avoiding the Representation of Adverse Interests
Currentness
(A) For purposes of this rule:
(1) “Disclosure” means informing the client or former client of the relevant circumstances and of the actual and reasonably foreseeable adverse consequences to the client or former client;
(2) “Informed written consent” means the client's or former client's written agreement to the representation following written disclosure;
(3) “Written” means any writing as defined in Evidence Code section 250.
(B) A member shall not accept or continue representation of a client without providing written disclosure to the client where:
(1) The member has a legal, business, financial, professional, or personal relationship with a party or witness in the same matter; or
(2) The member knows or reasonably should know that:
(a) the member previously had a legal, business, financial, professional, or personal relationship with a party or witness in the same matter; and
(b) the previous relationship would substantially affect the member's representation; or
(3) The member has or had a legal, business, financial, professional, or personal relationship with another person or entity the member knows or reasonably should know would be affected substantially by resolution of the matter; or

(4) The member has or had a legal, business, financial, or professional interest in the subject matter of the representation.

(C) A member shall not, without the informed written consent of each client:

(1) Accept representation of more than one client in a matter in which the interests of the clients potentially conflict; or

(2) Accept or continue representation of more than one client in a matter in which the interests of the clients actually conflict; or

(3) Represent a client in a matter and at the same time in a separate matter accept as a client a person or entity whose interest in the first matter is adverse to the client in the first matter.

(D) A member who represents two or more clients shall not enter into an aggregate settlement of the claims of or against the clients without the informed written consent of each client.

(E) A member shall not, without the informed written consent of the client or former client, accept employment adverse to the client or former client where, by reason of the representation of the client or former client, the member has obtained confidential information material to the employment.

(F) A member shall not accept compensation for representing a client from one other than the client unless:

(1) There is no interference with the member's independence of professional judgment or with the client-lawyer relationship; and

(2) Information relating to representation of the client is protected as required by Business and Professions Code section 6068, subdivision (e); and

(3) The member obtains the client's informed written consent, provided that no disclosure or consent is required if:

(a) such nondisclosure is otherwise authorized by law; or

(b) the member is rendering legal services on behalf of any public agency which provides legal services to other public agencies or the public.

Settlement Offers and Trials Under Professional Liability Policies With Hammer Clauses

In contrast to insureds under typical CGL or other liability policies who demand the insurer settle a claim within policy limits, the professional may demand the insurer to settle or demand the insure not to settle. Most professional liability policies have a consent to settle clause that allows professionals to decide whether to permit the insurer to settle a claim or proceed to trial. Professionals have reputations at stake, and they or their insurers may have to report claims and verdicts against them to licensing authorities. (E.g., Ala. Code § 34-24-56,[1] Alaska St.§ 98.64.345,[2] Calif. Bus. & Prof. Code § 801,[3] Ky. Rev. Stat. Ann. § 304.40-310,[4] Mass. Gen. Laws Ann. ch. 112, § 5C.[5]) This makes professionals sensitive to whether a settlement is in their best interest to resolve a legitimate claim, or a settlement is against their interest because they believe the claim is meritless and a settlement would impair their reputation and license. Insureds should not, however, gamble with the insurer's money because of vanity or pride or denial (*Clauson*

v. New England Ins. Co., 83 F. Supp. 2d 278, 282 (D.R.I. 2000)), and doing so constitutes moral hazard where the insured is able to transfer the risk of its decision to another party (the insurer) who will bear the true loss. Thus where the insurer believes a settlement is appropriate, and available at an appropriate price, the insurer should prefer that if the insured wants the trial that the risk of a verdict higher than the settlement is borne by the insured. (See, for example, 4-46 *California Insurance Law & Practice* § 46.10 (2015).) This risk is addressed in insurance policies with a "hammer clause" that "hammers" the insured to bear the risk of a verdict higher than what the insurer was willing to pay. These come in two basic forms. One is a pure hammer clause, which means the insured is responsible for all expenses above the settlement the insurer was willing to take:

> We have the right to solicit and negotiate settlement of any claim, but will not enter into a settlement without your consent, which you agree not to withhold unreasonably. If you withhold consent to a settlement recommended by us and acceptable to the party who made the claim, the most we will pay is the amount of our recommended settlement, plus claim expenses incurred up to the date of our recommendation.

(From IRMI's *Professional Liability Insurance*)

A variation is the coinsured hammer clause, which split the risk between the insurer and the insured in some proportion, usually from 50% to 90% as will be stated on the declarations page (like a policy limit or sublimit). A typical coinsured hammer clause is:

> If the Insured shall refuse to consent to any settlement or compromise recommended by the Underwriters and acceptable to the claimant and elects to contest the Claim, the Underwriters' liability for any Damages, Penalties and Claims Expenses shall not exceed:
>
> 1. the amount for which the Claim could have been settled, less the remaining Retention, plus the Claims Expenses incurred up to the time of such refusal; plus
> 2. fifty percent (50%) of any Claims Expenses incurred after the date such settlement or compromise was recommended to the Insured plus fifty percent (50%) of any Damages above the amount for which the Claim could have been settled. The remaining fifty percent (50%) of such Claims Expenses and Damages must be borne by the Insured at their own risk and uninsured;
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> or the applicable Limit of Liability, whichever is less, and the Underwriters shall have the right to withdraw from the further defense thereof by tendering control of said defense to the Insured.

(From IRMI's *Professional Liability Insurance*)

The reasons for the qualification that the insured "not unreasonably withhold consent" clause is that insurers have a duty to settle cases. (4-25 *New Appleman on Insurance Law Library Edition* § 25.05.) An insurer faced with a duty to settle and insured who refuses to settle is frozen as to what it can do and faces either bad faith by the insured for putting its interest's foremost by settling, or an excess verdict and direct action by going forward with a trial it knows will end badly.

Related or Interrelated Acts

Professional liability policies are claims made and reported policies (with rare exceptions possible). The policy responds to claims (timely reported), whether as written demand or as lawsuit, or when the insured reports a potential claim. This is a simple matter where one claimant makes a claim for one wrongful act. This gets slightly complicated when the claimant makes distinct claims in one lawsuit, sometimes for the reason to increase insurance coverage if the per occurrence or per claims limit is low.

Complications develop where the claim arises from several related acts of the insured, which may or may not have contributed serially or separately to the loss. The problem is that the policy bears a per claim limit, and an aggregate limit, so that multiple claims could be combined to come within a single limit, or proliferate as multiple claims. A claimant might prefer to have multiple claims so as to increase the recovery. The insurer and insured probably prefer a single claim to cap the limit.

The problem worsens as the number of claimants increase or the number of insured-actors (physicians, attorneys, salespeople) employed by the firm who performed services to the claimant increases. To address some of the possibilities, policies contain an interrelated acts provision. Some versions are below:

- a **Claim** alleging, arising out of, based upon or attributable to any facts or **Wrongful Acts** that are the same as or related to those that were either: (i) alleged in another **Claim** made against an **Insured**; or (ii) the subject of a **Pre-Claim Inquiry** received by an **Insured Person**.
- All CLAIMS arising out of the same act, error or omission, or acts, errors or omissions which are logically or causally connected in any way shall be deemed as a single CLAIM. All such CLAIMS whenever made shall be considered first made on the date on which the earliest CLAIM arising out of such act, error or omission was first made and all such CLAIMS are subject to the same limits of liability and deductible.
- **Claims** based on or arising out of the **wrongful incident** and any **affiliated wrongful incident** shall be considered a single **claim** and shall be considered first made during the policy period or the extended reporting period (if applicable), of the policy in which the earliest claim arising out of such act(s) or circumstance(s) was first made and all damages shall be subject to the same per claim limit of insurance.
- "Interrelated Wrongful Acts" means all Wrongful Acts based on, arising out of, directly or indirectly resulting from, or in any way involving the same or related facts, circumstances, situations, transactions or events.
- “[W]here a series of and/or (sic) several claims are made which are attributable directly or indirectly to the same event, condition, cause, defect or hazard or alleged defect or hazard or failure or alleged failure to warn of such, each and

> every one of such claims shall be deemed to be separate and distinct from each and every other one of such claims and shall be treated as a separate and distinct claims occurrence from each and every other one of such claims irrespective of the period or area over which the claims occur or the number of such set forth under Item 4 of the Policy Declarations and shall apply to each claim." *Trahan v. Savage Indus., Inc*., 692 So. 2d 490, 497 (La. Ct. App. 1997).

How courts interpret these to specific facts has enormous implications for the applications of deductibles, coverage limits, and coverage. One treatise sums it this way:

> generally, in the search for either a causal or logical connection, courts will examine a number of factors to determine whether claims are related, including: (1) when the wrongful acts alleged in the claims took place; (2) where the wrongful acts took place; (3) whether the claims are asserted by or on behalf of the same parties; (4) whether the claims are brought against the same parties; (5) whether the claims or loss for which relief is sought involve breaches of independent duties; (6) whether the claims involve independent business decisions; and (7) whether the claims allege a common pattern, method or modus operandi.
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> (*Professional Liability Insurance* § 6.07 (2015).)

Thus in *Home Ins. Co. of Illinois (New Hampshire) v. Spectrum Information Technologies, Inc*., 930 F. Supp. 825 (E.D.N.Y. 1996), dealing with a D&O policy, the court found three separate claims in the lawsuit (SEC inquiry, earnings restatements, and insider trading claims), a claim is distinct from suit, and a claim under a professional liability is different than a claim under the F.R.C.P.) Some other examples:

- medical malpractice: In *Wilson v. Ramirez*, 2 P.3d 778 (Kan. 2000) , one physician's mistaken diagnosis that the physician continued with through multiple examinations and treatment constituted one act or occurrence, (The case cites many useful prior cases from around the country.) In *Columbia Cas Co. v. CP National, Inc.* 175 S.W.23d 339 (Tex Ct. App. 2004), only one claim against hospital and its two physicians for twice failing to diagnosis T-cell lymphoma on the same x-ray, In *St. Paul Fire and Marine Ins. Co. v. Hawaiian Ins. & Guaranty Co.*, 636 P.2d 1146 (Hawaii Ct. App. 1981), two physicians administered an anesthetic on three separate occasions to one patient leading to his death, this constituted three acts of negligence and thus three claims In *Arizona Prop. & Cas. Ins. Guar. Fund v. Helme*, 735 P.2d 451, 457 (Ariz. 1987), the first physician failed to examine x-rays to diagnose the condition, second physician performed surgery without examining x-rays and caused further damage, were two separate occurrences. "… the number of acts producing injury or damage, rather than the number of injuries caused, is the key on which the definition of "occurrence" turns. Multiple acts causing a single injury will constitute multiple occurrences, while a single act will constitute a single occurrence even though it causes multiple injuries or multiple episodes of injury. It follows that Imperial's use of the word "related" in the phrase "series of

related acts" was meant to exclude *causally related* acts from the rule that multiple causative acts constitute multiple occurrences." In *Doe v. Illinois State Med Inter-Insurance Exchange*, 599 N.E.2d 983 (Ill. App. 1991), multiple wrongful acts by physician, including improperly prescribing medication, improper monitoring of patient, and improper feeding of patient held to be separate occurrences). In *Insurance Corp. of America v. Rubin*, 818 P.2d 389 (Nev. 1991), physician who made five different diagnoses of the same patient for similar but different symptoms on each occasion, yet failed to diagnosis brain tumor, were five occurrences.

- legal malpractice: In *Continental Cas. Co. v. Brooks*, 698 So.2d 763 (Ala.1997), one attorney prepared four quitclaim deeds and power of attorney for one client pertaining to one property were related acts. In *Bay Cities Paving & Grading, Inc. v. Lawyers' Mut. Ins.* Co., 5 Cal.4th 854 (1993), attorney filed mechanic's lien then failed to file stop work notice on the lenders and failed to file a complaint to foreclose, held, one single related act,. But in *American Home Assurance Co. v. Evans*, 589 F.Supp. 1276 (E.D. Mich 1984), *decision vacated* 791 F.2d 61, the court determined that the attorney did three different unrelated acts in one year (set up trust, real estate transaction, and gravel deal), and withdrew money from the trust the second year – though it is unclear whether this was a claims-made or occurrence policy).

Complications ensue where there are multiple claimants, whether from one wrongful act or entirely different wrongful facts. Is a class action one claim or multiple claims brought as one suit? Many courts have concluded the class action constitutes a single claim: *CheckRite Ltd., Inc. v. Illinois National Insurance Co.*, 95 F.Supp.2d 180 (S.D.N.Y. 2000); *American Medical Security, Inc. v Executive Risk Specialty Ins. Co.*, 393 .Supp.2d 693 (E.D. Wis. 2005). In cases that have multiple plaintiffs but are not class actions, courts have reached different outcomes:

- *Gregory v. Home Ins. Co.*, 876 F.2d 602 (7th Cir. 1989) – lawyers advice about securities registration and tax opinion were one claim as defined by policy, "Two or more claims arising out of a single act, error, omission or personal injury or a series of related acts, errors, omissions or personal injuries shall be treated as a single claim." *Continental Cas. Co. v. Wendt*, 205 F.3d 1258 (11th Cir. (Fla.) 2000) Multiple claimants in one lawsuit can have a similar outcome where the claims (and losses) arose out of common act, such as an attorney selling his client's promissory notes. *Kilcher v. Continental Cas. Co.*, 747 F.2d 983 (8th Cir., D. Minn. 2014) – four claimants in one lawsuit can be considered to have one claim even though each alleged the insurance agent engaged in churning, separately against them, because these were interrelated under the policy definition because they arose form a common scheme to churn, (policy "defined "the term "Interrelated Wrongful Acts" to mean acts that are "logically ... connected by reason of any common fact [or] circumstance[.]"). *Continental Cas. Co. v. Howard Hoffman and Associates*, 95 N.E.2d 1151 (Ill.App. 2011) – multiple embezzlements but the law firm's staff as to various estates were one related act. *Brecek & Young Advisors, Inc. v. Lloyds of London Syndicate*, slip copy, 2011 WL 4688837 (D. Kan. 2011) – investment flipping and churning by multiple brokers were all one investment

practice subject to one deductible). *American Med. Sec. Inc. v. Executive Risk Specialty*, 393 F. Supp. 2d 693 (7th Cir. 2005) - marketing of group medical insurance policies were one occurrence.

- multiple claims: *Scott v. American National Fire Insurance Company, Inc.*, 216 F.Supp.2d 689 (N.D.Ohio 2002) – attorney's acts in preparing corporate charter and related documents were multiple claims by the two investors and the corporation itself because separate duties were owed to each. *St. Paul Fire & Marine Ins. Co. v. Chong*, 787 F.Supp. 183 (D.Kan.1992) – attorney's representation of three defendants at trial were separate claims. *Lexington Ins. Co. v. Lexington Healthcare Group, Inc.* 84 A.2d 1167 (Conn. 2014). – fire at nursing home that caused multiple deaths and injuries were all separate acts,

More cases are collected under Westlaw key number 217k2389 and 217k2275.

The Seventh Circuit stated in its typically straight-up way, in a multiple sexual molestation case occurring over several policy periods: "Winners and losers will change with the circumstances.…[I]f tomorrow the victim's loss exceeds the maximum coverage for a single occurrence, the roles will be reversed." (*Lee v. Interstate Fire & Cas. Co.*, 86 F.3d 101, 104 (7th Cir. 1996) (applying Rhode Island law).)

For further reading, a good article with collection of cases is John E. Zulkey, "Related And Interrelated Acts Provisions: Determining Whether Your Claims Are Apples And Oranges, Or Peas In A Pod," 50 *Tort Trial & Ins. Prac. L.J.* 83 (2014).

Application of Deductibles and Self-Insured Retentions

As to the application of deductibles, new problems arise. The insurer might prefer there are multiple claims because then the insured is responsible for multiple deductibles, which could reduce the claim value to something under the deductible limits. In contrast, the insured might prefer a single claim to exhaust one deductible and shed the loss to the insurer, unless the claim is far above the per claim limit and the aggregate will be useful. (An excess policy can solve this problem.) Some policies address this with an anti-stacking/batch clause that combines all claims arising from one occurrence into one deductible event. IRMI's *Professional Liability Insurance* offers this representative anti-stacking/batch clause:

> A single Retention shall apply to Loss arising from all Related Claims.
> Related Claim means a Claim alleging, arising out of, based upon or attributable to any facts or Wrongful Acts that are the same as or related to those that were alleged in another Claim made against an Insured.

Interrelated Acts, Retro-Dates and Allocation

Claims made and reported policies require that claims or losses be reported as soon as practicable or as soon as the insured becomes aware of facts that might give rise to a claim. Policies have a retroactive date, where the occurrence (wrongful act) must have occurred after the retro date stated in the policy. This means that wrongful acts that began before the retro date are not covered, but wrongful acts that occurred after the retro date are covered. (23-146 *Appleman on Insurance Law & Practice Archive* § 146.4 (2d 2011).) Depending on the facts underlying the occurrence, the number of actual occurrences, and possibly the claims, it is possible that some acts (claims) could be covered, and some could be excluded. Thus if the acts were serial and separable, those that are prior to the retro date would be excluded. This has multiple implications. One is it creates a potential conflict of interest and need for a disclaimer or reservation of rights. A second is it may bear on the deductibles unless the batch clause (discussed earlier) is used in the policy. A third is whether an allocation can be made between acts prior to the retro-date and those afterwards, and whether state law allows allocations between covered and uncovered claims. (See *State v. Zurich Specialties London Ltd.*, 116 Wash.App. 1033, not reported in P.3d, 2003 Wash. App. LEXIS 519 (Apr. 7, 2003), *review denied,* 150 Wash.2d 1022.) This is a common problem under occurrence-based policies where determination of the date of occurrence is crucial. It is an uncommon problem under claims-made policies where the claim is the principal factor, however the retro-date brings back the date of occurrence problem. The interrelated acts clause tends to cement all acts together to make the issue rare, (J. Stephen Berry, Jerry B. McNally, "Allocation of Insurance Coverage: Prevailing Theories and Practical Applications," 42 *Tort Trial & Ins. Prac. L.J.* 999, 1022 (2007), but then the prior acts exclusion can erupt to knock out coverage altogether.

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[1] (a) Every physician or surgeon who holds a license, certificate, or other similar authority issued under the provisions of this article and every professional corporation or professional association of a physician or surgeon shall, during the first 30 days of each calendar year, report to the State Board of Medical Examiners any final judgment rendered against such physician, surgeon, or the professional corporation or professional association of any such physician or surgeon during the preceding year, or any settlement in or out of court during the preceding year, resulting from a claim or action for damages for personal injuries caused by an error, omission, or negligence in the performance of medical professional services, or in the performance of medical professional services without consent.

[2] A person licensed under this chapter shall report in writing to the board concerning the outcome of each medical malpractice claim or civil action in which damages have been or are to be paid by or on behalf of the licensee to the claimant or plaintiff, whether by judgment or under a settlement. This report shall be made within 30 days after resolution of the claim or termination of the civil action.

[3] (a) Except as provided in Section 801.01 and subdivisions (b), (c), and (d) of this section, every insurer providing professional liability insurance to a person who holds a license, certificate, or similar authority from or under any agency specified in subdivision (a) of Section 800 shall send a complete report to that agency as to any settlement or arbitration award over three thousand dollars ($3,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(b) Every insurer providing professional liability insurance to a person licensed pursuant to Chapter 13 (commencing with Section 4980), Chapter 14 (commencing with Section 4990), or Chapter 16

(commencing with Section 4999.10) shall send a complete report to the Board of Behavioral Sciences as to any settlement or arbitration award over ten thousand dollars ($10,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(c) Every insurer providing professional liability insurance to a dentist licensed pursuant to Chapter 4 (commencing with Section 1600) shall send a complete report to the Dental Board of California as to any settlement or arbitration award over ten thousand dollars ($10,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(d) Every insurer providing liability insurance to a veterinarian licensed pursuant to Chapter 11 (commencing with Section 4800) shall send a complete report to the Veterinary Medical Board of any settlement or arbitration award over ten thousand dollars ($10,000) of a claim or action for damages for death or injury caused by that person's negligence, error, or omission in practice, or rendering of unauthorized professional service. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(e) The insurer shall notify the claimant, or if the claimant is represented by counsel, the insurer shall notify the claimant's attorney, that the report required by subdivision (a), (b), or (c) has been sent to the agency. If the attorney has not received this notice within 45 days after the settlement was reduced to writing and signed by all of the parties, the arbitration award was served on the parties, or the date of entry of the civil judgment, the attorney shall make the report to the agency.

(f) Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without that written consent. The requirement of written consent shall only be waived by both the insured and the insurer. This section shall only apply to a settlement on a policy of insurance executed or renewed on or after January 1, 1971.

[4] (1) All malpractice claims settled or adjudicated to final judgment against a health care provider shall be reported to the commissioner of insurance by the malpractice insurer of the health care provider or the health care provider if self-insured, within sixty (60) days following final settlement or disposition of the claim. The report to the commissioner shall recite the following:

(a) Name and address of health care provider involved;

(b) Name and address of claimant;

(c) Nature of the claim;

(d) Damages asserted and alleged injury; and

(e) The amount of any settlement or judgment.

[5] Every insurer or risk management organization which provides professional liability insurance to a registered physician shall report to the board any claim or action for damages for personal injuries alleged to have been caused by error, omission, or negligence in the performance of such physician's professional services where such claim resulted in:

(a) A final judgment in any amount,

(b) A settlement in any amount, or

(c) A final disposition not resulting in payment on behalf of the insured.

Reports shall be filed with the board no later than thirty days following the occurrence of any event listed in paragraph (a), (b), or (c).

Such reports shall be in writing on a form prescribed by the board and shall contain the following information:

(a) the name, address, specialty coverage, and policy number of the physician against whom the claim is made; and

(b) name, address and age of the claimant or plaintiff; and

(c) nature and substance of the claim; and

(d) date when and place at which the claim arose; and

(e) the amounts paid, if any, and the date and manner of disposition, judgment, settlement, or otherwise; and

(f) the date and reason for final disposition, if no judgment or settlement; and

(g) such additional information as the board shall require. No insurer or its agents or employees shall be liable in any cause of action arising from reporting to the board as required in this section.