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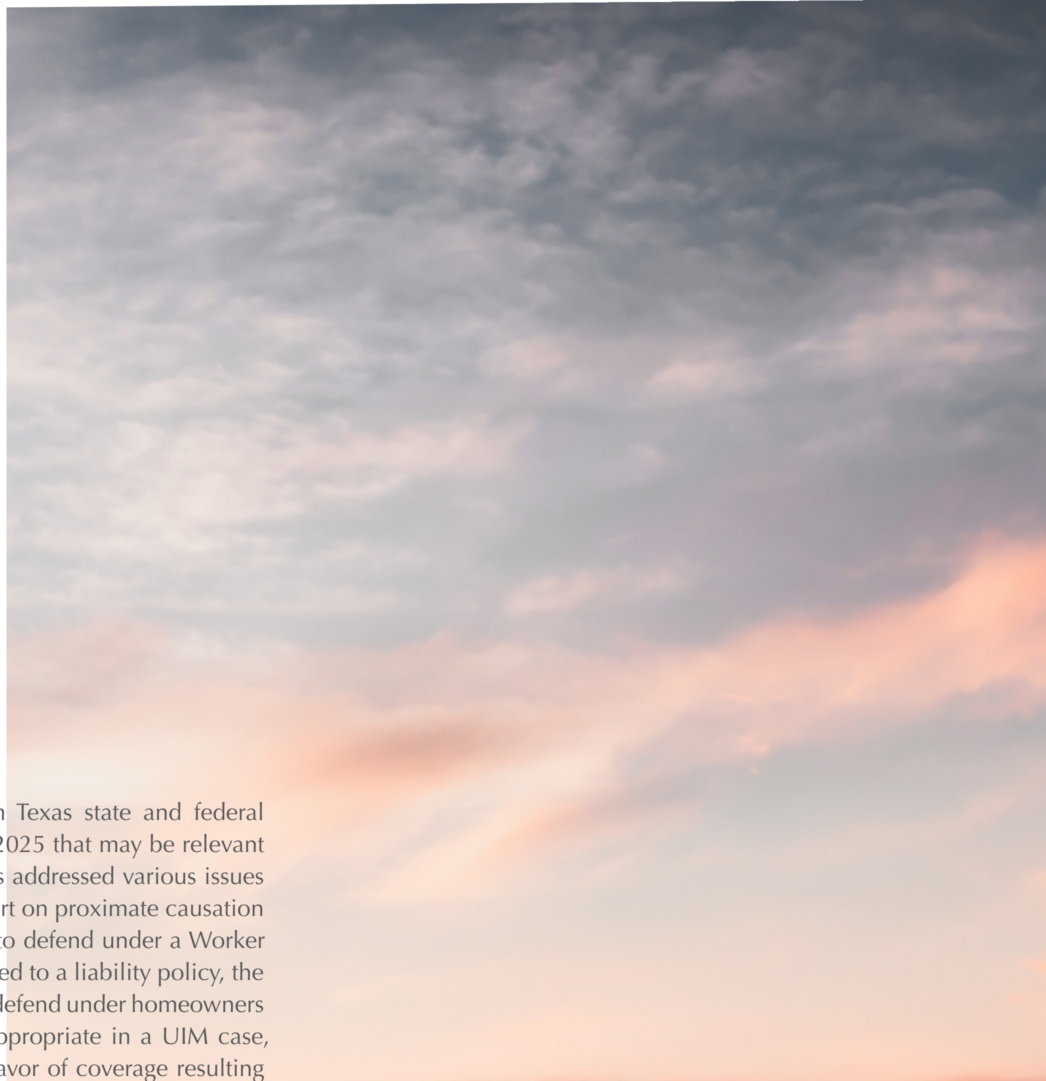
NEWS

OUR INSURANCE COVERAGE TEAM UPDATES OUR CLIENTS ABOUT TEXAS INSURANCE LAWS AND NOTEWORTHY DECISIONS FROM TEXAS STATE AND FEDERAL COURTS.



TEXAS INSURANCE LAW UPDATE

SECOND QUARTER 2025

There were several noteworthy decisions from Texas state and federal courts handed down in the Second Quarter of 2025 that may be relevant to your claims handling. This quarter, the courts addressed various issues including: a decision by the Texas Supreme Court on proximate causation in the negligence context, analysis of the duty to defend under a Worker Injury exclusion, choice of law analysis as applied to a liability policy, the use of extrinsic evidence in determining duty to defend under homeowners policies, when discovery against a carrier is appropriate in a UIM case, ambiguous language in a policy construed in favor of coverage resulting in Stowers exposure, fact issues in interpreting the Expected or Intended Injury exclusion, showing of prejudice when a commercial property policy contains a Prompt Notice Provision, whether renewal letter satisfied the "notice requirements" in Texas Insurance Code § 551.056, and a case involving the interpretation of pollution liability coverage. We also note two noteworthy legislative changes recently enacted

If you would like to discuss any of the cases in this report in more detail, please reach out to one of our team members at Cox PLLC

CGL, UMBRELLA, AND EXCESS COVERAGE

NORTHERN DISTRICT COURT HOLDS NO LIABILITY COVERAGE IN UNDERLYING WRONGFUL DEATH ACTION FOR ADDITIONAL INSURED UNDER WORKER INJURY EXCLUSION

In *Crum & Forster Specialty Insurance Co. v. Smallwood*, the district court of the Northern District of Texas granted an insurer's motion for summary judgment in a liability dispute following an underlying wrongful death action, holding that under the eight-corners rule, the unambiguous language of the policy's worker injury exclusion precluded any duty to defend or indemnify.[1]

This case involves the interpretation of an insurance policy related to a wrongful death lawsuit filed in state court. On January 26, 2022, Octavio Peguero was working at a construction site in Weatherford, Texas. The general contractor for the project, I&A Development and Construction LLC (I&A), provided a forklift for use on the property and constructed a wooden box on the forklift to deliver supplies to various levels of the four-story building. While working as an electrician on the fourth floor that day, Mr. Peguero attempted to retrieve materials from the forklift when the box tipped over, causing him to fall to the ground. Tragically, Mr. Peguero sustained fatal injuries from the fall. Mr. Peguero's family brought suit in the 342nd Judicial District Court of Tarrant County, Texas (the Underlying Lawsuit).[2] The Petition alleged that Mr. Peguero was working in the course and scope of his employment as an electrician, and that I&A, as the general contractor, contracted for the electrical work to be completed by Defendant Larry Smallwood d/b/a Electrical Solutions (Smallwood) or Quality and Prestige Remodeling (Quality).

The Pegueros reached a settlement with Smallwood in the Underlying Lawsuit. However, Crum & Forster pursued a declaratory judgment, arguing that I&A, as an "additional insured," was not entitled to any defense or indemnification from Crum & Forster in the Underlying Lawsuit. To support its position, Crum & Forster filed a motion, contending that the Policy's "Worker Injury" exclusion prevented any duty to defend or indemnify I&A or Smallwood in the Underlying Lawsuit. In light of Smallwood's settlement, the Court only addressed the arguments presented in the motion concerning I&A.

The Worker Injury exclusion precluded coverage for "bodily injury" to any "employee" or "temporary worker" of any insured arising out of or in the course of: 1. Employment by any insured; or 2. Performing duties related to the conduct of any insured's business; or … c. "bodily injury" to: 1. Any contractor, subcontractor, independent contractor, or any other person; or 2. Any "employee," "temporary worker," or "volunteer worker," or any day laborer or other person hired, engaged or retained in return for compensation or remuneration of any kind, working for, such contractor, subcontractor, independent contractor or any other person, arising out of or in the course of performing work or rendering services of any [*9] kind or nature whatsoever: a) for or on behalf of any insured; or b) for which the insured may become liable in any capacity; or d. any obligation to contribute to, share damages with, repay or indemnify someone else who must pay damages because of such "bodily injury."

Applying the "eight-corners" rule, the court held that Crum & Forster had no duty to defend or indemnify I&A in the underlying lawsuit due to the unambiguous language of the policy. Specifically, the court relied on a Cincinnati Specialty Underwriters Insurance case with a "strikingly similar" policy exclusion to conclude that the policy's Worker Injury exclusion precluded a defense. Based on the pleadings, the court found there were three possibilities as to Mr. Peguero's status: (1) Mr. Peguero was employed by Smallwood to complete the electrical work; (2) Mr. Peguero was employed by Quality to complete the electrical work; or (3) Mr. Peguero was hired by Smallwood or Quality to complete the electrical work as an independent contractor. The court found that under any of the three possibilities presented by the pleadings, Mr. Peguero's accident would be excluded due to the exclusion. First, if Mr. Peguero was employed by Smallwood, Section A(2)(a) of the exclusion would apply because Mr. Peguero was an employee of an insured (Smallwood). Second, if Mr. Peguero was employed by Quality, Section A(2)(c)(2) would apply because Mr. Peguero was an "employee" of a "subcontractor" (Quality) "performing work . . . on behalf of an[] insured" (I&A or Smallwood). And third, if Mr. Peguero was not "employed" by either Smallwood or Quality, and was instead hired as a contractor himself, Section A(2)(c)(1) would apply because Mr. Peguero was still hired as an "independent contractor" to "perform[] work . . . on behalf of any insured" (I&A as the general contractor over Smallwood and Quality, or Smallwood itself).

Since the Worker Injury exclusion applied to negate a defense owed to Mr. Peguero, the court also concluded that Crum & Forster was not obligated to indemnify I&A.

The court also held that the policy was not so broad as to render the coverage illusory because circumstances other than those at play in the case would trigger coverage. That is, the policy provided coverage for liability for injuries to non-workers but excluded coverage for liability for injuries to those performing work or rendering services on behalf of the insured.

PERSONAL AND COMMERCIAL AUTO

THE TEXAS SUPREME COURT DEFERS DISCOVERY FROM INSURER'S CORPORATE REPRESENTATIVE UNTIL AFTER A JUDGMENT DETERMINING LIABILITY IN THE CONTEXT OF UNINSURED MOTORIST COVERAGE

The Texas Supreme Court recently held that an insurer has the right to defer discovery and litigation costs in instances involving their UIM coverage until after the underlying trial determines liability.

In *In re State Farm Mut. Auto. Ins. Co.*, Mara Lindsey's car was rear-ended by Carlos Pantoja and she suffered personal injuries.[3] Lindsey settled with Pantoja's insurer for the $50,000 policy limit, after obtaining consent from her insurer, State Farm, as required by her underinsured motorist ("UIM") policy. Dissatisfied with State Farm's settlement offer of $689.58 on her UIM claim, Lindsey sued State Farm under the Uniform Declaratory Judgments Act for declarations regarding Pantoja's liability, her covered damages, and her entitlement to UIM benefits. Lindsey also sued State Farm and its claims adjuster for statutory violations related to failing to attempt a good-faith settlement of her UIM claim. State Farm moved to segregate the extracontractual claims and abate them until the declaratory judgment claims were resolved. Lindsey served notice to depose State Farm's corporate representative, which State Farm moved to quash based on proportionality concerns.

On writ of mandamus, the Court determined that the trial court abused its discretion by denying the insurer's motions to abate the extracontractual claims and to quash the deposition. "In the distinctive UIM context, a party to the suit may invoke the sever- or bifurcate-and-abate rule described above and is entitled to its application when the insurer has offered to settle the insured's claim for UIM benefits, the insured has not yet obtained a judgment establishing UIM coverage, and the insured's extracontractual claims seek damages that are dependent on the right to receive UIM benefits."

The court held that after applying the sever- or bifurcate-and-abate rule, a trial court should grant an insurer's motion to quash the deposition notice of its corporate representative during the UIM-coverage portion of the action if the insurer has stipulated to the matters within its personal knowledge, produced the nonprivileged documents in its possession that relate to the insured's car crash and damages, and submitted evidence supporting its proportionality complaints and lack of personal knowledge regarding the disputed issues for the initial car-crash trial.

For the holding on the sever- or bifurcate-and-abate rule, the Court reasoned that the logic of prior cases requiring severance or bifurcation of extracontractual claims from UIM coverage claims applies even when the insured brings only extracontractual claims. Allowing the extracontractual claims to proceed before establishing the insured's entitlement to UIM benefits would undermine the insurer's substantial right to avoid unnecessary litigation costs. For the holding on quashing the corporate representative deposition, the Court concluded that State Farm met the standard set forth in a prior case by stipulating to matters within its knowledge, producing its non-privileged claim file, and submitting evidence that the proposed deposition would be unreasonably cumulative and its burden would outweigh any likely benefit at this stage.

> The Court conditionally granted the insurer's petition for writ of mandamus and ordered the trial court to vacate its orders denying the insurer's motions to abate and quash and to grant the motions.

HOMEOWNERS AND COMMERCIAL POLICY

SOUTHERN DISTRICT COURT RULES THAT EVIDENCE THAT THE HOMEOWNER DID NOT RESIDE AT THE PROPERTY SATISFIED THE MONROE EXTRINSIC EVIDENCE EXCEPTION.

In *Benchmark Insurance Co. v. Linan*, the federal district court for the Southern District of Texas granted an insurer's uncontested motion for summary judgment, holding that evidence that the homeowner did not reside at the property at policy inception satisfied the Monroe Exception to the eight-corners rule and established there was no duty to defend or indemnify the homeowner in the underlying personal injury lawsuit.[4]

Benchmark Insurance Company issued a homeowners insurance policy to Defendant Yazmin Linan, insuring a property located in Katy, Texas. Though the Policy provides that coverage extends only to "[t]he one-family dwelling where [Yazmin Linan] reside[s] ... on the inception date of the policy period," Yazmin Linan testified in a deposition that she did not reside at the Property on the inception date of the Policy's policy period.

The Linan's were sued in state court under theories of premises liability and gross negligence for an alleged incident that occurred on the property and resulted in bodily injury of a third party ("the Underlying Lawsuit"). Benchmark brought a coverage action seeking a declaration that it was not liable for defense or indemnity benefits under the policy. Benchmark argued it was entitled to such declaration both because the policy barred coverage of the property and because the Linans failed to cooperate in the investigation, settlement, or defense of the Underlying Lawsuit.[5]

Benchmark presented extrinsic evidence supporting its argument that it did not have a duty to defend the Linans in the Underlying Lawsuit. Specifically, it submitted deposition testimony from Yazmin Linan to show that she did not live at the property on the inception date of the policy. The court held that it may consider the testimony under the Monroe exception to the eight-corners rule. The court reasoned that (1) the testimony at issue went solely to the issue of coverage and did not overlap with the merits of the Underlying Lawsuit, (2) the testimony did not contradict facts alleged in the pleadings of the Underlying Lawsuit, and (3) the testimony established that Yazmin Linan did not live at the property on the inception date. Additionally, the court held that because Benchmark did not owe a defense to the Linans, it did not owe indemnity under the policy.

TEXAS APPELLATE COURT AFFIRMS NO DUTY TO DEFEND OR INDEMNIFY WHERE EXTRINSIC EVIDENCE SHOWED STUDENT STEPDAUGHTER DID NOT MEET HOMEOWNERS POLICY'S "INSURED" DEFINITION

In Beasley v. Allied Trust Insurance Co.[6], the Twelfth Court of Appeals affirmed summary judgment in favor of Allied Trust Insurance Company, holding that the insurer had no duty to defend or indemnify a homeowner's stepdaughter in a wrongful death lawsuit arising out of a fatal shooting. The Court found that the stepdaughter did not qualify as an "insured" under the policy and that extrinsic evidence could be considered to resolve that threshold coverage question.

The underlying suit involved the death of Davontrius Henderson, a 17-year-old who was fatally shot while socializing at the apartment of Uriyah Smith, then 19 years old. The plaintiffs alleged that Smith was negligent in allowing a dangerous condition and activity on her premises, where co-defendant Christopher Wansley discharged a handgun, mistakenly believing it was unloaded. Smith, a student at Tyler Junior College ("TJC"), was living independently in an apartment at the time.

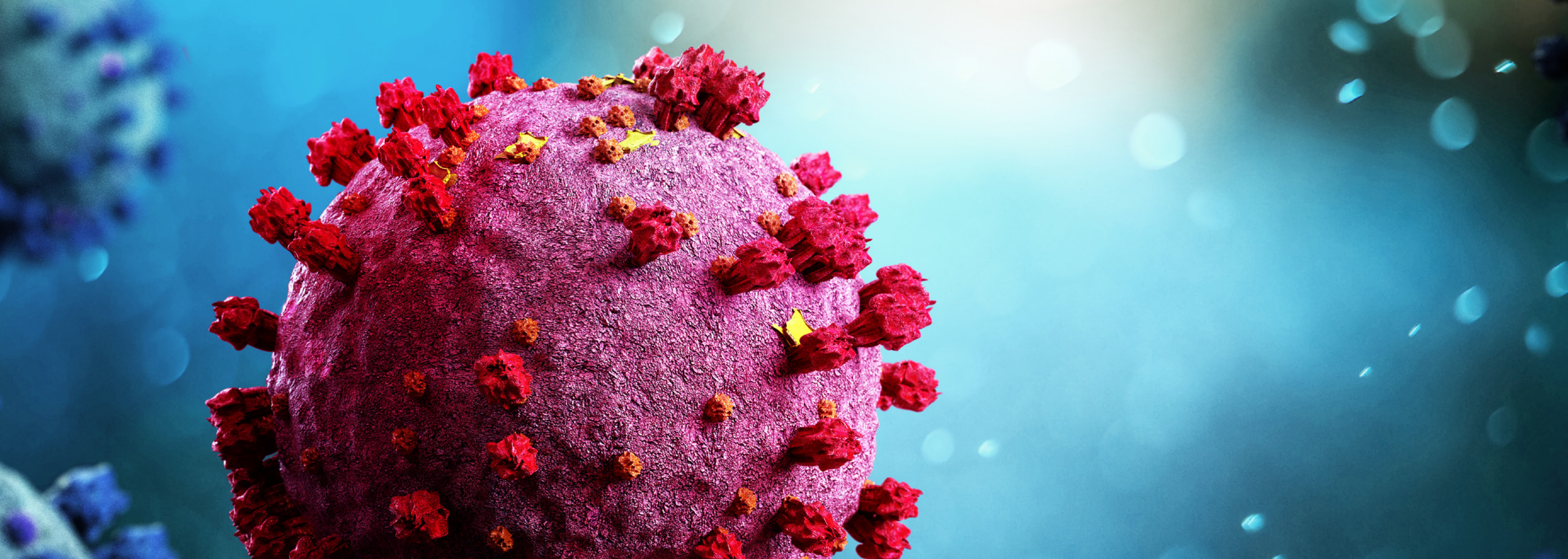
Smith's mother and stepfather were insureds under a homeowners policy issued by Allied. The plaintiffs sought coverage for Smith's alleged negligence under the theory that she was an "insured" under the policy. Allied filed a declaratory judgment action seeking a ruling that Smith was not covered.

The policy defined an "insured" to include a relative under the age of 24 who was a full-time student, and who "resided in the insured's household before moving out to attend school." Although Smith was a full-time student by TJC's standards, Allied presented evidence showing that Smith had moved out of the family home during high school due to personal conflicts—not for the purpose of attending college. Allied also submitted evidence that Smith financially supported herself, was not listed as a dependent on the Locketts' tax returns, and had not lived in their household since 2019.

The trial court granted summary judgment for Allied, and the appellate court affirmed. Importantly, the Court acknowledged that while Texas follows the "eight-corners rule" in determining the duty to defend, that rule does not apply where the petition does not contain facts necessary to resolve the coverage question and the extrinsic evidence goes only to a discrete, coverage-only issue that does not overlap with the merits. Because the question of whether Smith qualified as an "insured" turned on facts not alleged in the underlying petition—such as the nature of her move from the family household—extrinsic evidence was admissible and properly considered by the trial court.

The Court also confirmed that because there was no duty to defend, there could be no duty to indemnify. While the duty to indemnify typically requires a determination of facts in the underlying suit, it may be resolved at the summary judgment stage when there is no possibility of coverage as a matter of law.

This decision provides useful guidance for insurers evaluating coverage under homeowners policies with student resident-relative provisions. Insurers should carefully examine the factual basis for the claimed status as an "insured," including the student's living arrangements, financial independence, and the purpose of leaving the insured household. Where those facts are not alleged in the pleadings, insurers may be able to introduce extrinsic evidence to establish a lack of coverage without conflicting with the underlying liability claims. The Beasley opinion underscores that the duty to defend is broad, but not limitless, and that Texas law allows courts to resolve coverage-only disputes where liability and coverage do not intertwine.



THE NORTHERN DISTRICT OF TEXAS HELD THAT COVID-19 LOSSES DID NOT TRIGGER CIVIL AUTHORITY OR INFECTIOUS DISEASE COVERAGE UNDER COMMERCIAL PROPERTY POLICIES AND DISMISSED THE SUIT WITH PREJUDICE

In *Crow Family, Inc. v. Continental Casualty Co.*[7], the U.S. District Court for the Northern District of Texas affirmed that coverage under civil authority and business interruption provisions requires allegations of direct or imminent physical loss. The Court granted motions to dismiss by Continental Casualty Company, Illinois Union Insurance Company ("IUIC"), and Lloyd's Underwriters – Brit (collectively, "the Insurers") and dismissed the complaint with prejudice.

Crow Family, Inc. and its affiliated entities ("Crow") sought coverage under commercial property insurance policies for business interruption losses caused by COVID-19-related government shutdown orders. Crow owns three hotels whose operations were interrupted by civil authority orders during the pandemic. Crow's business suffered financial losses because of state and local stay-at-home orders issued during the Covid-19 pandemic. Crow asserted that the loss of use and access due to governmental shutdowns triggered coverage under (1) Civil or Military Authority provisions, and (2) IUIC's Special Time Element provision covering infectious disease-related income loss. Crow also alleged violations of Chapters 541 and 542 of the Texas Insurance Code.

The policies' Civil Authority Provision provided Time Element coverage for losses caused by "direct physical loss, damage or destruction, or imminent loss by a peril insured by this Policy" within ten miles of an insured location, where civil authority orders prevented access. IUIC's policy included a similar provision, modified by endorsement to apply within five miles. Crow argued that the language covered both physical and non-physical imminent loss and that the COVID-19 restrictions fell within this coverage. However, the Court rejected this interpretation, concluding that "imminent loss" must be construed in context with surrounding terms—namely, "direct physical loss, damage or destruction"—and therefore must also refer to physical loss. Relying on *Golden Corral Corp. v. Illinois Union Ins. Co.*[8], the Court held that civil authority coverage requires allegations of actual or imminent physical loss, not merely operational disruption due to health measures. The Court emphasized that the provision could apply where, for example, a property was evacuated due to an impending hurricane, but not where shutdowns occurred to curb disease spread without evidence of property damage or imminent destruction.

Crow further argued that IUIC's Special Time Element provision, which provided limited coverage for business interruption caused by infectious disease, constituted a "peril insured" sufficient to trigger the Civil Authority Provision. The Court disagreed. First, the Special Time Element was subject to a separate sublimit and distinct terms and therefore could not be grafted onto the broader Civil Authority coverage. Second, IUIC's General Amendatory Endorsement deleted the Special Time Element provision entirely, and endorsements prevail over conflicting declarations. Thus, Crow could not state a claim against IUIC for breach of the Special Time Element provision. Crow also brought statutory bad faith claims under Texas Insurance Code Chapters 541 and 542, asserting the Insurers wrongfully denied coverage. The Court dismissed these claims as derivative, reiterating the rule that an insured cannot recover for bad faith where the underlying claim for policy benefits fails. Because the Court found Crow was not entitled to benefits under any theory, it dismissed the statutory claims as well.

Importantly, the Court denied Crow's Motion for Leave to Amend its pleadings, concluding that the defects in Crow's pleadings were incurable given the unambiguous policy terms and the nature of Crow's allegations. The Court noted that the policies did not insure for COVID-19-related shutdowns in the absence of tangible or imminent physical damage, and that no amendment could remedy the legal insufficiency of the claims. Accordingly, the Court granted the Insurers' Rule 12(b)(6) motions and dismissed Crow's complaint in its entirety, with prejudice. The court opinion reaffirms that coverage under civil authority and business interruption provisions requires allegations of direct or imminent physical loss or damage, and that COVID-19-related shutdowns, absent such physical loss, do not trigger coverage under standard property insurance policies.

THE EASTERN DISTRICT OF TEXAS ENFORCED A CONTRACTUAL APPRAISAL CLAUSE AND ABATED LITIGATION PENDING COMPLETION OF THE APPRAISAL PROCESS

In *Blackwood v. American Economy Insurance Co.*[9], the United States District Court for the Eastern District of Texas granted the insurer's motion to compel appraisal and abate litigation, holding that the policy's appraisal clause was valid, enforceable, and had not been waived despite the pending lawsuit.

The plaintiffs, Donald and Delois Blackwood, filed suit against their homeowner's insurer, American Economy Insurance Company ("American Economy"), alleging that the insurer failed to pay for property damage from a winter storm in February 2021. The lawsuit, originally filed in state court in March 2023 and removed to federal court in August 2023, proceeded through mediation in September 2024. Shortly after mediation failed, American Economy invoked the policy's appraisal clause and moved to compel appraisal and stay the litigation.

The Plaintiffs opposed the motion, arguing that the insurer had waived its right to appraisal by unreasonably delaying its invocation of the appraisal process. They pointed to the ongoing litigation activities, including removal to federal court, participation in mediation, and hiring experts to opine on the amount of the damages. The Plaintiffs argued these actions were inconsistent with the insurer's right to demand appraisal. The Court rejected this waiver argument, relying on the Texas Supreme Court's holding in *In re Universal Underwriters of Texas Insurance Co.*[10], which provides that waiver by delay is measured from the point of impasse—when both parties recognize further negotiations would be futile. The Court found that American Economy invoked appraisal just eight days after mediation, which marked the point of impasse. Therefore, the timing of the insurer's demand was reasonable under Texas law.

Moreover, the Court emphasized that little discovery, including no depositions, had occurred prior to the Motion to Compel. As such, the Court concluded that any alleged prejudice was either unsupported or not attributable to the insurer. More importantly, the policy's appraisal clause explicitly permitted either party to invoke appraisal "during the pendency of a timely filed lawsuit" and required abatement of any related litigation upon request. Because the clause was unambiguous, had not been waived, and was invoked pursuant to its terms, the Court found it enforceable. Accordingly, the magistrate judge recommended that the Motion to Compel appraisal and abate the litigation be granted. The Court ordered the parties to submit a joint status report within ten days of the appraisal's completion and to file updates every sixty days during the process. All pending deadlines in the litigation were abated pending the outcome of the appraisal.

The court opinion reaffirms that under Texas law, an insurer does not waive its right to invoke appraisal by participating in litigation, so long as the demand is made within a reasonable time after an impasse is reached.

WESTERN DISTRICT OF TEXAS HOLDS THAT PREJUDICE TO INSURER NOT REQUIRED FOR DISCLAIMER WHERE THE INSURED VIOLATED A SPECIFIC DEADLINE TO PROVIDE NOTICE

In *RC Mgmt*[11], RC Management, Inc. ("RC Mgmt") was insured under a commercial property surplus lines policy issued to it by Third Coast Insurance Company ("Third Coast") that it purchased through Acrisure that was in effect from April 1, 2020 to April 1, 2021 (the "Policy"). The Policy included a "Windstorm (including Hail) Notice of Loss Amendment Endorsement" that provided that "In addition to your obligation to provide us with prompt written notice of loss or damage, with respect to any claim wherein written notice of the claim is reported to us more than one year after the reported date of loss or damage, this Policy shall not provide coverage for such claim." (the "Prompt Notice Provision").

RC Mgmt alleged that on May 27, 2020, a property referred to as Park South Village (the "Property") was damaged during a hail and windstorm. RC Mgmt notified Third Coast of the loss on April 14, 2022. Third Coast issued a reservation of rights letter that broadly reserved its rights under the policy while disavowing any waiver. Thereafter, Third Coast had the Property inspected. Third Coast's inspector found that there was no hail damage caused by the storm on the date of loss and sent correspondence to RC Mgmt citing the Prompt Notice Provision and denied the claim. RC Mgmt requested that the property be reinspected a year later, and Third Coast continued to deny the claim following the supplemental inspection. RC Mgmt then hired a roof consultant who determined that the damage to the Property was caused by the storm and was more significant than the damage found by Third Coast's inspector, and contended that it notified Third Coast of the claim on July 21, 2023.

Thereafter, RC Mgmt filed suit against Third Coast alleging breach of contract and violations of the Texas Deceptive Trade Practices Act. Third Coast moved for summary judgment arguing, in pertinent part, that RC Mgmt's claims failed as a matter of law because it failed to report its loss within one year of the date of loss. Specifically, RC Mgmt argued that the late notice provision is a condition precedent for coverage under the Policy. The Court agreed, noting that the Policy expressly labels the Prompt Notice Provision as a "condition precedent," and then moved on to consider whether Third Coast was required to show that it had been prejudiced by the late notice. The Court held that it did not. Looking at the plain language, and summarizing federal and state law on the issue, the Court reasoned that the parties expressly agreed to a specific deadline for notice—one year—as opposed to a more generalized required—such as "as soon as reasonably practicable—and that it would not impose a prejudice requirement into the contract. Moreover, the Court found it important that both parties were "sophisticated commercial entities." Therefore, because RC Mgmt provided notice of loss to Third Coast more than one year after the May 2020 storm, the Court held that Third Coast was entitled to summary judgment.

COURT FINDS FACT ISSUES EXISTED AS TO WHETHER RENEWAL LETTER SATISFIED THE "NOTICE REQUIREMENTS" IN TEXAS INSURANCE CODE § 551.056

In *First Baptist Church of Sour Lake v. Church Mut. Ins. Co.*[12], Church Mutual Insurance Company ("Church Mutual") insured the property, which included a parsonage residence located at 220 Olive Street in Sour Lake, Texas, of First Baptist Church of Sour Lake ("First Baptist") for more than fifteen years. Of relevance, the 2019 to 2020 Policy included a "Special" cause of loss form, which covered damage resulting from freezing pipes, subject to certain conditions, had a policy limit of $209,000.00, and used replacement cost as the valuation method for the parsonage. In early 2020, Church Mutual decided to reduce the coverage for the parsonage when the 2019 Policy was set to renew on April 23, 2020.

By a letter dated March 16, 2020 (the "Renewal Letter"), Church Mutual reduced the coverage for the parsonage in three key ways: (1) it reduced the policy limit to $125,400.00 dollars, (2) changed the valuation method for the parsonage from replacement value to actual cash value, and (3) changed the applicable cause of loss form to the "Basic" form with theft coverage. The 2021-2022 and 2022-2023 Policies were identical in all relevant respects to the 2020-2021 Policy.

On December 24, 2022, a cold weather event caused pipes in the parsonage to freeze and burst, resulting in substantial water damage to the parsonage. Church Mutual denied the claim and explained that the 2022 Policy only covered 13 named perils under the "Basic" cause of loss form and that frozen pipe burst damage was not a covered peril.

First Baptist sued Church Mutual seeking, among other damages, reformation of the 2022-2023 Policy to cover the damage to the parsonage. The issues presented via cross-motions for summary judgment was whether the Renewal Letter satisfied the "notice requirements" in Texas Insurance Code § 551.056 (the "Statute"). The initial threshold matter was whether the Renewal Letter contained any "material changes" to the 2019 Policy. The Statute defined "material change" to mean "a change to a policy that, with respect to a previous or existing policy: (1) reduces coverage; (2) changes conditions of coverage; or (3) changes the duties of the insured.[13] The district court, with little discussion, held that the Renewal Letter contained "material changes" to the upcoming renewal policy.

The main point of contention was whether the Renewal Letter met or satisfied the four separate "notice requirements" in § 551.056(c) of the Statute:

> (c) Notice provided under Subsection (b) must:
>
> (1) appear in a conspicuous place in the notice of renewal;
> (2) clearly indicate each material change to the policy being made on renewal;
> (3) be written in plain language; and
> (4) be provided to the insured not later than the 30th day before the renewal date.[14]

As to the first requirement of "conspicuous," the district court looked to Texas Business and Commercial Code § 1.201(b)(10), which the Texas Supreme Court adopted as to the meaning of "conspicuous" in the context of indemnity provisions.[15] First Baptist argued that the Renewal Letter did not satisfy the "conspicuous" requirement because it lacked contrast – i.e., it was written in identical, all caps text and has a uniform font size. The district court noted that:

> First Baptist's argument seems to gloss over the meaning of "conspicuous place in the notice of renewal." In other words, it lacks spatial context.
>
> Here, the one-page Renewal Letter encompasses the entire "notice of renewal." And the description of material changes can be found in this one-pager. Cases suggest that the extreme brevity of the "notice of renewal" here makes the notice of material changes contained therein conspicuous per se. . . . .
>
> And this line of cases makes good sense. Under the controlling meaning, courts must assess whether "a reasonable person" "ought to have noticed" the material policy changes. . . . . For these reasons, the Court concludes that the Renewal Letter contains a "conspicuous" notice of material changes and satisfies § 551.056(c)(1). Brevity overcomes the lack of contrast.[16]

As to whether the Renewal Letter "clearly indicate[s]" material changes to the renewal policies, the court found that it did in that "[a]ll three changes are bolded and separated into three, bite-sized paragraphs" and that "[t]hese changes are nearly impossible to miss."[17]

However, the district court determined that fact issues existed as to whether the Renewal Letter included plain language which describes each material change and an explanation as to effect of the material change (i.e., the Basic cause of loss form provides lesser coverage). In finding a fact issue remained, the court noted that:

> The Renewal Letter does not specify what the cause of loss form is being changed from. . . . . Relatedly, the Renewal Letter does not explain that the new cause of loss form removes coverage for certain perils that would've been covered under the "Special" form. . . . . And lastly, Pastor Thornton's testimony appears temporally specific; it described his perception of the Renewal Letter in 2023, after Church Mutual denied the Claim and the church members had discussed the letter. As a matter of logic, if the meaning of a document is discerned only after a discussion and the benefits of hindsight, it is probably not written in plain language.[18]

The district court did determine that the phrase "provided to the insured" meant the 30-day notice requirement was determined based on the day or date the named insured received the notice of material changes letter from the insurer. That is, whether the 30-day requirement was met was determined based on when First Baptist received the Renewal Letter and not the date it was mailed by Church Mutual. However, due to conflicting factual arguments, the district court held that a fact issue existed.[19]

Lastly, the federal district court agreed with First Baptist that reformation was the proper remedy if determined that the Renewal Letter violated § 551.056(c) – that is, if it did not meet all of the "notice requirements."

PROFESSIONAL LIABILITY

NORTHERN DISTRICT OF TEXAS FINDS THAT AMBIGUOUS TERMS IN THE POLICY ARE INTERPRETED IN FAVOR OF COVERAGE, RESULTING IN STOWERS EXPOSURE

In *Carpenter v. Twin City Fire Ins. Co.*,[20] the United States federal court for the Northern District of Texas, Dallas Division, considered whether an employment practices liability carrier was liable for damages in excess of the policy limits where the only disputed element of a Stowers claim was whether the claim was covered under the policy.

By way of background, the Plaintiff, Carpenter, entered into a "pay to stay" agreement with his employer, who allegedly later breached that agreement. The employer was insured under an employment practices liability policy issued by Twin City Fire Insurance Company (the "Policy"). During the pendency of the underlying case, Carpenter offered to settle his claim within the Policy limits, which Twin City declined. At trial, the jury found the employer breached the pay to stay agreement and awarded Carpenter damages in excess of the Policy limits. The Employer's claim against Twin City was assigned to Carpenter and he brought suit against Twin City for Stowers liability.

Twin City admitted to each element of Stowers liability except whether liability for the underlying judgment was within the scope of the Policy. Carpenter moved for summary judgment as to that element. The parties disputed the interpretation of two provisions in the insurance policy. First, the Policy excluded from coverage "employment termination severance payments." Second, the Policy excluded payments for "salaries, wages, or bonuses, except as a component of a front or back pay award." (emphasis added). Carpenter argued that these exclusions were inapplicable because the term "employment termination severance agreement" was ambiguous. Twin City's position was that the exclusions precluded "any payment paid out to an employee on termination of employment, usually as a reward or incentive for length of service." Carpenter proposed that it excluded "only payments given in exchange for termination of employment, usually related to a waiver of alims and with the end of employment being the key condition for receiving the funds." The Court found that both interpretations were reasonable, and as a result, the insured's interpretation applied. Because the pay to stay agreement was an agreement to pay Carpenter if he would stay and assist with the transition and sale of the company, it did not meet Carpenter's reasonable definition of employment termination severance payment. Accordingly, coverage was not excluded on the basis that the pay to stay agreement was a severance payment.

Second, the Court found that the term "back pay award" was ambiguous because both Twin City and Carpenter offered reasonable interpretations. The Policy did not define "back pay." Twin City interpreted back pay to be "limited only to specific equitable remedy available in certain wrongful-termination or employment discrimination cases," whereas Carpenter interpreted the term to be "owed but unpaid compensation for past performance." Because there were multiple reasonable interpretations of the term, the Court was constrained to adopt the insured's interpretation. As per the evidence, Carpenter could show that he rendered "distinct past performance and was not paid for it," the exception to the exclusion for payments of salaries / wages was triggered and therefore, the exclusion did not apply. Thus, the Court granted Carpenter's motion for summary judgment.

Carpenter is an illustration of a circumstance in which, because of the size of potential exposure, and in particular, Stowers exposure, it may be prudent to file an early declaratory judgment action on the applicability of coverage defenses.

FEDERAL MOTOR CARRIER CASES

U.S. DISTRICT OF NEBRASKA RULES DEFENSE OWED TO INSURED BECAUSE FACTS WERE DISPUTED AS TO WHETHER DRIVER INTENTIONALLY CAUSED ACCIDENT DURING MENTAL HEALTH CRISIS AND THEREFORE THE EXPECTED OR INTENDED INJURY EXCLUSION DID NOT PRECLUDE A DEFENSE AS A MATTER OF LAW.

In *Hoxbridge Insurance Co. v. Netlane Logistics, Inc.*,[21] the dispute arose as the result of a collision involving a semi-truck operated by Alfred Nelson, a driver for Netlane Logistics ("Netlane") that sideswiped another tractor-trailer driven by Murat Kilicarslan and resulted in injuries to Kilicarslan. Notably, after the crash, Nelson left the scene on foot, told responding officers that he believed people were after him, and claimed he had caused the accident in an attempt to take his own life. These statements led to his placement in protective custody and subsequent mental health evaluation. Kilicarslan later filed a personal injury lawsuit in Illinois state court, asserting claims of negligence, vicarious liability, and willful and wanton misconduct against Nelson and Netlane.

Hoxbridge Insurance Company ("Hoxbridge") issued a commercial auto policy to Netlane that included a standard exclusion for injuries "expected or intended" by the insured, as well as an MCS-90 endorsement. Following its investigation, Hoxbridge filed a declaratory judgment action seeking a ruling that it had no duty to defend or indemnify Netlane due to Nelson's alleged intent to cause the collision. Hoxbridge asserted that Nelson's own statements, alongside his guilty plea to third-degree assault and reckless driving, established that the accident was the result of an intentional act excluded from coverage under the policy.

Netlane opposed the DJ suit, emphasizing that Nelson was in the midst of a severe mental health crisis during the incident and had later testified that he could not recall any of the events surrounding the collision. In an Examination Under Oath, Nelson testified that he did not remember saying he caused the crash on purpose and questioned the reliability of those statements due to his psychotic state. He emphasized that his recollections resumed only days later after waking up in a mental health facility. Netlane contended that Nelson's inability to recall the event, along with his psychological state, made it impossible to determine whether he possessed the intent required to trigger the policy exclusion.

Ultimately, the Court rejected Hoxbridge's argument that coverage was precluded by the expected or intended injury exclusion. Instead, the Court noted that the policy was governed under Illinois law, therefore, the applicability of the expected or intended injury exclusion depended on the insured's subjective intent—whether the individual desired the harmful result or knew it was substantially certain to occur. The Court noted specifically that Illinois law requires an inquiry into whether the insured had the requisite free will to be capable of intending the accident. Given the conflicting evidence about Nelson's mental state and whether he intended to cause the crash, the Court found genuine disputes of material fact. The Court noted that while Hoxbridge relied on the initial police report and Nelson's statements at the scene, the Court emphasized that Nelson later recanted those statements and had no memory of making them. Accordingly, the Court ruled that Hoxbridge had not met its burden to deny a defense under the exclusion as a matter of law because Nelson's intent could not be conclusively determined on the existing record. Therefore, the Court held that Hoxbridge had a continuing duty to defend Netlane in the personal injury suit because Kilicarslan's complaint included multiple negligence-based claims against both Nelson and Netlane, including failure to properly hire, train, or supervise Nelson.

> The Court stayed the indemnity determination until the resolution of the personal injury suit, recognizing that Nelson's mental state at the time of the crash remained a disputed issue. However, the Court, in dicta, noted that in the event that Hoxbridge was ultimately found not to owe the duty to indemnify due to application of the expected or intended injury exclusion, then the MCS-90 endorsement would nonetheless apply to satisfy any judgment.

This case underscores the importance for insurers that the applicability of the "expected or intended injury" exclusion may hinge not only on the insured's actions, but also on the insured's mental state at the time of the incident. As this case demonstrates, certain jurisdictions will hold that express statements that an insured intended or expected harm is insufficient to trigger the exclusion if there is credible evidence that the insured was experiencing a severe mental health crisis and/or incapable of forming the requisite intent at the time of the accident. Accordingly, insurers should be mindful of which jurisdictions will analyze this exclusion under a subjective standard that requires the Court to determine whether the insured had the requisite cognitive capacity to expect or intend the resulting injury. For policies that are subject to interpretation in these jurisdictions, insurers should conduct a thorough inquiry into the insured's mental capacity and competency before relying on this exclusion to deny coverage.

WESTERN DISTRICT OF VIRGINA APPLIES TEXAS LAW TO HOLD THAT THERE IS NO DUTY TO DEFEND IN AN UNDERLYING LAWSUIT SEEKING SOLELY TOWING AND CLEAN-UP COSTS RESULTING FROM AN 18-WHEELER ACCIDENT

In *Trisura Specialty Insurance Co. v. Brian Omps Towing & Repair, LLC*,[22] the central issue concerned whether Trisura Specialty Insurance Company ("Trisura") had a contractual obligation to defend or indemnify its insured, CSI Freight, LLC ("CSI"), in a state-court action initiated by Brian Omps Towing & Repair, LLC ("Omps"). The state-court action arose out of a single-vehicle rollover accident involving a tractor-trailer owned by CSI in Warren County, Virginia. The vehicle, which was hauling sacks of flour, veered off the roadway and overturned. No other vehicles were involved in the incident, and the driver was uninjured. Following the accident, the Virginia Department of Transportation ("VDOT") dispatched Omps to the scene under its Towing and Recovery Incentive Program ("TRIP"), which authorizes designated towing providers to respond to incidents along specific highway segments.

Upon arrival, Omps undertook cleanup and recovery operations, including towing the damaged tractor-trailer and its cargo to its storage facility. Omps subsequently billed CSI for these services, initially issuing an invoice for $42,840.00. As time passed and storage fees accumulated at a rate of $75 per unit per day, Omps increased its demand to a total of $98,390.00 by August 2023. CSI did not pay the invoiced amounts, prompting Omps to initiate a state-court lawsuit seeking enforcement of a statutory lien, statutory reimbursement, and relief under an unjust enrichment theory.

At the time of the accident, CSI held a commercial auto insurance policy issued by Trisura ("Trisura Policy"). The Trisura Policy obligated Trisura to cover damages for "bodily injury," "property damage," or "covered pollution cost or expense" arising from covered accidents. However, Trisura declined coverage, asserting that Omps's claims were purely economic and did not involve any covered damages.

In response to the state court case, Trisura agreed to defend CSI under a reservation of rights, however, Trisura also initiated a federal declaratory judgment action that it owed no duty to defend or indemnify CSI in the state court case. The Court interpreted the Trisura Policy under Texas law because CSI was a Texas limited liability company with its principal place of business in Houston, Texas and therefore analyzed Trisura's duty to defend under the well-established "eight-corners rule." Ultimately, the Court found that Omps's state-court complaint did not allege any bodily injury or property damage, as defined by the Trisura Policy. The Court noted that Omps's claims were strictly economic in nature—stemming from the unpaid invoice for towing, recovery, and storage services provided after CSI's tractor-trailer accident. The Court further noted that Omps did not allege that any of its property had been damaged or that its employees had been injured during the recovery operations. Therefore, there was no claim for "property damage" or "bodily injury" arising from the accident.

However, the Trisura's Policy also afforded limited pollution coverage for a "covered pollution cost or expense". Specifically, the Trisura Policy only provided coverage for pollution if it was caused by the same accident that also caused either "bodily injury" or "property damage." This conditional coverage structure required a two-part trigger: (1) a pollution-related cost caused by the accident, and (2) that same accident also caused "bodily injury" or "property damage." The court found that Omps's state-court complaint did not satisfy either condition. There were no allegations of pollution—such as a chemical spill or environmental contamination—arising from the accident. Furthermore, there were no claims of "bodily injury" or "property damage", which the policy explicitly required to accompany any pollution-related claim. As such, even if pollution had occurred (which was not alleged), coverage would still be unavailable without the requisite "bodily injury" or "property damage". Accordingly, the Court concluded Omp's Complaint only alleged economic losses from services rendered and. therefore, the pollution coverage clause was not implicated.

Accordingly, the Court held, under a strict eight-corners analysis that Trisura's duty to defend was not triggered in the underlying state court action because there were no allegations of "bodily injury", "property damage", or a "covered pollution cost or expense". Regarding Trisura's duty to indemnify, the Court declined to issue a declaratory judgment reasoning that since Omps's state lawsuit remained pending and could potentially reveal facts supporting coverage, the Court found it premature to rule on Trisura's duty to indemnify.

This case is a reminder to carriers of the importance of ensuring that commercial auto policies are interpreted under the correct state's law when considering coverage. The present case concerned a single-car accident in Virginia, but the Court analyzed the Policy concluding that Texas law governed interpretation of the Policy. In addition, this case also serves as a reminder of the importance of ensuring that all conditions precedent to pollution coverage are satisfied because the pollution coverage afforded under a motor carrier policy could be dependent upon allegations of a covered claim for "bodily injury" or "property damage" in order to trigger the limited scope of pollution coverage.

MISCELLANEOUS

CHOICE OF LAW ISSUES IMPACT WHICH STATE'S LAW APPLIES TO CONTRACT CLAIMS AND TO EXTRA-CONTRACTUAL CLAIMS AGAINST CARRIER

In *Transform Holdco LLC v. Starr Indem. & Liab. Co.*, 2025 Tex. App. LEXIS 4077 (Tex. App. Dallas, June 13, 2025), the Dallas Court of Appeals analyzed which state's law applied to the insurance contract under the Restatement (Second) Conflict of Laws. In Transform, the insured, Transform Holdco LLC, was a Delaware LLC with its principal place of business in Illinois. It contracted with Starr Indemnity & Liability Company, an insurance company incorporated in Texas with its principal place of business in New York, to insure merchandise Transform bought from the Sears bankruptcy. The insurance contract did not have a choice-of-law provision. A tornado in Dallas, Texas damaged merchandise stored at Transform's distribution center in Garland, Texas. Transform submitted an insurance claim to Starr, which Starr denied, leading to a lawsuit by Transform against Starr.

Transform asserted that the trial court erred in determining that New York law applied to the contract claims and its extra-contractual claims for common-law bad faith and violations of the Texas Insurance Code. With regard to the extra-contractual claims for common-law bad faith and violations of the Texas Insurance Code, it argued the factors in both Section 145 and Section 6 of the Restatement pointed to application of Texas law. Starr argued the relevant factors supported the trial court's decision (New York). The court applied the Section 145 factors, which applies to tort claims, to conclude New York law applied.

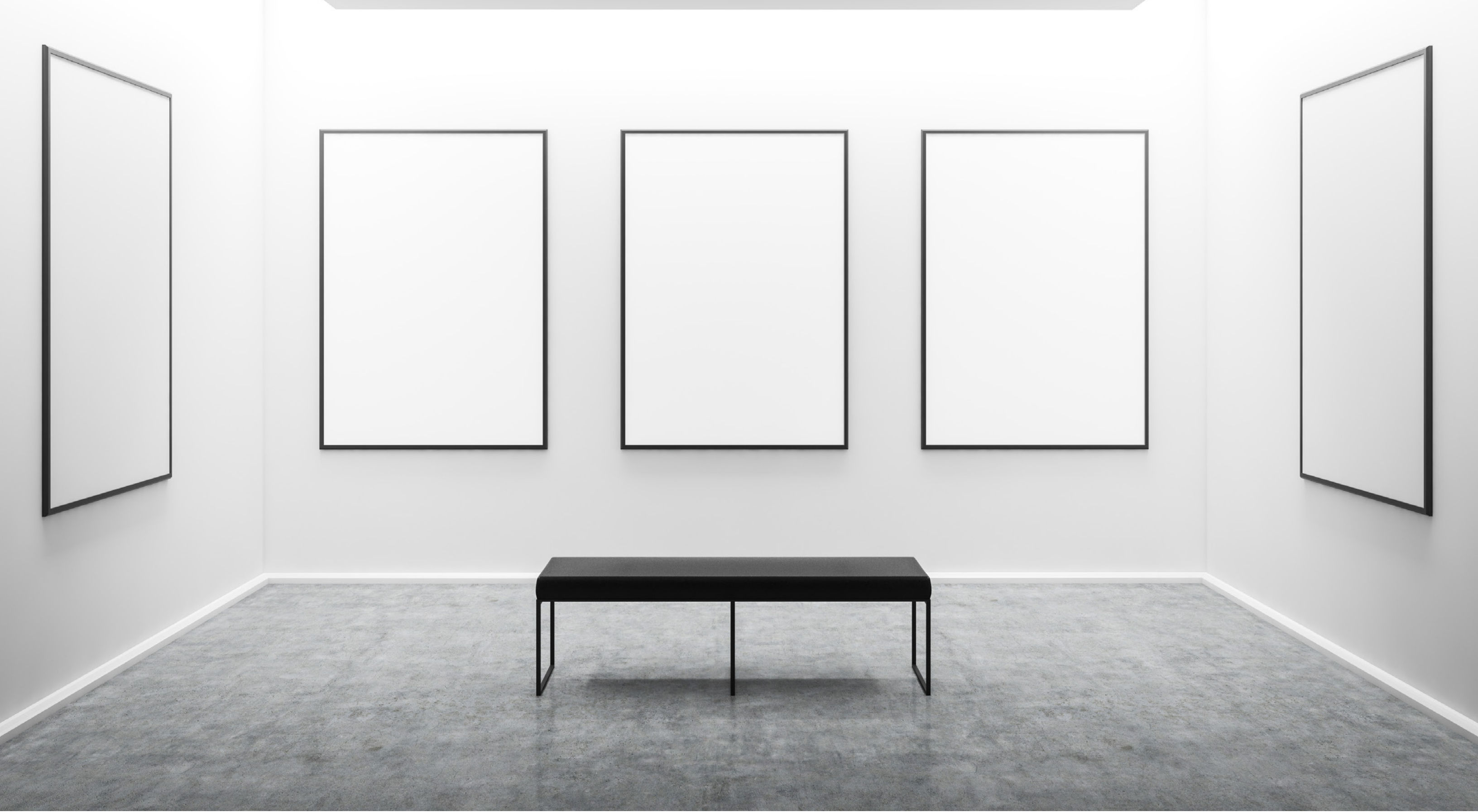
For Transform's extra-contractual causes of action, "the issue is Starr's handling of the insurance claim." Transform alleged Starr violated the insurance code in various ways, including: (1) knowingly misrepresenting pertinent facts or policy provisions relating to coverage, (2) failing to attempt in good faith to effect a prompt, fair, and equitable settlement of a claim submitted in which liability has become reasonably clear, (3) failing to properly provide a reasonable explanation of the basis for denial, and (4) refusing to pay without conducting a reasonable investigation. Similarly, the basis for Transform's common-law bad faith claim is Starr's refusal to pay under the Policy without a reasonable basis for doing so.

The first factor in a Section 145 analysis is the place where the injury occurred. Transform contended the injury occurred in Texas because Transform's property was damaged here or occurred in Illinois, where it is headquartered. Starr argued the injury occurred in Illinois because Transform's legal injury is the loss of insurance proceeds, not the physical damage to the merchandise. The court found that by its extra-contractual claims, Transform sought to recover the amount of its insurance claim, plus statutory penalties and treble damages. "A financial injury will normally be felt most severely at the plaintiff's headquarters or principal place of business." Because Transform's headquarters was in Illinois, the court found that this factor favored application of Illinois law.

The court next concluded the next factor, the place where the conduct causing injury occurred, was New York. "Transform's legal injury is the denial of its insurance claim, and the decision to deny the claim was made by Starr in New York." The third factor is the parties' domicile, residence, nationality, place of incorporation, and place of business. The court said: "[w]ith respect to most conflict-of-law issues, a corporation's principal place of business is a more important contact than its place of incorporation." Transform's principal place of business is in Illinois, and Starr's is in New York. This factor points to either Illinois or New York, not Texas. The last factor is the place where the relationship, if any, between the parties is centered. Transform argued this factor favored application of Texas law because it is the location of the loss, investigation, and salvage dispute, while Starr maintained the parties' relationship was centered in New York. The court agreed with Starr. "The parties' relationship was based on the Policy. The Policy was underwritten and issued in New York."

The court concluded that none of the Section 145 factors weighed in favor of Texas law. Illinois is the place where the injury occurred and Transform's principal place of business. New York is Starr's principal place of business, the place where the conduct causing injury occurred, and the place where the parties' relationship is centered. The court concluded that "New York, where Starr has its headquarters, has the most significant relationship to the substantive issues of whether Starr's handling of Transform's insurance claim and failure to pay proceeds violated Starr's common-law and statutory duties.The claim was denied in New York and policy proceeds were expected to be paid from New York."

The court also concluded that New York law applied to Transform's contractual claims (which included a request for attorney fees under Texas statute) after applying the factors in the Section 188(2) of the Restatement (Second) of Conflict of Laws. Notably, the court applied the factors in the tort section of the Restatement to the tort claims but applied the factors in the contract section of the Restatement to the contractual claims. In this case, the analysis pointed to New York law as to all claims. However, under this approach, it would appear possible a court could find that two different state's laws applied to a single policy, based on the nature of the causes of action brought by the insured.



TEXAS COURT OF APPEALS REJECTS ENFORCEMENT OF SETTLEMENT AGREEMENT THAT DID NOT REFLECT MUTUAL ASSENT ON MATERIAL TERMS

In *Ahmad Ibrahim v. Sentinel Insurance Co., Ltd.*[23], the Dallas Court of Appeals reversed a trial court's judgment enforcing a purported settlement agreement between an insured and insurer, holding that the insurer failed to prove mutual assent on all material terms. The ruling serves as an important reminder that even seemingly routine post-mediation email exchanges can fall short of creating an enforceable contract—particularly where additional terms are later introduced.

The dispute arose after a burglary at Ibrahim's art gallery led to a claim under his property insurance policy issued by Sentinel. Following a coverage dispute, the parties mediated in December 2020. Although both sides appeared to accept a mediator's proposal via email, no formal settlement agreement was signed at the time. Several days later, Sentinel circulated a draft release and settlement agreement containing significant additional provisions—including a $30,469 offset for attorneys' fees, broad indemnity obligations, and confidentiality terms—that were not discussed during mediation or included in the prior email exchanges.

When Ibrahim declined to sign the Proposed Agreement, Sentinel filed suit seeking specific performance and attorneys' fees. The trial court granted Sentinel's motion for summary judgment, ordering Ibrahim to sign the Proposed Agreement and awarding Sentinel $30,000 in attorneys' fees. The Dallas Court of Appeals reversed.

The Court emphasized that under Texas law, an enforceable contract requires a meeting of the minds and mutual consent to all material terms. While email communications may in some cases form a binding agreement, here the Court found that the additional terms inserted into the Proposed Agreement—particularly the attorney fee offset and indemnity provisions—were material and had not been accepted by Ibrahim. As a result, there was no enforceable agreement as a matter of law, and specific performance was inappropriate. Notably, the Court rejected Sentinel's argument that the post-mediation email exchange constituted a binding Rule 11 agreement. While Rule 11 allows enforcement of certain agreements between attorneys, it does not override the basic principles of contract formation, which require clarity on essential terms. The Court also reversed the award of attorneys' fees and declined to grant judgment for either party, instead remanding the matter for further proceedings.

This case serves as a reminder that insurers should be cautious when relying on informal settlement communications, particularly email exchanges following mediation. While such communications may support enforceability in some cases, introducing additional or modified terms after the fact—especially provisions related to indemnity, confidentiality, or fee offsets—can create fatal inconsistencies. Even standard release language, if not explicitly agreed to during negotiations, may render a proposed agreement unenforceable. To avoid these pitfalls, it is critical to document all material terms contemporaneously and, where possible, to reduce the parties' agreement to a signed writing without delay. Courts are unlikely to enforce settlement documents that materially alter the parties' agreed terms, even when those documents reflect an insurer's routine practices. This case underscores the need for vigilance in ensuring that all parties' intent is clear and aligned before closing the loop on settlement, particularly in contentious or protracted coverage disputes.

THE TEXAS SUPREME COURT IMBUES THE 'SUBSTANTIAL FACTOR' IN THE PROXIMATE CAUSE ANALYSIS WITH A DOSE OF COMMON SENSE

On the morning of December 30, 2014, the National Weather Service ("NWS") issued a winter weather advisory indicating that ice was likely to accumulate on the roads and lead to hazardous driving conditions in West Texas, near Odessa. At 2:50 p.m., the NWS updated its advisory to state that freezing rain had begun and that temperatures would remain below freezing all afternoon. At 4:25 p.m. that afternoon, Trey Salinas ("Salinas") was driving his F-350 pickup with four passengers – Jennifer Blake and her three children – on I-20 eastbound near Odessa, Texas. Salinas lost control and crossed over the 42-foot grassy median into oncoming highway traffic headed westbound. The Ford F350 collided nearly head-on with an 18-wheeler owned and operated by Werner Enterprises ("Werner"), and driven by Shiraz Ali ("Ali"), an employee of Werner.

On May 17, 2018, a jury found Werner and Ali liable, apportioning 70% of the responsibility for causing the Blake family members' injuries to Werner (based on claims such as negligent training, supervision, and hiring), 14% to Ali, and 16% to Salinas. The Blake family was awarded a total of $68,187,994.00 in damages for their injuries caused by a head-on collision between a Ford F350 Heavy Duty pickup and an 18-wheeler. The Houston Court of Appeals upheld the judgment on May 18, 2023 (now totaling over $100,000,000.00).

On appeal to the Texas Supreme Court, the central issues were (1) whether Ali proximately caused the accident and (2) whether the Court should adopt the "Admission Rule" when assessing employer liability. The Texas Supreme Court in Werner Industries initially noted that Texas courts have described proximate cause as requiring application of "a practical test, the test of common experience, to human conduct when determining legal rights and legal liability." The Texas Supreme Court focused on whether the acts or omissions of Ali in his operation of the 18-wheeler was a "substantial factor" in causing the accident and in bringing about the injuries of the Blake family.

The Texas Supreme Court emphasized that the "substantial factor" component of proximate cause included the common sense concept of responsibility in that "the defendant's conduct has such an effect in producing the harm as to lead reasonable men to regard it as a [substantial] cause, using that word [substantial] in the popular sense . . . ." However, if the defendant's conduct "merely creates the condition that makes the harm possible, it is not a substantial factor in causing the harm as a matter of law." In other words, "cause in fact is not established where the defendant's negligence does no more than furnish a condition which makes the injuries possible."

The Court looked at the circumstances of the accident through a lens of common sense, finding that Salinas – and not Ali – proximately caused the accident:

> Under the undisputed facts of this case, the Blakes' injuries happened because [Salinas], in the course of two or three seconds, lost control of his F-350, hurtled across the median into oncoming traffic on I-20, and collided with a vehicle driving below the speed limit in its proper lane on the other side – a vehicle which, tragically for the Blakes, happened to be an 18-wheeler. . . . .
>
> Nothing Ali did or didn't do contributed to Salinas's truck hitting ice, losing control, veering into the median, and entering oncoming traffic on an interstate highway. However Ali was driving, the presence of his 18-wheeler in its proper lane of traffic on the other side of I-20 at the precise moment Salinas lost control is just the kind of "happenstance of place and time" that cannot reasonably be considered a substantial factor in causing these injuries. Instead, Salinas losing control and hurtling across the median was the substantial factor in bringing about the injuries. . . . .
>
> Surely, as the [Blake family] urges, if Ali had been driving more slowly, Salinas would not have collided with him. Just as surely, however, if Ali had been driving 100 miles per hour, Salinas would not have collided with him. Had either driver been driving much slower or faster, this accident would not have happened as it did. And if no vehicle at all had been in Salinas's path as he crossed into oncoming traffic, the Blakes would not have been injured. On the other hand, if the vehicle in that spot had been a small car rather than an 18-wheeler, Salinas's F-350 could have killed or severely injured its occupants.
>
> The position and speed of the vehicles on the other side of a broadly divided highway when an oncoming F-350 suddenly hurtles across the median toward them is precisely the kind of "happenstance of place and time" that can have enormous consequences for the victims of an accident but cannot reasonably be considered as the proximate cause of the accident or the resulting injuries.

The Werner Court concluded that Ali's negligence was not a proximate cause or a substantial factor in causing the accident and that any finding of derivative liability against Werner was in error and could not stand. As such, the Texas Supreme Court reversed the judgment of the trial court and the appellate court and rendered judgment in favor of Werner and Ali.

NOTEWORTHY LEGISLATIVE DEVELOPMENTS

NEW LAW MANDATES APPLICATION OF TEXAS LAW TO ARBITRATION PROVISIONS IN SURPLUS LINES INSURANCE POLICIES IN CERTAIN CASES

A surplus lines insurer is, by definition, not authorized to issue insurance in Texas. Under § 101.201(a) of the Texas Insurance Code ("TIC"), an unauthorized insurer is barred from denying coverage based on an exclusion or limitation in an insurance contract. The Texas Legislature later enacted Chapter 981 of the TIC which permits surplus line insurers to provide insurance in Texas if the insurer qualifies as an "eligible surplus lines insurer," by meeting certain requirements and being approved by the Texas Department of Insurance. Moreover, under Chapter 981, the restriction in § 101.201(a) "does not apply to insurance procured by a licensed surplus lines agent from an eligible surplus lines insurer as defined by Chapter 981 . . ..

The addition of surplus lines insurers allows Texas-based insureds who could not normally obtain coverage from an authorized insurer or who could only obtain such coverage by paying an incredibly high premium, to have indemnity coverage. The trade-off is that surplus lines policies often include a forum selection and choice of law clause which specify that a specific state's laws apply and any suit or legal proceeding regarding a claim under the policy must be brought in the specified state.

The inclusion of a forum selection and/or choice of law provision in a policy may present obstacles for an insured in asserting legal rights under the policy in foreign forums under unfamiliar laws and rules of practice. For example, in Chandler Mgmt. Corp. v. First Specialty Ins. Corp., the named insured, Chandler Management Corporation ("Chandler") managed apartment complexes in Texas and Virginia, including two complexes in Dallas. To insure the complexes, Chandler purchased a surplus lines commercial property insurance policy issued by First Specialty Insurance Corporation ("First Specialty"). In May 2011, a wind and hail storm damaged the roofs of the Dallas apartments managed by Chandler. Within a month, Chandler reported the loss to First Specialty, who determined that the amount of damage was below the $25,000 deductible, and it denied payment of the claim. Chandler brought suit in June 2012, alleging the damage from the storm was over $1.5 million and asserted claims for breach of contract and for unfair settlement practices under the TIC. First Specialty moved to dismiss the suit without prejudice to Chandler refiling in New York pursuant to the policy's forum selection clause. The trial court granted the motion and dismissed the suit without prejudice to the suit's filing in New York.

On appeal, the Dallas Court of Appeals upheld the forum selection clause and dismissed Chandler's suit against First Specialty in December 2014. Chandler re-filed its lawsuit in New York against First Specialty on August 5, 2015. First Specialty filed a motion to dismiss with prejudice the Chandler lawsuit on the basis it was time-barred under the 12-month suit limitation provision of the First Specialty insurance policy.

The First Specialty Policy provided that "[n]o one may bring a legal action against us under this Coverage Part unless (1) There has been full compliance with all of the terms of this Coverage Part" and (2) "The action is brought within 12 months after the date on which the direct physical loss or damage occurred." The New York court acknowledged that Chandler had timely filed suit in Texas, but that First Specialty had "successfully moved to dismiss the 2012 Texas Action on the ground that Chandler failed to comply with the New York forum selection clause in the First Specialty Policy which was upheld on appeal." The New York court dismissed the lawsuit with prejudice holding that "[h]ere there is no dispute that Chandler failed to commence this action within 12 months after the alleged occurrence on May 24, 2011. According to the terms of the First Specialty Policy, Chandler was required to commence a New York lawsuit against First Specialty within 12 months of any loss, or no later than May 24, 2012. Here Chandler waited until August 5, 2015, more than three years beyond the deadline." As such, Chandler was left with no recourse or avenue to recover the estimated $1,500,000.00 in damages to the apartment complex under the First Specialty policy.

In In re first Specialty, the GPISD school buildings and campuses sustained extensive damage due to Hurricane Harvey in August 2017. GPISD alleged that it sustained more than $10,000,000.00 in property damage, but the insurers valued the damages at only $840,000.00. On August 27, 2019, GPISD filed suit against multiple insurers, including First Specialty, seeking in excess of $10,000,000.00 in benefits for the damage to the school buildings. On October 7, 2019, First Specialty filed a motion to dismiss GPISD's complaint against it on the basis of the forum selection clause in its insurance contract which specifically required that any dispute against First Specialty be exclusively brought in New York State Court and be governed by New York Law. After an in-depth discussion of the enforceability of forum selection clauses, the Corpus Christi Court of Appeals upheld the forum selection clause and dismissed GPISD's suit against First Specialty. If GPISD files suit in New York, it is likely that First Specialty will secure dismissal based on the 12-month statute of limitations provision just as in Chandler above.

Senate Bill 455:

Under Senate Bill 455 which was recently enacted, any surplus lines insurance contract covering a risk located entirely within the state which includes an arbitration agreement, that arbitration proceedings will be conducted in Texas and governed by Texas law unless certain requirements are met:

SEC. 981.101. REQUIREMENTS FOR SURPLUS LINES DOCUMENTS.
[Effective September 1, 2025]

Subsection (d) and (e) are added and apply to contracts delivered, issued for delivery, or renewed on or after January 1, 2026. Contracts executed before that date remain subject to the laws in place at the time.

(d) A surplus lines insurance contract for a risk located wholly in this state and that contains an arbitration agreement must provide that:
  (1) the arbitration will be:
    (A) conducted in this state; and
    (B) governed by the laws of this state; and
  (2) the insurance contract will be interpreted in accordance with the laws of this state unless:
    (A) the insurer and policyholder agree to a different venue after the insurer provides written notice to the policyholder of the insurer's request for a different venue; and
    (B) the insurer provides the policyholder with a premium credit for the costs incurred by the policyholder as a result of the change in venue.

(e) Notwithstanding Subsection (d), for surplus lines insurance contracts for over $2 million in insured value, the insurer and policyholder may agree by mutual consent to a different arbitration venue and governance under another state's laws, provided the agreement is in a form.

This law is designed to anchor arbitrations in familiar legal territory for Texas-based insureds, and to prevent the results such as in the above First Specialty cases. That is, it reflects a clear intent to ensure that arbitrations involving surplus lines insurance contracts for in-state risks are handled under Texas jurisdiction, unless both sides decide otherwise.

Key Provisions of the law:

If an arbitration agreement is included, the law mandates that the arbitration must occur in Texas and be subject to Texas law, unless the insurer follows certain procedures for the application of a different state's law. The law requires that the insurance contract itself be interpreted according to Texas law, with a limited exception for situations where both parties agree to a different venue after specific disclosures and premium adjustments. An insurer must provide the policyholder with a premium credit to cover the costs associated with a change of venue from Texas, if such a change is agreed upon.

TEXAS LAW TO END THE "WIDOW PENALTY" FOR HOME AND AUTO INSURANCE POLICIES

Imagine this: You've just lost your spouse. You're grieving, overwhelmed, trying to pick up the pieces. You're all alone. One of the pieces you have to take care of is notifying institutions such as your bank, credit card companies, and even your insurers that your spouse is deceased and to take his or her name off the policy.

If anything, you expect that your premium rates would decrease as there is one less driver or household member. You would be wrong. Insurers in Texas routinely raise premiums solely based on the change in marital status due to the death of a spouse – reclassifying the widow or widower as "single" rather than "married." This scenario, known as the "widow's penalty," is what Senate Bill 1238 was designed to stop. Senate Bill 1238 will make it illegal for insurers to discriminate against people whose spouses have died by reclassifying them as "single" and raising their rates.

Critics of the "widow's penalty" as discriminatory and essentially punishment for losing a spouse and for being alone – i.e., a widow. The quest to end the "widow penalty" has been at least a decade in the making and has culminated in the signing into law Senate Bill by Governor Greg Abbott on May 20, 2025. The enrolled version of Senate Bill 1238 is as follows:

AN ACT RELATING TO PROHIBITED INSURANCE DISCRIMINATION ON THE BASIS OF AN INSURED'S MARITAL STATUS FOLLOWING THE DEATH OF THE INSURED'S SPOUSE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 544.002, Insurance Code, is amended by adding Subsections (d) and (e) to read as follows:

(d) Notwithstanding Section 544.003, an insurer may not:

> (1) refuse to continue to insure or provide coverage to an individual or limit the amount, extent, or kind of coverage available to an individual because the individual is widowed or the individual's marital status otherwise reflects the death of a spouse; or
>
> (2) charge an individual who is widowed or whose marital status otherwise reflects the death of a spouse a rate that is different from the rate that would be charged if the individual's marital status was married.

(e) Subsection (d) may not be construed to prohibit a title insurance company or title insurance agent from imposing a reasonable requirement on a widowed insured or widowed individual seeking insurance coverage for the purpose of determining heirship, probate matters, or other similar issues in the same manner as an insured or individual who is not widowed.

SECTION 2. The change in law made by this Act does not apply to an insurance policy that is delivered, issued for delivery, or renewed before the effective date of this Act. An insurance policy that is delivered, issued for delivery, or renewed before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2025.

Key Provisions:

Discriminatory Practice: The Bill describes and characterizes the practice of reclassification of a spouse from "married" to "single" to justify or impose higher premiums as a discriminatory practice under Texas law.

Continued Level of Coverage: The Bill makes it illegal for an insurer to refuse to continue to provide, unilaterally change or alter, or lessen the type, kind, level, or amount of coverage on the basis the individual is widowed or the individual's marital status otherwise reflects the death of a spouse.

Premium Status: Insurers are prevented from raising an individual's premium rates on the basis the individual is widowed or the individual's marital status otherwise reflects the death of a spouse.

Effective Date: The law goes into effect on September 1, 2025. Any new insurance policy, or insurance policy which is delivered, issued for delivery, or renewed after the effective date of this Act – September 1, 2025 – is subject to the prohibitions against discriminatory conduct related to an individual's status as a widow or because the individual's marital status otherwise reflects the death of a spouse.

[1] *Crum & Forster Specialty Ins. Co. v. Smallwood*, No. 4:23-cv-01079-P, 2025 U.S. Dist. LEXIS 108711 (N.D. Tex. 2025).
[2] *Michelle Peguero, et al. v. I&A Development & Construction, LLC, et al.*, Cause No. 342-340963-23.
[3] No. 23-0755, 68 Tex. Sup. Ct. J. 692, 2025 Tex. LEXIS 324 (Apr. 25, 2025)
[4] *Benchmark Ins. Co. v. Linan*, No. 4:24-CV-01884, 2025 U.S. Dist. LEXIS 118264 (S.D. Tex. 2025).
[5] See *Juan Ramon Guevara Ortez v. Linses Land LLC, Jorge Adrian Linan, and Yazmin Linan a/k/a Irasema Yazmin Sesatty*, Cause No. 23-DCV-307962, 400th Judicial District Court of Fort Bend County, Texas.
[6] No. 12-24-00358-CV, 2025 Tex. App. LEXIS 3102 (Tex. App.—Tyler Apr. 30, 2025, pet. filed)
[7] No. 3:24-CV-2490-B, 2025 U.S. Dist. LEXIS 89645 (N.D. Tex. May 12, 2025).
[8] 559 F. Supp. 3d 476 (E.D.N.C. 2021), aff'd, 2022 WL 3278938 (4th Cir. 2022).
[9] *Blackwood v. American Economy Insurance Co.*, No. 4:23-CV-00780-ALM-AGD (E.D. Tex. May 1, 2025).
[10] *In re Universal Underwriters of Texas Insurance Co.*, 345 S.W.3d 404 (Tex. 2011).
[11] *RC Mgmt. v. Third Coast Ins. Co.*, No. SA-24-CV-00711-XR, 2025 U.S. Dist. LEXIS 111871 (W.D. Tex. June 11, 2025).
[12] *First Baptist Church of Sour Lake v. Church Mut. Ins. Co.*, 2025 U.S. District LEXIS 121082 *3 (E.D. Tex. May 9, 2025).
[13] *First Baptist Church of Sour Lake*, 2025 U.S. District LEXIS 121082 *10.
[14] TEX. INS. CODE ANN. § 551.056(c).
[15] *See Dresser Indus., Inc. v. Page Petroleum, Inc.*, 853 S.W.2d 505, 510-11 (Tex. 1993).
[16] *First Baptist Church of Sour Lake*, 2025 U.S. District LEXIS 121082 *14-15.
[17] *Id.* at 21.
[18] *Id.* at 23-24, fn. 18 (internal citations omitted) (emphasis in original).
[19] *Id.* at 29-30.
[20] No. 3:23-CV-00769-N, 2025 U.S. Dist. LEXIS 76113 (N.D. Tex. Apr. 22, 2025).
[21] No.4:23-cv-3018, 2025 U.S. Dist. LEXIS 69438, 2025 WL 1093340 (D. Neb, April 11, 2025).
[22] No. 5:24-cv-00002, 2025 U.S. Dist. LEXIS 72413, 2025 WL 1128829 (W.D. Va., April 16, 2025).
[23] No. 05-23-01018-CV, 2025 Tex. App. LEXIS 2993 (Tex. App.—Dallas Apr. 30, 2025, no pet. h.)
[24] *Werner Enters., Inc. v. Blake*, ___ S.W.3d ___, 2025 Tex. LEXIS 585 * (Tex. June 27, 2025)
[25] *Werner Industries*, ___ S.W.3d ___, Tex. LEXIS 585 at *13.
[26] *Werner Industries*, ___ S.W.3d ___, Tex. LEXIS 585 at *14 (citing RESTATEMENT (SECOND) OF TORTS § 431 cmt. a; see Lear Siegler, Inc. v. Perez, 819 S.W.2d 470, 472 (Tex. 1991); Transcon. Ins. Co. v. Crump, 330 S.W.3d 211, 224 (Tex. 2010); Zanetti, 518 S.W.3d at 402; Borg-Warner Corp. v. Flores, 232 S.W.3d 765, 770 (Tex. 2007).
[27] *Werner Industries*, ___ S.W.3d ___, Tex. LEXIS 585 at *15 (citing Stanfield v. Neubaum, 494 S.W.3d 90, 97 (Tex. 2016) (internal quotation omitted).
[28] *Werner Industries*, ___ S.W.3d ___, Tex LEXIS 585 * 15-16.
[29] *Werner Industries*, ___ S.W.3d ___, Tex. LEXIS 585 at *20-23.

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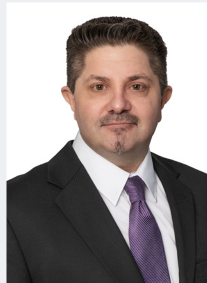

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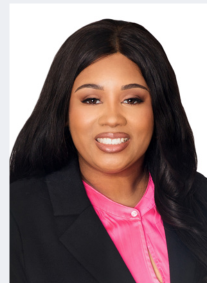

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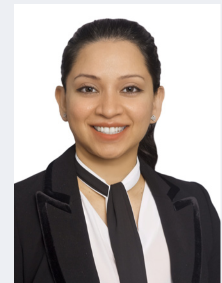

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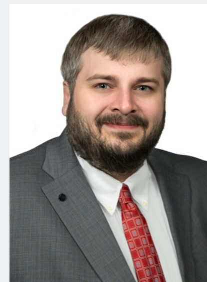

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