Sigelman v. Lawyers' Mutual Insurance Co.

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It is well settled that material misstatements or concealment of material facts in an application for insurance, even if unintentional, entitle an insurer to rescind the insurance policy. (Mitchell v. United Nat. Ins. Co. (2005) 127 Cal.App.4th 457, 468-469 (Mitchell); Ins. Code, §§ 331, 359.)[1] The insurer must prove that the insured made a material "false representation" in the application. A representation is false "when the facts fail to correspond with its assertions or stipulations." (§ 358.) This issue often arises in the context of the manner in which the insured answered a question on the application form.

According to the plaintiff in this case, attorney and professional corporation Kenneth Sigelman, et al. (Plaintiff and Respondent), when he answered a question about claims experience on the application for coverage issued by his former professional liability insurer, defendant and appellant Lawyers' Mutual Insurance Company (Insurer or LMIC), he did not know of any error or omission that "might reasonably give rise to a claim or suit" against him.[2] Following his tender of two legal malpractice claims brought against him by former clients, Insurer paid over $1 million to defend and settle them, subject to its reservation of rights to seek reimbursement.

Plaintiff then filed this complaint for declaratory relief to establish coverage and defense obligations. In response to being sued by Plaintiff, Insurer brought a cross-action for declaratory relief and reimbursement of monies paid on his behalf, and the matter went to court trial. Both sets of pleadings raised the same issues about whether Plaintiff had made false representations in his application for the insurance policy, by failing to indicate or disclose his knowledge about facts known to him relating to "any error or omission" that "might reasonably give rise to a claim or suit" within the upcoming policy period. (§§ 332, 358.) Insurer sought to recover from Plaintiff the amounts it had paid on his behalf to settle the claims, by rescinding or voiding the policy. (§§ 331, 358, 359.)[3] The trial court ruled in favor of Plaintiff and Insurer appeals.

According to Plaintiff, judgment was appropriately issued because his answer on the application for coverage was not inaccurate. He argues he had no obligation to report the known errors and omissions until they matured into a "claim," as he understood that term to be defined in the policy.

He also asserts that the question, as phrased in the application, was ambiguous, and because of these ambiguities, he subjectively and in good faith believed that his answer was accurate, such that the trial judge, who found him credible at trial, correctly determined that his answer was not false.

We disagree with Plaintiff and conclude that Insurer was entitled to judgment. Although there is no existing rule that "an incorrect answer to any question on an insurance application automatically would constitute a material misrepresentation for purposes of rescission" (Mitchell, supra, 127 Cal.App.4th 457, 475), there are many cases in which the materiality of a misrepresentation on an insurance application may be established as a matter of law, and will give rise to a right to rescission of the policy. (Ibid.) The relevant criteria include " 'the nature of the insurance coverage which [applicant] sought, the quality and quantity of the information which was not disclosed,' " and whether the insurer " 'specifically requested the information on its application and therefore relied upon it in issuing the policy.' " (Ibid., citing Imperial Casualty & Indemnity Co. v. Sogomonian (1988) 198 Cal.App.3d 169, 181-182 (Imperial Casualty).) In such a case, the insurer is entitled to rescind the policy. This is such a case, because the evidence at trial about the facts known to Plaintiff demonstrated it was objectively unreasonable for Plaintiff to form any belief that the requested information was not material, and to withhold certain information that he knew.

On de novo review of the policy provisions, in light of applicable statutory provisions, and on materially undisputed facts, we conclude the trial court erred as a matter of law in declaring that Plaintiff was entitled to prevail. The trial court had no basis in the record to utilize a purely subjective standard to evaluate as true the supposed "belief" of Plaintiff, because that belief was not justified by the facts Plaintiff knew as presented at trial. As signed by Plaintiff, the application designated the information requested as material to its decision to issue the policy, and the undisputed facts in the record demonstrate that when Plaintiff applied for the policy, he was in possession of such information about his own practice so that, under a reasonable attorney standard, his answer to the application question was objectively false, as we will explain.

Because of our conclusions about the inadequacy of the answers on the application, we need not reach the additional coverage questions that are argued by the parties, since the policy was void at the outset and subject to rescission. We reverse with directions to issue declaratory relief accordingly.

FACTUAL AND PROCEDURAL BACKGROUND

A. Representation of Plaintiff's Former Clients

Plaintiff Sigelman is an attorney with a well-established personal injury practice, and he is educated in both law and medicine. Beginning in 1987, Plaintiff was issued Insurer's professional liability policy, renewed yearly upon separate applications, until 2005. The policy consists of six articles and a declarations page. The cover sheet of the policy gives notice that "this is a 'claims-made' policy." Article 6 of the policy, "Other Conditions," includes section 6.1 regarding applications, as follows:

"By acceptance of this policy, the Insured agrees that the statements in the application are his representations, that they shall be deemed material, that this policy is issued in reliance upon the truth of such representations and that this policy embodies all agreements existing . . . relating to this insurance." (Bold emphasis omitted.) The application itself contains similar language above the signature line, that the Insurer will rely upon the representations made. Plaintiff did not read the policy, although he looked at the declarations pages received yearly.

In 2002, Plaintiff received referrals from another attorney, Albert Valle, for two personal injury cases. In the first, Ms. Duran and her partner, Mr. Miranda (Clients #1), sought to recover damages for allegedly negligent obstetrical care that resulted in the loss of their baby during delivery. By the time Plaintiff filed the complaint on their behalf in superior court in San Francisco, it was one day before the limitations period ran, and the clerk rejected the pleading because the filing fee submitted was inadequate. The statute of limitations ran before the filing was made, and eventually, demurrers by the defendant health care providers were sustained without leave to amend, based on untimeliness of the complaint. The dismissal was upheld on appeal and review was denied by the Supreme Court on March 17, 2004. Plaintiff did not contact Clients #1 at that time, because he knew the referring attorney was in touch with them. He understood that the statute of limitations on any potential malpractice action would not expire until March 2005. Later, at trial, he admitted that he was aware sometime around October 2002 through early 2003 that he had been professionally negligent in the sense of failing to timely file their complaint.

In 1999, the husband of Ms. Collazo (Client #2) was killed in a vehicle rollover accident in New Mexico, allegedly due to tire tread separation. After the case was referred to Plaintiff, he filed a complaint in New Mexico on September 11, 2002, which was later removed to federal court and then coordinated with a multidistrict litigation case in district court in Indiana, involving defendants Ford and Firestone. At some point, Plaintiff made a $7 million settlement demand. Ultimately, Client #2's case was dismissed after Plaintiff, in his capacity as her attorney, missed certain discovery deadlines and after dispositive defense motions were granted involving spoliation of evidence (missing tire). The district court order terminating the case outlined in excruciating detail the procedural defects for which Plaintiff was responsible. Plaintiff was unable to obtain any relief from the missed deadlines, and defendants obtained summary judgment and dismissal in an order of April 20, 2004. Plaintiff did not contact Client #2 at that time, and he knew the referring attorney was in touch with her. He understood that the statute of limitations on any potential malpractice action would not expire until March 2005. Later, at trial, he admitted that he was aware as of March 2004 that he had committed malpractice in pursuing her case.

B. Policy Terms; Plaintiff's Contacts From Former Clients Regarding Claims

In July 2004, Plaintiff had an existing policy with Insurer, with a policy period running from September 29, 2003-September 29, 2004. In July of 2004, he sought renewal of this professional liability policy, by filling out an application labeled "special risk," although he later testified he did

not know why he was in a special risk category. In the application, he reported two unrelated previous claims against him, one of which was closed and one of which remained under stay while appeals were pending.[4]

In response to another claims experience question, Plaintiff answered negatively, as follows: "G.2. Does the applicant law firm, or any lawyer named in Question No. A9, for whom coverage is sought by this application, have knowledge of any error or omission or any disagreement with the client which might reasonably give rise to a claim or suit against him or her or against the applicant law firm? ___ Yes _x_No. If yes, give details on a separate sheet." (Italics added.) In his application for the previous year's policy, he had also answered no to the same question. On the signature line, he acknowledged that he was aware that the carrier would rely upon his answers.

Effective September 29, 2004, Insurer accepted the application and renewed the policy for another year. The applicable coverage clause in this policy is entitled, Prior Acts Inclusion Endorsement, and it gives a date of August 10, 2000 as the operative date for the endorsement. In pertinent part it provides as follows:

"Subject to the terms and conditions of this policy . . . [e.g., limits of liability and reduction of claim payment], and in reliance upon the representations made in the Application attached to and made a part hereof, the Company agrees to pay on behalf of the Insured all sums in excess of the Deductible stated in the Declarations which the Insured shall become legally obligated to pay as damages as a result of CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED IN WRITING TO THE COMPANY DURING THE POLICY PERIOD: [¶] (a) By reason of any act, error, omission or personal injury arising out of Professional Services rendered or that should have been rendered by the Insured . . . ; [¶] . . . [¶] Provided that such act, error or omission or such Personal Injury happens on or after the PRIOR ACTS INCLUSION DATE set forth below with respect to each Insured. . . . [Aug. 10, 2000]." (Italics added.)[5]

Section 5 of the insurance policy, "Claims," begins by stating that notice of a claim or suit shall be given to the Company "[a]s a condition precedent to the Insured's right to the protection afforded by this insurance. . ." (§ 5.1.)[6] Section 5.3 is entitled "Date Claim Made," and it begins: "No Claim . . . shall be deemed first made against the Insured during the Policy Period if such claim or any act, error or omission . . . giving rise to such Claim was reported by the insured prior to the effective date of this policy to the Company . . . , or was known to the Insured prior to the effective date of this policy." (Italics added.) Section 5.3 next creates a reporting option or requirement for errors and omissions, which reads as follows:

"If during the Policy Period the named insured shall first become aware that an Insured has committed an act, error or omission or Personal Injury with respect to which no Claim has been made and if the Company shall be given written notice of [the specific acts/error/omission; the injury or damage; the circumstances by which insured first became aware of the act/error/omission], then

any claim that may subsequently be made against the Insured arising out of such act, error, omission or Personal Injury shall be deemed for the purpose of this insurance to have been made and reported in writing on the date such notice is received by the Company." (Italics added.)[7]

Shortly before October 15, 2004, Plaintiff received a telephone call and then a letter from an attorney in San Francisco, who stated that Clients #1 had retained him as their attorney to investigate filing an action for professional negligence against him. No one had previously asked Plaintiff to withdraw from their case. On October 19, 2004, Plaintiff forwarded to Insurer that information about the potential claim by Clients #1.

Around March 22, 2005, Plaintiff received a telephone call and letter from an attorney who represented Client #2, stating that an action for professional negligence against Plaintiff would be filed unless he agreed to mediate her potential claims. Again, Plaintiff forwarded to Insurer that information about the potential claim by Client #2, on March 25, 2005.

Moreover, to the extent that Plaintiff now contends that Insurer failed to prove actual reliance on the alleged misstatements or omissions in the application, Plaintiff mistakenly relies upon inapposite tort cases involving fraud and deceit. (Schroeder v. Auto Driveway Co. (1974) 11 Cal.3d 908, 917; Mirkin v. Wasserman (1993) 5 Cal.4th 1082, 1088; McLaughlin v. National Union Fire Insurance Co. (1994) 23 Cal.App.4th 1132, 1148.) The insurance statutes create entirely different standards for reliance upon answers in insurance applications, and this Insurer preserved its rights to dispute coverage when these claims were tendered. Where insurance policies are issued based upon false or incomplete disclosures, they may be rescinded on grounds of materiality of the information withheld, where the policies were void from the outset. This type of legal theory makes it unnecessary for subjective opinion testimony from an underwriter to be presented, to the effect that coverage would have been denied if the information given had been different. Also, this case was tried on declaratory relief theories, presenting issues of law, and not presenting a credibility contest between the insured and the Insurer, particularly looking backward to the time that the insurance contract was entered into. Although the record contains deposition testimony from several of Insurer's claims counsel, including its underwriting manager describing its usual application procedures, the lack of direct underwriter opinion testimony here did not prevent declaratory relief from being issued in favor of the Insurer, as to the rights and duties of the parties under the insurance contract, when they are analyzed under the correct standards.

C. Action Taken by Insurer Regarding Defense; Filing of Complaint and Cross-Complaint

Upon receiving the October 2004 letter from Plaintiff, regarding Clients #1, Insurer's claims examiner notified him Insurer would be conducting a review and investigation of coverage issues. An attorney was appointed to represent him, and Insurer provided a defense.

Upon receiving the March 2005 demand letter regarding Client #2, Insurer forwarded that letter and

the claim file to its outside counsel, Wayne Littlefield. Insurer also forwarded the claim file for Clients #1 to Littlefield, and Plaintiff discussed the cases with him during April 2005. Littlefield then notified Plaintiff on April 26, 2005 that Insurer was taking the position there was no coverage for either claim. Subsequently, Insurer allowed Plaintiff to retain independent counsel.

Plaintiff's independent counsel mediated both cases on his behalf. With his consent, in July 2005, the case for Client #2 was settled for $650,000. Plaintiff was in favor of the settlement to avoid his personal exposure to excess liability. The case for Clients #1 was settled for $400,000 with his consent, because Plaintiff thought he would lose at any malpractice trial.

Plaintiff then filed this action against Insurer to seek declaratory relief that the two claims were covered and Insurer was therefore responsible for paying the settlement funds, defense fees and costs. Insurer followed this by answering and filing its own cross-complaint, seeking a declaration of entitlement to reimbursement of settlement funds, fees, and costs. Insurer relied upon section 5.3 of the insurance policy, entitled "Date Claim Made," to contend that the claims were not covered, and upon the application answers, to support the position that it was entitled to rescind the policy.

D. Trial; Ruling

At trial, the court reviewed the pertinent documents, including stipulated facts about the amounts of the settlements and the attorney fees incurred at mediation. Deposition excerpts from representatives of Insurer were entered into evidence. The court took testimony from Plaintiff and a claims representative of Insurer. Plaintiff testified that he knew Insurer had relied upon the truth of the representations he made in answering the application questions. Plaintiff was not seeking coverage under the policy in effect from 2003-2004, but instead was contending that he had given due notice of the claims when he received them in October 2004, and that he had no actual intent to deceive Insurer in answering the question about whether he knew of any errors or omissions that "might reasonably" have led to a claim against him.

According to Plaintiff's testimony, he was surprised to hear from the new attorney for Clients #1 in October 2004, about malpractice allegations, because their case had been dismissed over a year previously, and he understood that they were no longer together as a couple. Plaintiff also testified that he was surprised to hear from an attorney for Client #2, because of the lapse of time after the dismissal, and because the client had been in touch with the referring counsel, who had not called him. In any case, Plaintiff believed that the adverse summary judgment obtained in her case reflected the current status of the law, and her case was problematic because of missing evidence. He admitted at trial that when he filled out the application, he knew the statute of limitations had not expired as to either Clients #1 or Client #2.

In Plaintiff's testimony, he further stated that even though he was aware that he had made legal errors or omissions in both of those clients' cases, he did not believe that claims had been or would

be filed upon them, within the meaning of a "claims-made" policy. Rather, he thought that he answered the questions in the application correctly, because as of July and September 2004, he had not heard from either set of clients or counsel for them, about a "claim."

Insurer opposed the complaint and pursued its cross-complaint on the same theories, contending that the answers in the application were false under an objective standard, of what a reasonable attorney would have done. Insurer's representative, senior claims examiner Kimberly Adams, testified at trial about the claims department, its examination of the underwriting files, and how this set of claims was referred to coverage counsel, due to concerns about the insured's lack of timely notification of potential claims. The record contains deposition testimony from other claims representatives, claims counsel, an underwriting manager, and outside coverage counsel, describing how these claims were processed and a no-coverage position taken. The underwriting manager testified that the decision whether to require a special risk application to be filled out at renewal time was made on a case-by-case basis, in response to factors such as the insured's claims history with the Insurer, and the longevity of the lawyer's career and law firm, which might demonstrate whether the insured had any management or calendaring issues. Also, Insurer's responses to interrogatories are included in the record, concerning the referral of the file to coverage counsel and the results of his investigation. In particular, Insurer answered a question about any request for rescission of the policy by stating that the grounds for rescission were stated in coverage counsel's letter, which it summarized as stating that Plaintiff had failed to disclose material information in his application for insurance, specifically, the admitted malpractice in the two matters for Clients #1 and #2.

Insurer further argued that it did not make any difference that Plaintiff said he had not read the policy and did not understand the meaning of its section 5.3, regarding the date claims were made. Insurer took the position that in some ways, section 5.3 of the policy expanded the definition of claims, by including those in which only notice of errors and omissions had been given. In any case, Insurer contended that section 5.3 should preclude coverage of the two claims, because Plaintiff had not made the appropriate disclosures. Since Insurer had already paid to defend and settle the cases, it was now seeking reimbursement for nondisclosure. Insurer argued that because of Plaintiff's admitted knowledge about his earlier malpractice, there was no coverage under the 2003-2004 policy, and none was being sought. The subsequent policy, 2004-2005, was unenforceable because of the misrepresentations in the application for it.

In its oral statement of decision, the court began by stating that there were "few disputed issues of fact in this case. The parties agree on most of what happened. However, the parties very much disagree as to the legal significance and effect of what happened." The trial court first evaluated the testimony from Plaintiff as an admission that he had recognized the two instances of malpractice before any claims were made against him. Plaintiff had submitted two applications for insurance by answering question G.2, about errors and omissions that might reasonably lead to a claim, "No." However, the trial court determined that Plaintiff had not falsely answered that question, because:

"First, the question itself is somewhat ambiguous and is subject to the interpretation of the reader, that is, Mr. Sigelman. Mr. Sigelman's position regarding his answer of 'no' is plausible. Second, the court found Mr. Sigelman to be credible. The court's assessment of his credibility on the witness stand is buttressed by the fact that he appears to have been candid about his mistakes to the superior court in San Francisco, to the federal court in Indiana, and to this court. However, the court's conclusion that Mr. Sigelman was truthful does not end the analysis."

Next, the trial court turned to the coverage issues, analyzing the terms of section 5.3 of the insurance policy, regarding the date a claim was made: "No Claim . . . shall be deemed first made against the Insured during the Policy Period if . . . any act, error or omission . . . giving rise to such Claim was . . . known to the Insured prior to the effective date of this policy." The trial court acknowledged that it was undisputed that prior to the effective date of the 2004-2005 policy, Plaintiff knew of both sets of "acts, errors or omissions" that ultimately gave rise to the claims made against him by both sets of clients. The court then drew a conclusion that when the language of section 5.3 is considered in conjunction with other language in the policy and with its placement in the policy, it is ambiguous. Specifically, the cover page states it is a claims-made policy, and there is also a full prior acts inclusion endorsement. The court believed that the statements about errors and omissions in section 5.3 were not conspicuous, because they were placed under the heading of "Claims," but that language actually dealt with limiting coverage. The trial court ruled as follows:

"That language purports to exclude coverage for any claim based on, quote, any act, error or omission, unquote, that, quote, was known to the insured prior to the effective date of this policy, unquote. Logic dictates that in some, and perhaps many, instances an attorney will be aware of an act, error or omission upon which a claim, whether anticipated or unanticipated by the attorney, is later based. Here, for example, Mr. Sigelman was aware of his two errors or omissions, but he did not anticipate the two claims. Although he admits he did not read the entire policy, he was, rightly in the court's view, under the impression he truly had a claims-made policy. He even had a full prior acts inclusion endorsement. The exclusion of claims as contended by LMIC here would effectively turn LMIC's claims-made policy into an occurrence policy for some claims. The language of the policy is ambiguous."

The court further concluded that section 5.3, representing an exclusion, was in conflict with the reasonable expectations of the insured, and was not sufficiently conspicuous, plain and clear to be enforceable. The court therefore ruled for Plaintiff and cross-defendants and against defendant and cross-complainant Insurer. Insurer appeals.

DISCUSSION

These cross-actions each seek declaratory relief about the rights and duties of the parties with respect to this liability insurance policy, regarding the effect of the representations made by Plaintiff in his application for the policy, that he had no knowledge of any error, omission, or disagreement

with a client "which might reasonably give rise to a claim or suit against him" or his firm. Plaintiff had acknowledged in the application that the answers given amounted to information that was material to Insurer's decision to issue the policy, and Insurer would retain the right to rescind, if false answers were given. The application was incorporated into the terms of the policy and the coverage clause states that Insurer relied upon those representations in issuing the policy. Similarly, the "Date Claim Made" section found in the policy, section 5.3, sets forth a procedure to disclose the insured's knowledge of any acts, errors or omissions that have not yet given rise to a claim.

Although the parties have extensively argued on appeal not only the misrepresentation issues, but also coverage claims, and the trial court likewise addressed all those issues, our resolution of this appeal is based only on the standards for evaluating answers to insurance application questions. The trial court's approach was fundamentally erroneous in applying a purely subjective standard to evaluate the truth or falsity of Plaintiff's answers or beliefs in responding to the questions asked by the Insurer. On this record, the facts known to Plaintiff about the fates of the cases of these clients, which were facts that occurred during and immediately after representation and were known to him at times before the limitations period for them to sue him had expired, require us to conclude that as a matter of law, his answers to the application questions were objectively false. The application sought information that he admitted at trial was known to him about certain errors and omissions in the previous cases, and Plaintiff was aware and the application stated that the Insurer would rely on such information in deciding whether to issue the policy. As a matter of law, the omitted information was material to an insurer's decision to issue such a policy, and therefore this insurer is entitled to rescission of the policy.

To explain these conclusions, we outline the applicable standards for evaluating the accuracy, completeness, and materiality of the answers to questions on a professional liability insurance application, and discuss when objective, as opposed to subjective, standards must apply for setting the extent of required disclosures. First, however, we address the procedural propriety of resolving these declaratory relief cross-actions in light of rules set forth in related authority, dealing with pleadings that expressly seek rescission of insurance policies. (§§ 331, 358, 359.) We may then examine the record to evaluate the trial court's resolution of the parties' respective entitlements to declaratory relief, under all of the applicable standards.

I. NATURE OF RELIEF SOUGHT: RESCISSION AND REIMBURSEMENT

In his complaint, Plaintiff sought declaratory relief regarding coverage obligations. In response, the answer and cross-complaint by Insurer sought similar relief, and added allegations that the application responses were inaccurate, such that reimbursement of the policy proceeds paid to settle the underlying cases of Clients #1 and Client #2 should be ordered. On appeal, Plaintiff contends that since Insurer proceeded to defend those cases, even under a reservation of rights, it lost its opportunity to seek rescission of the policy, since Plaintiff had already filed his action before any such relief was specifically requested by Insurer.

"The procedures governing rescission are set forth in sections 1689 through 1693 of the Civil Code. Section 1691 in particular provides: '[T]o effect a rescission a party to the contract must, promptly upon discovering the facts which entitle him to rescind . . .

(a) Give notice of rescission to the party as to whom he rescinds; and [¶] (b) Restore to the other party everything of value which he has received from him under the contract or offer to restore the same upon condition that the other party do likewise, unless the latter is unable or positively refuses to do so. [¶] When notice of rescission has not otherwise been given or an offer to restore the benefits received under the contract has not otherwise been made, the service of a pleading in an action or proceeding that seeks relief based on rescission shall be deemed to be such notice or offer or both.' [Citation.]" (Resure, Inc. v. Superior Court (1996) 42 Cal.App.4th 156, 163-164 (Resure).)

Plaintiff fails to recognize that in cases in which an insured has allegedly withheld information about a pending or potential claim in its application for insurance, the insurer has alternate remedies beyond bringing an immediate action for rescission. As stated in Williamson & Vollmer Engineering, Inc. v. Sequoia Ins. Co. (1976) 64 Cal.App.3d 261, 275 (Williamson): " 'Rescission is not the exclusive remedy of one who has become entitled to avoid a contract by reason of acts or omissions of the other party to it which are fraudulent in their nature. He may cancel the contract by its rescission; or he may seek affirmative relief in a court of equity for any injury sustained by the wrongful act or omission of the other; or he may set up the fraud by way of defense to an action brought to enforce the apparent liability. [Citations.]' [Citations.]" Likewise, in LA Sound USA, Inc. v. St. Paul Fire & Marine Ins. Co. (2007) 156 Cal.App.4th 1259, 1267-1268 (LA Sound), the same argument (proposed by the same plaintiff's counsel involved here) was recently rejected. There, the plaintiffs were contending that the insurer could not rescind the policy "because plaintiffs sued first. They rely on section 650, which provides, '[w]henever a right to rescind a contract of insurance is given to the insurer by any provision of this part such right may be exercised at any time previous to the commencement of an action on the contract.' " (Ibid.) In LA Sound, the court relied on Resure, supra, 42 Cal.App.4th 156, for this reasoning: "[S]section 650 bars an insurer only from filing a separate suit for judicial rescission once a policyholder has filed an action to enforce the policy. [Citation.] It does not deprive insurers of their right under Civil Code section 1691 to provide the required notice and offer to restore simply by serving a pleading seeking rescission. [Citation.] And it does not undermine the '[e]stablished law' that 'clearly affords the insurer the right to avoid coverage by way of cross-claims and affirmative defenses when the insured files an action on the contract before the insurer can file its action for rescission.' [Citation.]" (LA Sound, supra, at p. 1268; see also De Campos v. State Compensation Ins. Fund (1954) 122 Cal.App.2d 519, 529 (De Campos).)[8]

These rules clearly allow the rescission issue to be presented here, even though this is not a fraud cause of action, because this cross-complaint properly sought to enforce statutory standards upon representations made in applications for insurance, by way of declaratory relief. An insurer is entitled to rescission of an insurance contract where there has been a material misrepresentation by the insured "even though the insured's misstatements were the result of negligence or, indeed, the

product of innocence." (Barrera v. State Farm Mut. Automobile Ins. Co. (1969) 71 Cal.2d 659, 666, fn. 4 (Barrera).) Adequate notice of the grounds for rescission were pled in the cross-complaint.

Plaintiff is also incorrect that an insurer must sustain a higher burden of proof regarding intentional fraud, in order to show the insurer's entitlement to declaratory relief regarding reimbursement of benefits paid, based on allegations of material misrepresentations in the application for the policy. (See, e.g., Textron Financial Corp. v. National Union Fire Insurance Co. (2004) 118 Cal.App.4th 1061, 1073-1074.) No proof of an insured's intent to deceive was required in this procedural context: "Courts have applied Insurance Code sections 331 and 359 to permit rescission of an insurance policy based on an insured's negligent or inadvertent failure to disclose a material fact in the application for insurance. [Citations.] One authority has noted that under Insurance Code sections 331 and 359, 'misstatement or concealment of "material" facts is ground for rescission even if unintentional. The insurer need not prove that the applicant-insured actually intended to deceive the insurer.' [Citation.]" (Mitchell, supra, 127 Cal.App.4th 457, 468-469.)

Moreover, public policy supports the actions of an insurer who, as here, provides a defense to an insured, under a reservation of rights, in order to protect the potential interests of an injured third party claimant. In Barrera, supra, 71 Cal.2d 659, it was held that even if an automobile liability insurer had failed to make a required investigation, and thus lost a right to rescind its policy, it had not forfeited other remedies against the insured for misrepresentations made in entering into the policy. The high court was mindful that the purpose of the policy was to protect innocent parties who were injured through the use of automobiles, and the insurer could provide benefits to them under the policy while still pursuing its own insured for damages for wrongful misrepresentation, under the policy. Alternatively, the insurer could defend in an action brought by the insured, by alleging and proving misrepresentations in the application. (Id. at p. 681.)

In short, Insurer was justified in litigating these declaratory relief claims regarding its rights to seek to avoid coverage by bringing cross-claims and affirmative defenses, in response to the insured's action that was brought to enforce the insurance contract obligations. (Resure, supra, 42 Cal.App.4th at pp. 161-163, 167; LA Sound, supra, 156 Cal.App.4th at pp. 1266-1267.) No more explicit rescission language was required to be pled. We may accordingly turn to analyzing the respective claims for declaratory relief about the parties' rights and duties under this policy.

II. ISSUES REGARDING APPLICATION ANSWERS

A. Introduction and Standards

" '[I]nterpretation of a written instrument, even though it involves what might properly be called questions of fact [citation] is essentially a judicial function . . . .' " (Harustak v. Wilkins (2000) 84 Cal.App.4th 208, 214-215 (Harustak).) The interpretation of the meaning of the questions on the application is a matter of law subject to de novo review. (Williamson, supra, 64 Cal.App.3d 261,

268-269.)

In this case, the application is incorporated into the policy, and it designates the requested information as material in nature, with respect to the insurer's decision to issue the policy. The nature of claims-made policies and their reporting requirements allow an insurer to gain knowledge of actual and potential claims, in order to set sufficient premiums and to hold adequate claims reserves. (Pacific Employers Insurance Co. v. Superior Court (1990) 221 Cal.App.3d 1348, 1358-1360.)

Well-established statutory standards exist for evaluating the accuracy of the representations made in applying for insurance, as well as their materiality as to the decision to issue the policy. (§ 330 et seq.) In Resure, supra, 42 Cal.App.4th 156, 161-164, the court relied on De Campos, supra, 122 Cal.App.2d 519, for the proposition that the portions of the Insurance Code pertaining to misrepresentations, concealment, and rescission " 'are in the nature of special provisions pertaining to insurance contracts, which are superimposed upon those provisions of law which govern contracts generally. . . .' " (Resure, supra, at p. 161.) These statutory requirements for disclosure of material information serve as a means of safeguarding the parties' freedom to contract, based upon an accurate assessment of risk. (Mitchell, supra, 127 Cal.App.4th 457, 468-469.)

In evaluating the trial court's application of statutory standards, we apply de novo review. (Harustak, supra, 84 Cal.App.4th at pp. 212-213.) In particular, "the application of a statutory standard to undisputed facts is reviewed de novo. [Citation.]" (Ibid.) Even where there are mixed questions of law and fact when legal issues predominate, a de novo standard of review will be applied. " 'If the pertinent inquiry requires application of experience with human affairs, the question is predominantly factual and its determination is reviewed under the substantial-evidence test. If, by contrast, the inquiry requires a critical consideration, in a factual context, of legal principles and their underlying values, the question is predominantly legal and its determination is reviewed independently.' [Citation.]" (Ibid.)

To determine the outcome of this appeal, we next analyze the undisputed facts about the responses given on the application, in light of the statutory requirements which govern the relationship between insured and insurer, at the application phase of formation of the insurance contract. These are questions of law, "for which appellate courts are particularly well suited." (See Harustak, supra, 84 Cal.App.4th 208, 214-215.)

B. Rules Defining Materiality as Question of Fact or Law; Proof

Generally speaking, "[t]he fact that the insurer has demanded answers to specific questions in an application for insurance is in itself usually sufficient to establish materiality as a matter of law." (Thompson v. Occidental Life Ins. Co. (1973) 9 Cal.3d 904, 916.) An insurer has a right to know all that the applicant for insurance knows regarding the condition or state of the subject of the insurance policy. "Material misrepresentation or concealment of such facts are grounds for rescission of the

policy, and an actual intent to deceive need not be shown. [Citations.] Materiality is determined solely by the probable and reasonable effect which truthful answers would have had upon the insurer. [Citations.]" (Ibid.)

An insurance application seeks information on questions of insurability, risk, and premium for the particular type of potential liability involved. (Mitchell, supra, 127 Cal.App.4th 457, 475-476.) Such information is material if it is sufficiently related to the nature of the insurance coverage sought, based on its quality and quantity, and if insurer has specifically requested the information on its application and thereafter relied upon it in issuing the policy. (Imperial Casualty, supra, 198 Cal.App.3d at pp. 181-182.) In the Insurance Code, "heavy burdens of disclosure are placed upon both parties to a contract of insurance and any material misrepresentation or the failure, whether intentional or unintentional, to provide requested information permits rescission of the policy by the injured party." (Id. at pp. 179-180, fn. omitted.)

An applicant's duty to disclose material facts is governed by these sections:

"§ 332. Required disclosure. Each party to a contract of insurance shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract and as to which he makes no warranty, and which the other has not the means of ascertaining."

"§ 334. Materiality. Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries."

"§ 360. Materiality. The materiality of a representation is determined by the same rule as the materiality of a concealment."

In Imperial Casualty, the court discussed whether this materiality issue should be treated as a factual question or an issue of law. The court characterized the materiality test, with respect to the insurer, as "a subjective test; the critical question is the effect truthful answers would have had on Imperial, not on some 'average reasonable' insurer. [Citation.]" (Imperial Casualty, supra, 198 Cal.App.3d at p. 181.) However, where only uncontradicted evidence is presented about the probable effect of the nondisclosed information, no factual issues remain to be tried. (Id. atpp. 181-182; Croskey, et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2007) ¶ 5:229, p. 5-52.1 (Croskey).) Plaintiff here apparently believes that he had the ability to determine what was material information for the Insurer to consider, in renewing the policy, but the subjective standard he relies upon does not apply to insureds. (Id. at § 5:204, p. 5-44, ["insured's belief not controlling"]; see Coca-Cola Bottling Company v. Columbia Casualty Insurance Co. (1992) 11 Cal.App.4th 1176, 1189, fn. 4.) Applicants for insurance have obligations to disclose known material information, as imposed by the statutes summarized above. (See fn. 9, post.)

Likewise, in Mitchell, supra, 127 Cal.App.4th 457, the court found that there was uncontradicted evidence that certain misrepresentations in an insurance application were material to the type of policy applied for, because: "The information sought went directly to questions of insurability, risk, and premium. The insured admitted that there were misrepresentations on the application, and that the insurer considered the information important to its underwriting decisions. Under these circumstances, a reasonable trier of fact could not find that the representations in this case were not material. [Citation.]" (Id. at p. 476.) There were no factual issues remaining, only questions of law.

In LA Sound, supra, 156 Cal.App.4th 1259, 1269, the court noted that such a misrepresentation on an application will be deemed material when it affects the company's evaluation of risk and the amount of the premium charged. The insurer can make an adequate showing that the misrepresentation was material to its decision, without actually presenting testimony from the underwriters who reviewed the application. Rather, "[m]ateriality may be shown by the effect of the misrepresentation on the ' "likely practice of the insurance company" ' ' "[t]he test is the effect which truthful answers would have had upon the insurer." ' [Citation.]" (Ibid.) Insurer's cross-action in our case requested a determination of no coverage under the policy under the same general grounds relied upon in coverage counsel's letter, i.e., that Plaintiff had failed to disclose material information in his application of insurance, specifically, the admitted malpractice in the two matters for Clients #1 and #2. It was not essential for Insurer to present more specific underwriting testimony, where it was arguing as a matter of law, with support in the record, that the omitted information was material within the terms of the application itself. (See New Hampshire Ins. Co. v. C'Est Moi, Inc. (9th Cir. 2008) 519 F.3d 937, 940 [where an applicant's misrepresentations are properly deemed to be material as a matter of law, testimony from an underwriter is "beside the point" and rescission may be granted]; also see LA Sound, supra, 156 Cal.App.4th at pp. 1268-1269.)

C. Trial Court's Erroneous Use of Subjective Standard for Evaluating Responses

To defend the judgment, Plaintiff argues that the trial court made credibility determinations in the statement of decision and judgment, about Plaintiff's subjective beliefs in the accuracy of his answers to the questions on the application, such that a substantial evidence standard should apply. (See In re Marriage of Hoffmeister (1987) 191 Cal.App.3d 351, 358.) The trial court heard Plaintiff testify that he admitted to knowing about these two instances of clear malpractice, before the application was completed in July of 2004. However, the court apparently accepted Plaintiff's theory that he had a certain understanding of the definition of the terminology, "claims," based on the policy language, so that he did not believe he would become subject to any duty to report the known errors and omissions until they matured into a "claim," as he understood a claim to be defined. Plaintiff contends he had a reasonable expectation that only a formal claim was required to be reported.

Similarly, Plaintiff contends he was confused by ambiguous language in the application and policy, about the meaning of the term "claim or suit," and therefore he was confused about the information

that he was obligated to disclose in the application. However, any such argument incorrectly merges policy provisions relevant to coverage with the definition of "claim" as it is relevant to questions in the application.

On a different note, Plaintiff testified that he did not think these clients would follow through and sue him (because they were unsophisticated or forgiving persons?).

He even seems to argue on appeal that it should make no difference that he did not report this information earlier, since the October 2004 claims might have qualified for coverage under the earlier-issued policy (even though at trial he did not pursue such coverage).

We first observe that Plaintiff cannot rely upon his failure to read the policy as a whole in defense of his subjective beliefs about what the application required, for a "claims-made" insurance policy. (See Telford v. New York Life Insurance (1937)9 Cal.2d 103, 105-107; Appalachian Insurance Co. v. McDonnell Douglas Corp. (1989) 214 Cal.App.3d 1, 19-20.) If he had read it, he would have noted that section 6.1, regarding applications, states: "By acceptance of this policy, the Insured agrees that the statements in the application are his representations, that they shall be deemed material, that this policy is issued in reliance upon the truth of such representations and that this policy embodies all agreements existing . . . relating to this insurance."

We therefore disagree with Plaintiff that the issue of the adequacy of his responses to questions on the insurance policy application boils down to a credibility determination about his beliefs, that would be suitable for substantial evidence review. The trial court erred in concluding that the title of the "claims-made" policy somehow protected the insured from the specific requirements in the application. The nature of the information requested in the application for this professional liability insurance policy requires us, next, to consider whether Plaintiff's asserted beliefs were reasonable under an objective standard, such as how a "reasonable attorney" would respond in answer to such a question.

D. Evaluation of Application Responses: Standards

This case hinges upon the requests in the application for reporting of "errors and omissions" that "might reasonably" lead to a claim or suit being filed, and upon whether the information sought was material with respect to the particular risks being insured. As recognized in Mitchell, supra, 127 Cal.App.4th 457, as cited in Croskey, "Courts are split on whether the insured's answers to questions in the insurance application must be regarded as material as a matter of law, or whether their materiality is a question of fact in each case. [Citation.]" (Croskey, supra, § 5:208, p. 5-45.) Case law has not clearly defined whether an insured's answers in an application should be evaluated by an objective or subjective standard. Different conclusions about how to measure the accuracy of answers on an application for insurance have arisen in the cases, depending on the types of questions asked, the language in the application, and the entire set of circumstances presented. (Mitchell,

supra, at pp. 474-476; Croskey, supra, ¶ 5:212, p. 5-46.)[9]

For example, in Liebling v. Garden State Indemnity (N.J.Super.A.D. 2001) 767 A.2d 515, 517 (Liebling), the appellate court ruled that a question on an application, about whether the attorney-insured "was aware of any circumstances . . . , which may result in a claim being made" was subjective in nature. However, the court also concluded that "no reasonable fact-finder could conclude that his [negative] answer truly reflected his actual opinion." (Ibid.)

In Liebling, supra, 767 A.2d 515, the court relied on Shaheen, Capiello, Stein & Gordon v. Home Ins. Co. (N.H. 1998) 719 A.2d 562, 564(Shaheen), for the observation that when an insurer asks in its application a question such as, "is any lawyer aware of . . . any incident, act or omission which might reasonably be expected to be the basis of a claim . . . ," the insurer is requiring that "its insureds exercise professional judgment at several critical junctures." (Id. at p. 566.) These include an exercise of judgment "before triggering the reporting requirement for potential claims" (ibid.), or in applying for renewal of a policy, such as being asked to disclose " 'any incident, act or omission which might reasonably be expected to be the basis of a claim or suit arising out of the performance of professional services for others.' " (Ibid.) The result in Shaheen was that "the application question would not permit a denial of coverage so long as the insured had made a good-faith professional judgment." (Liebling, supra, 767 A.2d at p. 520.)

"Attorney malpractice is to be determined by the rules that apply to professional negligence generally, subject to the necessary qualification that the court must determine legal questions which underlies [sic] the ultimate decision. There are cases involving the question of attorney malpractice where reasonable minds cannot differ on the ultimate result that the conduct does or does not satisfy the duty of care. In those, the question is treated as one of law and not of fact, as it is in any negligence action. [Citations.] There are cases where regardless of the attorney's negligence his advice or action was correct because of a governing legal principle so that the negligence does not proximately cause harm. [Citations.] Except in those situations, the issue is one of fact." (Wright v. Williams (1975) 47 Cal.App.3d 802, 808-809 (Wright), fn. omitted.) In the latter case, in which a trial court makes such determinations of fact, an appellate court will examine the record to determine any support for the factual findings, in light of the applicable standard of care governing the performance of legal services. (Ibid.)

We next look to the record to determine whether the statutory requirements were adequately complied with by Plaintiff, to disclose errors and omissions that were known or reasonably should have been known in the exercise of his professional judgment.

E. Facts Known to Insured, as Potential Excuses From Duty to Disclose?

Insurer argues for an objective standard to evaluate the undisputed facts, and states that on this set of facts, a reasonable attorney would have known, as of the July 2004 date of the application, that

upcoming malpractice claims from Clients #1 and Client #2 were inevitable or at least so very likely that they amounted to "errors and omissions that might reasonably lead to" a claim, within the language of the application. Insurer points out that the application showed that Plaintiff was in a special risk category already, due to earlier claims against him, and it argues that disclosure was essential under all the circumstances. Further, Insurer argues that any reasonable attorney would have understood this application question as calling for disclosure of admitted previous malpractice instances, in light of the language it used.[10]

To defend his beliefs as reasonable and his application answers as accurate, Plaintiff relies on a number of factors about his state of knowledge in July 2004: the dissolving family situation of Clients #1, the changes in the complexity of the litigation for Client #2, the role of the referring attorney, and/or the silence of the clients and the referring attorney up to that point, regarding any upcoming claims by the clients. There had been some lapse of time (several months) since the underlying, respective adverse dismissals.

None of the factors relied on by Plaintiff to excuse the omissions in his application would justify his professed subjective belief as objectively reasonable, under all the circumstances. The wrongful death cases brought by both sets of these clients, the subject of the errors and omissions, represented significant personal losses to the clients of an ongoing nature with potentially high compensatory values, for which redress was very likely to be sought in some form. Plaintiff had previously evaluated the case for Clients #1 as strong regarding potential liability, and for Client #2, he had previously made a multimillion dollar demand, before the dynamics of the case changed upon its transfer to federal court. It is not dispositive that he now says there were other serious problems with the second case, such as lost evidence.

The dismissals of those cases arguably compounded the personal losses of the clients, by depriving them of redress in the original actions, so that an alternative source of compensation (malpractice damages) might reasonably likely be sought. Nothing in the record shows that Plaintiff was given to believe or assured by the former clients or the referring attorney that no malpractice allegations or actions would be forthcoming. Since the statute of limitations for the filing of such actions had not lapsed, a reasonable attorney would realize under the circumstances that either matter could remain open as to whether claims or suit might still be brought against him during the relevant time periods. Whether the statute of limitations for professional malpractice allegations on a relevant matter has run is a known factor affecting insurability.

This undisputed knowledge of his own professional errors and omissions that led directly to dismissal of the actions he had brought on behalf of Clients #1 and Client #2 placed Plaintiff, as the applicant, on notice that such errors and omissions might reasonably lead to a formal claim being made at some future time after the errors and omissions took place. Not only is the requested information deemed material by the terms of the application, those known facts are material under section 334 with respect to their "probable and reasonable influence" upon an insurer (ibid.), "in

forming [an] estimate of the disadvantages of the proposed contract, or in making [its] inquiries." (Ibid.; see Croskey, supra, ¶ 5:203, pp. 5-44 to 5-48.) Knowledge of such potential upcoming claims might reasonably affect Insurer's decision whether to renew the policy or to adjust the premium, particularly since Plaintiff was in a special risk category, as shown on the application. This created the necessary nexus between Plaintiff's nondisclosures and harm to the Insurer. (See Wright, supra, 47 Cal.App.3d at pp. 808-809.)

Accordingly, this case falls into the categories identified above in Wright, supra, 47 Cal.App.3d 802, 808-809, in whichreasonable minds cannot differ on the ultimate issue whether Plaintiff's conduct of the cases of both sets of clients satisfied the duty of care; he admits and there is no dispute that it did not (i.e., missing the statute of limitations and missing court-ordered deadlines). The next logical step requires us to conclude that reasonable minds cannot differ on whether he should have disclosed the information he had about Clients #1 and Client #2, as requested by the Insurer. Only questions of law regarding the reasonableness of his expectations about the existence of any upcoming claim or suit were presented to the trial court, regarding the accuracy or completeness of his answers to the application questions. The application did not ask about Plaintiff's hopes and fears, it asked about whether he had "knowledge" of any "errors and omissions" or disagreements with a client that "might reasonably give rise to a claim or suit" against him. The nature of the facts known to him put him on notice that these exact circumstances existed, at least until such a time as the applicable statute of limitations for malpractice claims or suits against him had run.

An insured has an independent or statutory duty to disclose material information in the application, regardless of any ultimate coverage determination. (§ 332 [Applicant must communicate to the insurer "in good faith, all facts within his knowledge which are or which he believes to be material to the contract and as to which he makes no warranty, and which the other has not the means of ascertaining"]; italics added.) This duty is particularly supported here by the technical nature of this insurance and the sophistication of the insured, regarding potential claims that might reasonably be thought to arise in the relevant time period, as evaluated by an attorney-insured who is able to exercise professional judgment and has knowledge of his or her own practice that is superior to that of the insurer. (See Telford, supra, 9 Cal.2d at pp. 107-108.)

We emphasize that this opinion is not intended to anticipate all possible scenarios of an applicant insured's known errors and omissions and duties to disclose in this context. Our conclusions are limited to the facts in this record, in which the omitted information goes to the heart of the errors and omissions coverage requested. This application, labeled "special risk," is incorporated into the policy, and it identifies as material the requested information about any negligent acts known to the Insured prior to the inception of the renewed policy. At the time Plaintiff completed the application, he was on constructive notice of two potentially viable malpractice claims or suits against him, that could likely arise from errors and omissions on his part that were well known to him, and that were not disputed at trial. He also knew the statutes of limitations had not expired, and he had received no indication that either client intended to forego a malpractice action. Plaintiff should have understood

the significance of all these factors, in the exercise of his professional judgment. Taken together, all of these factors require us to conclude that as a matter of law, regardless of any subjective intent or belief on Plaintiff's part, the answers he gave are objectively false as to material information.

(Williamson, supra, 64 Cal.App.3d 261, 273; see Shaheen, supra, 719 A.2d 562 at pp. 566-567; Imperial Casualty, supra, 198 Cal.App.3d 169, 179-181.) Insurer is entitled to rescind this policy for noncompliance with the requirements of the application, under statutory standards. (§§ 331, 359; Civ. Code, § 1692; Imperial Casualty, supra, at p. 182.)

F. Further Proceedings

Section 359 provides, "If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false." In Imperial Casualty, supra, 198 Cal.App.3d 169, 184, it is stated: " 'The consequence of rescission is not only the termination of further liability, but also the restoration of the parties to their former positions by requiring each to return whatever consideration has been received. [Citations.] Here, this would require the refund by [Insurer] of any premiums and the repayment by the defendants of any proceed advance which they may have received.' "

This mathematical determination of the respective amounts due should be left to the trial court's resolution. We reverse the judgment with directions to issue declaratory relief in favor of Insurer, including a calculation of the reimbursement of policy proceeds paid on behalf of Plaintiff, as adjusted by Insurer's restoration of premiums paid by Plaintiff.

DISPOSITION

Reversed with directions to conduct further proceedings to issue declaratory relief in accordance with the views expressed in this opinion.

WE CONCUR: HALLER, J., IRION, J.

1. All further statutory references are to this code unless noted. Section 331 states, "Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance." Rescission of a policy is justified under section 359 under these circumstances: "If a representation is false in a material point, whether affirmative or promissory, the injured party is entitled to rescind the contract from the time the representation becomes false."

2. Plaintiff answered "no" to the following application question: "G.2. Does the applicant law firm, or any lawyer . . . , for whom coverage is sought by this application, have knowledge of any error or omission or any disagreement with the client which might reasonably give rise to a claim or suit against him or her or against the applicant law firm? ___ Yes _x_No. If yes, give details on a separate sheet." (Italics added.)

3. In the alternative, the parties disputed whether the subject insurance policy precluded coverage for the two malpractice claims, because of its definitions, policy language and claims requirements.

4. That claims experience question read: "G.3. Has the applicant law firm, or any lawyer named in Question No. A9, had any claim made against it, him or her during the past 10 years alleging any liability arising from the performance of professional services whether or not you were named as a party? [¶] __x_ Yes __ No. If yes, how many? __2__. A separate claims information sheet must be completed for each claim."

5. The Prior Acts Inclusion Endorsement replaces the original section of the policy entitled Coverage for Professional Liability.

6. The cover sheet of the policy reads, "This is a 'Claims-Made' policy," and coverage is limited to claims "which are first made against the Insured and reported in writing to the Company while the policy is in force." In the first article of the policy, definitions are given, including "claim": "a demand including service of suit or institution of arbitration proceedings, for money against an Insured."

7. Plaintiff contends section 5.3 is an exclusionary provision or an optional reporting clause, whereas Insurer claims it is a separate and mandatory reporting requirement. We do not decide any such coverage issues here.

8. In LA Sound, the insured applied for a policy covering advertising injury but failed to disclose information specifically requested by the application, i.e., whether the insured was involved in any joint ventures. That nondisclosure had serious consequences, since the application was held to be a misrepresentation sufficient to void the policy. (LA Sound, supra, 156 Cal.App.4th 1259, 1268-1269.)

9. This dispute about an objective standard for use in evaluating the accuracy of an insured's answers upon an application for insurance should not be confused with the subjective standard that applies to an insurer in deciding whether to accept the application. The insurer is entitled to determine, based on the application answers, whether the policy should be issued and for what premium. (Thompson, supra, 9 Cal.3d 904, 916; Imperial Casualty, supra, 198 Cal.App.3d at p. 181; Croskey, supra, ¶ 5:203, p. 5-44.)

10. Although Insurer has also relied on the policy provisions as expressly requiring disclosure of errors and omissions in an application (e.g., § 5.3), the application circumstances themselves provide a sufficient basis for the disposition of this set of allegations, and we do not decide such coverage issues.