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PROPERTY & LIABILITY INSURANCE COUNSELORS

Insurance Advisory - for Attorneys

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Legal Notes...By Donald I. Renau JD, CPCU, CIC, AAI

An August, 1999, California Supreme Court case covered two important insurance questions and generated great interest of the insurance industry to the tune of 35 Amicus briefs.

The case was Vandenberg v. Superior Court of Sacramento County, 1999.(CA.0042750 <http://versuslaw.com>.)

One issue considered was whether a judicially confirmed award in an arbitration under that state's private arbitration law is entitled to collateral estoppel in favor of a nonparty to the arbitration. The second issue was to determine whether a commercial general liability policy (CGL) which provides coverage for sums the insured is "legally obligated to pay as damages" might cover losses from a breach of contract.

The underlying litigation arose from damage to land that Vandenberg leased from Boyd to use as an auto sales and service facility. Before leasing, the owner had operated an auto dealership on the property. The leases were from 1958 to 1988. In 1998, the lessee ceased doing business and the land reverted to Boyd. In his preparation to sell the land, Boyd removed three underground waste oil storage tanks. Testing revealed contamination of soils and groundwater. Boyd sued Vandenberg for breach of contract, negligence, waste, strict liability among other torts, alleging that the lessee had installed and operated the waste oil storage tanks which were the source of the contamination.

The lessee had a series of CGL policies during his tenancy, many of which had pollution exclusions other than for "sudden and accidental" discharges.

The lessee asked his carriers for defense, but only one, USF&G, agreed to defend. During judicially supervised settlement proceedings, the lessor, lessee and the one carrier agreed to resolve the litigation.

The agreement provided that all would contribute jointly to the investigation and remediation, with the carrier bearing the largest share of the cost, Boyd, the owner, agreed to release USF&G from any claims and Vandenberg, the lessee, agreed to release it from claims of bad faith, breach of contract, and extracontractual damages. Boyd released all claims against Vandenberg except those based on the theory that the contamination constituted a breach of the lease. The two parties then agreed to resort to arbitration on the unsettled theory and that it was to be "binding".

A retired federal judge was the arbitrator, who ruled for Boyd, the owner, in the amount of \$4 Million confirmed by a superior court judgment.

The lessee then filed the underlying action against the other insurers, since they refused to indemnify. The trial court ruled that relitigation of the source and causation of contamination was precluded by collateral estoppel and that there was no coverage for Vandenberg under the policies for the arbitration award because the claims submitted to the arbitrator were contractual.

The Court of Appeal reversed both Summary adjudication orders. It held that a party to a private arbitration is not barred from relitigating issues decided by the arbitrator when those issues arise in a different case involving a different adversary and different causes of action. It also reasoned that when there is damage to property, the focus of the inquiry should be the nature of the risk or peril that caused the injury and the specific policy language, not the form of action brought by the injured party. The California Supreme Court upheld the Court of Appeal.

The court said that a reasonable layperson would certainly understand "legally obligated to pay" to refer to any obligation which is binding and enforceable under the law, whether pursuant to contract or tort liability. It said that "under general insurance principles, we must interpret the phrase...in accordance with the ordinary and popular sense, not the legalistic, and erroneously premised, interpretation of the language urged by insurers".

We often see complaints which don't trigger coverage, such as breach of contract, without allegations of bodily injury or property damage, "covered" breach of contract, personal injury (libel, slander, etc.). The insured is usually dumbfounded that his CGL policy doesn't offer defense or if it does offer, it is under a "reservation of rights letter". Will this case rectify this coverage problem for your clients, especially in other states? We might suggest that in the more complex non-automotive cases, that the complaint be reviewed by an insurance consultant in order to trigger coverage for the defendant based on the assumption that the defendant has the most common policy coverage forms.

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COBRA and the Courts

By COBRA Compliance Systems, Inc.

COBRA Compliance Systems Testifies before the IRS

Five industry experts, including L. Colleen Clearwater, Senior Vice President of COBRA Compliance Systems, Inc. (CCS), testified June 8, 1999 in Washington. DC at the Internal Revenue Service (IRS) hearings on the Final and Proposed COBRA Regulations. Following is an explanation of the New Regulations and recommendations from those who testified:

1. INSIGNIFICANT PREMIUM UNDER PAYMENTS

New Regulation: When a Qualified Beneficiary makes a COBRA payment for an amount that is insignificantly less than the amount due, the plan must either accept the check as payment in full or send a notice to the individual informing them that they need to pay the difference. The IRS recommends the plan give the Qualified Beneficiary a reasonable

amount of time to pay the difference. The IRS suggests that 30 days from the date of the notice would be reasonable.

Recommendation:

- Define "insignificant" in terms of the largest underpayment an employer must accept, by either a dollar amount or a percentage.
- Reduce the 30-day safe harbor period outlined by the IRS (grace period employers must give beneficiaries when re-collecting premiums once an underpayment is received) to ten days.

IRS' next steps?

At some point, the IRS may specify a precise time frame for grace periods following insignificant premium underpayments.

The change would be facilitated through an amendment to the Final Regulations with temporary regulations, a ruling on changing the Final Regulations or an interpretation by the courts when the situation arises.

2. FLEXIBLE SPENDING ACCOUNTS (FSAs)

New Regulation: FSAs most likely would not need to be offered to individuals in any plan year following the year in which the Qualifying Event occurred, and may not need to be offered to the Qualified Beneficiary even at the time of the Qualifying Event.

Recommendations:

- Either stop offering medical FSAs under COBRA or limit them even more than specified by the new Proposed Regulations. Under the current system, many Qualified Beneficiaries take advantage of the system by submitting claims after the Qualifying Event. For example, a person who by March 1 has only funded \$300 of an \$1,800 annual FSA election could get reimbursed for a 2 \$1,500 claim and then drop coverage, leaving \$1,500 unfunded.
- By using a spend-down approach, employers would be required to keep accounts with positive balances open for the remainder of the plan year in which the Qualifying Event occurs. No COBRA election or premium payment would be required. The Qualified Beneficiary would simply use the amount of the positive balance left at the time of the event for the remainder of the plan year. A terminated employee who has funded \$600 of a FSA. But has used only \$400, could use \$200 during the rest of the plan year.

3. ALTERNATIVE COVERAGE

New Regulation: If alternative coverage is provided that meets the definition of COBRA coverage, COBRA need not be offered. If alternative coverage does not meet the definition of COBRA coverage, then COBRA must be offered side by side with the alternative coverage.

Recommendation:

- Clarify the provision that now Includes premium increases as part of the definition of "loss of coverage" since it could confuse Qualified Beneficiaries and cause them to select inferior coverage. For example, a retiree entitled to continue active medical coverage at a higher price but still less than COBRA at 102 percent should not be offered COBRA, which is clearly inferior to his alternative coverage.

IRS' next steps?

According to the IRS, offering COBRA in the above situation still affords employers and beneficiaries procedural protections under the law. One solution could be to apply some of the same mandated COBRA procedures - such as time frames for notification of rights - to alternative coverage as opposed to offering both options.

4. GROUP HEALTH REINSTATEMENT

New Regulation: COBRA Qualified Beneficiaries should be reinstated upon timely election of continuation coverage.

Recommendation:

- Clarify that employers are allowed to reinstate a Qualified Beneficiary on the group health plan once a COBRA premium payment is received. When currently reinstating upon election, employers may be asked by the carrier to pay all back premiums. Require the insurer to reimburse the employer for COBRA premiums paid on behalf of a beneficiary ((if the beneficiary doesn't pay the employer.

CCS also submitted written comments prior to the IRS hearings which included:

DETERMINING COBRA ELIGIBILITY - OWNERS & INDEPENDENT CONTRACTORS

New Regulation: Only full-time and part-time common law employees would count toward the 20 employee count to determine whether a plan is or is not a small employer plan and therefore exempt from COBRA. Self-employed, independent contractors and directors are not counted as employees when determining the 20 count.

While owners and self-employed individuals are often eligible for the group health plan according to the 1999 Final Regulations, they do not count as employee's. In determining whether an employer must comply with COBRA. This provision removes the responsibility for certain employers to comply with the law, thereby decreasing the number of employees and dependents protected by COBRA.

CCS Recommendation

Consider those Involved in the day-to-day business operations as employees for determining COBRA eligibility. Independent contractors would only count if they were eligible for the group health plan.

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Life Insurance & the Law...

By Dave Goodwin

CASH VALUES MAY MASK ABUSES

Choose the correct answer; there's only one:

In a Whole Life policy, the cash value is owned by:

- the insured
- the beneficiary
- the policy owner
- a trustee for the insurance commissioner
- the author of this article
- none of the above

"None of the above" is the only correct answer. The cash value reserve is owned by the insurance company. It serves to fund the level underpayments promised by the policy in the insured's older years --- meaning high 70s, 80s and 90s. It is built by the overpayments in the insured's younger years. In effect, the cash value is a form of premiums - paid - in - advance, to subsidize old age premiums. There are many disadvantages and some advantages to cash values; I feel that most insurance buyers are not given enough information to be able to make informed decisions about their purchase.

In any event, cash values are a legitimate tool to be used by those who want assurance that at about age 75 and thereafter they will be able to renew the policy at the same premium as at original purchase time. (75 is the approximate age when Whole Life rates become lower than term rates).

Potential abuses arise, however, when the purpose and nature of cash values are "sold" by companies and/or agents in misleading ways. Some of those ways include the selling of cash values as "savings," "investment," "retirement" or "pension" plans. Cash values are none of those. In effect, cash values may be seen as (a) the salvage value if the policy is cashed in, or O>) part of the death benefit paid in advance - - - at a cost! - - - if the policy is used as collateral for a loan of its cash value.

This is not the place to weigh the pros and cons of the "Term vs. Cash Value" debate. As an agent, I have bought and sold both term and cash value policies; each has its function. The purpose here is to alert you to potential abuses and to suggest a few ways to help avoid abuses and to identify when they've occurred.

INSURANCE PROPOSALS

If your client is shown a cash value policy as a proposed savings, investment, retirement or pension product, a potential abuse is probably in the making, in my opinion. There have already been class action suits, awards and settlements totaling hundreds of millions of dollars in resolving such abuses, but they continue to be used in sales and advertising. I feel that the vast majority of this *category* of abuse has not yet been cured.

EXISTING POLICIES

If your client owns, or is insured by a cash value policy, a few basic questions might lead to revealing abuse. Such questions might be: "Why did you buy this policy?" "What did your agent say about revealing the cash value?" "Do you have the sales proposal, brochure, advertising, correspondence or any other material about the policy?" Even without such individualized materials, many abuses can be spotted in company promotions, advertising and other widely available items. Discovery, of course, can uncover much more.

Please don't misunderstand. I'm not saying that all cash value policies are necessarily

abusive, or that only such policies are abusive. (There's plenty abuse to go around.) I am saying, however, that by its nature, the cash value policy is easily (and often) misrepresented in ways which materially harm the premium-payer and the beneficiary. The courts have already verified that. I'm saying further that advisors (including attorneys) can help avoid much of the ongoing abuse, can help identify existing abuses which may still be remediable, and can initiate remedies.

Further, because of punitive, coercive clauses in many agents' producer contracts with insurers, agents are often prohibited from advising their clients to drop an abusive policy or to replace it. (Abusive agents' contracts were discussed in a previous issue of "Insurance Advisory for Attorneys.")

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Matters of Insurance & Law

Lee M. Hoffman CIC, LIC, CPIA

Business ownership has its perks, but not without insurance pitfalls.

There are as many reasons for becoming an entrepreneur as there are entrepreneurs. One thing is certain, with the risks come the perks and one of the most frequently provided business perk is the automobile. Its not unreasonable, and usually expected, that the owner of a business be provided a vehicle for their business and personal use. The standard Business Auto Policy (BAP) has very few exclusions regarding the "use" of a covered auto. Racing is one exclusion that comes to mind but for the most part, a covered auto can be used by an authorized driver for most business or pleasure purposes. But what about coverage for "family members". Is any coverage available? After all, the BAP states that coverage is included for "family members".

In at least one jurisdiction, however, "family membership" coverage does not apply to corporations even though the coverage is provided in the policy. In the Texas Supreme Court case of *Grain Dealers Mutual Ins v. Gerald Wayne McKee and wife, Dana Michelle McKee!*, individually and a/n/f of Kelly McKee, a minor, 1997.TX.1095 or on-line by pointing your browser to: <http://www.vesuslaw.com> 943 S.W. 2d 455, 458 (Tex.1997), the court decided in this Underinsured Motorist case that coverage does not apply to "family members" when the only "named insured" is a corporation.

Gerald McKee was the sole owner and stock holder of Future Investments, Inc. The only "named insured" on the policy was Future Investments, Inc. There were no other names on the **BAP** or on the Uninsured/Under-insured Motorists (UM/UIM) endorsement.

While riding in her adult stepsister's car, Kelly McKee, the minor child of Gerald and Diana McKee was severely injured in an auto accident. The insurance companies for the adult sister (living independently and not insured by Grain Dealers) and the other driver paid Kelly \$350,000. Gerald McKee then sought Underinsured Motorists (UIM) coverage from his corporate insurance policy.

The trial court granted summary judgment in favor of McKee, finding that Kelly was entitled to coverage under the policy's UIM. The court of appeals affirmed, concluding

that the policy was ambiguous and that the ambiguity should be resolved in favor of the insured. The Texas Supreme Court however reversed. The Business Auto Policy UIM endorsement provides for three categories of "who is an insured":

1. You and any designated person and any family member of either.
2. Any other person occupying a covered auto.
3. Any person or organization for damages that person or organization is entitled to recover because of bodily injury sustained by a person as described above.

In order for coverage to apply, Kelly would have to be an insured as defined above. In the first category of "who is an insured" above "You" refers only to the named insured (Future Investments, Inc.). In addition, there were no other "designated persons" named on the policy. As for being a family member, since the only named insured was the corporation, Kelly was not a "family member" to the corporation. Under Texas law, and the laws of most jurisdictions, a corporation is an entity separate from its shareholders. Sole ownership and control of a corporations stock is not a basis for ignoring the difference between a shareholder and the individuality of the corporate entity. Therefore, McKee's sole ownership and control of all the corporate stock does not default to "named insured" status on the Future Investments, Inc. insurance policy. The argument was raised that if the policy's family coverage provision could not apply to a corporation, the provision was being illegally nullified. The court stated that when properly endorsed, family coverage could apply for Underinsured Motorist as well as Uninsured Motorist and no fault coverages. One way would to have been the addition of Gerald McKee and or Kelly McKee to the policy or it's endorsements as a "designated person(s)II.

In the second category above, both parties agreed that the auto Kelley was riding in was not a "covered auto". The car Kelley was riding in was owned by her married stepsister's husband. For coverage to apply in the third category, Kelly would have to have been a person covered in #1 or #2. Although Gerald McKee argued ambiguity on several issues, the Supreme Court disagreed.

Attorney's cannot be expected to know all the in's and out's of insurance. However, it makes good sense when consulting with your business clients to advise them that no matter what type of business they form, their personal names and those of immediate family members should appear as "named insureds" or "designated insureds" on their business auto policy. This should include and any applicable endorsements attached to the policy like Uninsured Motorists, Under-insured Motorists and no fault coverages. Better yet, always insure at least one personal use vehicle on a family auto policy.

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As it relates to your clients...
Kevin Quinley CPCU ARM AIC AIM ARE

Seven Ways to Improve Service: Do's and Don'ts of Insurance Client Surveys

Former New York City Mayor Ed Koch was renowned for periodically asking his Big Apple constituents, "How'm I doin'?"

After a long reign, Hizzoner eventually left office when the answer came to be, "Not so good!" Still, he asked.

Attorneys who have an insurance practice must take a page from Ed Koch's book, periodically asking their insurance company clients, "How'm I doin'?"

Periodically take your client's service temperature. Conduct service surveys. Here are seven tips on surveying your insurance clients for customer satisfaction:

Sweat the details! I've gotten law firm service surveys addressed to Kelvin Quinley, Keith Quinley, Kevin Quigley. My assistant - named Cindy - has received from some law firms surveys addressed to Andy, Cathie, etc.

This is like receiving junk mail addressed to "Occupant." What do you do with those? Usually, you throw trash them. If you're going to take the time to survey your customers, sweat the details. the name right. Proofread. Clients think - fairly or unfairly - that if you can't get the little things right, maybe you don't get the Big Things right either. that the message you want to project?

Be mindful of the client's time when designing the surveys. I wish I had time to complete 100 questions over five or six pages. Insurance clients are extremely busy. Their time is at a premium. Ever notice when you go to some hotel chains, they have lengthy surveys in 6-point type? If the survey is longer than, say, ten questions, I don't bother. I doubt I'm unusual. Life is too short and time too scarce to spend 30 minutes completing out a survey, even if it's for a good cause.

Moral: Make your service surveys user-friendly. Determine what are the ten key things you want to know. Limit the questionnaire to no more than that many questions. Present questions in a type size that doesn't induce eye strain.

Don't be afraid of criticism. To find out what your insurance clients like and dislike, you must have the courage to put your ego on the line. Be prepared to brace for criticism. You may find that your clients are satisfied overall. You could learn things that disturb you.

For example, when you send them reports concluding with the comment, "Please call me to discuss," this may annoy some clients. Others may find billings too heavy-handed. Still others might think that seasoned partners do the rainmaking, but the neophyte associates do the work. Don't survey insurance clients unless you're ready to step up to the plate and hear things which may go against your preconceptions.

Acknowledge, even if you don't agree. A few years ago, a Detroit law firm sent me a service survey. Mostly I was complimentary, but I included some constructively critical comments on the response. I expected to hear back from the firm. Instead, there was deafening silence. Nine months post-survey, the firm's partner called to inquire as to why he had received no recent case assignments. I mentioned the lack of suits in his area, adding that I was off-put by not getting any response to my survey comments. He tried to recover by saying that an upcoming partner's meeting would address the survey results. Sure!

Lesson: If an insurance client takes the time and trouble to complete your survey, especially if there are critical items, you MUST follow up to acknowledge. Otherwise, clients become cynical and feel that the firms aren't listening or that the service survey is simply window-dressing.

Construct an action plan. Go a step beyond acknowledging the criticism. Take steps to address the insurance client's and concerns. What are the three things you will do to address client fee concerns? What are the five steps you will take to improve accessibility and responsiveness? What four actions will enable you to harness the Internet to make yourselves easier to do business with? If a client's criticism is unfounded or if it's simply infeasible to address, have a consensus within the firm to this effect. You can't please all the people all of the time.

Close the loop with the client. Let clients know you've gotten the message. More important, let them know what you intend to do. Not every survey suggestion is going to be worthy of implementation. Still, unless you're prepared to "walk the walk" as well as "talk the talk" don't go to the trouble of surveying your insurance clients. Just because insurance work has the reputation of being high volume, don't assume that insurance companies view themselves as commodities or will tolerate mass production, commodity-type service. The trick is to give what appears to be boutique service to an industry which in no way resembles a boutique.

Return to step one and repeat the process. Unfortunately, many law firms view client surveys as something that you do, then cross it off your checklist and move on to the next thing. This is a dangerous approach and undermines a long-term commitment to total quality service. You must have a sustained commitment to set your practice apart from the herd and draw business your way.

Customer service to insurance clients is not a flavor-of-the-month practice. The law firm's service survey is just the start - not the end - of the process. If you really want to know what we think, send us your questionnaire, but design it with these seven principles in mind!

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The Professor's Corner

C. Michael Smith, Ph.D.

Ethics & Creativity - Part 3

In part 1 of this series we explored the relationship between mental preparation and professional competence. We suggested that a lawyer can enhance competency, and go beyond it to creative excellence by understanding the creative process and developing creativity skills. In Part 2, we reviewed the research findings on creative mental process reduced to Four Stages:

- 1. PREPARATION**, and Absorption with the Problem and related Domain.
- 2. INCUBATION**, during which ideas are processed below the threshold of consciousness.
- 3. EUREKA**, the creative synthetic insight. You must decide if it is valuable.
- 4. ELABORATION**, involves refinements and formal articulation in which you make your case public, share your findings. New insights are put to the test, rejected if necessary, or adopted if useful. This is the 90 % perspiration that Thomas Edison spoke of.

In addition to this Four-Stage Process, we'd like to call your attention to four important strategies for increasing and refining the creative possibilities of your own mind. These

strategies are skills that have been developed by the most highly creative individuals in our culture. You can learn them to harness your own creativity and problems resolution skills in legal practice, and in your life generally.

FOUR STRATEGIES FOR ENHANCING CREATIVITY:

Capturing -(Holding On to the Creative stream) When we were children we were very open to creative process. But education and enculturation teaches us convergent thinking, that is, teaches us how to think and perceive like everyone else. In time the creative flow may shrivel to insignificance. Or, we may have kept the valve open a bit. But not much will come of our creativity if we don't know how to grab it. We may have zillions of novel ideas, many of them will be insignificant, but some will be significant. Artists store ideas in sketchpads, gourmets keep recipe cards, entertainers and writers often use cassette tape recorders or journals to capture their ongoing creative flow. These vessels contain ideas, which may later be studied and explored to see if they have any real social value.

2. Challenging - (Usefulness of Error) A.N. Whitehead said, "error is the price we pay for progress". It is through failure, trial and error that innovations often come. When something doesn't work, we may give up our habitual strategies and get creative in trying to think of another way. Often we have to let go of old assumptions. Problems often present us with challenges that are fertile grounds for creative thinking.

3. Expanding - (Use of Domains of Knowledge) Without specialized knowledge of our domain, we will have no problem to challenge us, and nothing for incubation to gestate upon. When a problem arises in our practice, it is important to begin by immersing ourselves in the domain or special areas of law and fact finding. It is only after such conscious and skillful absorption that we can take a break, play golf, and let our unconscious process can organize, synthesize or creatively reorganize what we know.

4. Surrounding - (Environmental Support & Stimulation) Surrounding is simply putting you in the right environment. Often we need our studies or law offices for the fact finding and legal research aspects. We may also need to be around other knowledgeable or resourceful people to stimulate or creative synergy. Eventually, we should take a break from conscious effort. We may then need a place by the Lake or a golf course to support the nonconscious processing, and for working the insights thus gained into a novel solution or proposal.

In our next discussions we shall explore creativity related personality characteristics and habits of mind and attitude that you can begin to cultivate for the purpose of increasing your mind's creative potential.

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