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Insurance Law Alert

July/August 2017

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"We go to them for their experience; their work product is flawless"

***–Chambers USA* 2017, quoting a client**

Massachusetts Supreme Judicial Court Rules That Duty To Defend Does Not Require Insurer To Prosecute Insured's Affirmative Counterclaims

The Massachusetts Supreme Judicial Court ruled that an insurer is not obligated to fund the prosecution of an insured's affirmative counterclaims in the underlying suit. *Mount Vernon Fire Ins. Co. v. Visionaid, Inc.*, 477 Mass. 343 (2017). (Click here for full article)

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The Texas Supreme Court ruled that a judgment against an insured builder was not enforceable against the builder's insurer (notwithstanding the insurer's wrongful refusal to defend) because the judgment was not the product of a "fully adversarial proceeding." *Great American Ins. Co. v. Hamel*, 2017 WL 2623067 (Tex. June 16, 2017). (Click here for full article)

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The Eleventh Circuit ruled that whether an intentional act constitutes an "occurrence" under an insurance policy must be evaluated from the standpoint of the insured and that an intentional shooting by a non-insured party may be deemed a covered occurrence if it was unexpected and unintended by the insured. *Allstate Prop. and Cas. Ins. Co. v. Roberts*, 2017 WL 2683996 (11th Cir. June 21, 2017). (Click here for full article)

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A Tennessee federal district court ruled that although a claim arose during the policy period, insurers were not obligated to indemnify a settlement because the notice of claim was insufficient. *First Horizon Nat'l Corp. v. Houston Casualty Co.*, 2017 WL 2954716 (W.D. Tenn. June 23, 2017). (Click here for full article)

California Appellate Court Rules That Coverage For Pipeline Explosion Is Barred By Professional Services Exclusion

A California appellate court ruled that a professional services exclusion bars coverage for losses arising out of a pipeline explosion. *Energy Ins. Mut. v. Ace Am. Ins. Co.*, 2017 WL 2953677 (Cal. App. Ct. July 11, 2017). (Click here for full article)

Second Circuit Deems Employer's Liability Exclusion Ambiguous

The Second Circuit ruled that an employer's liability exclusion is ambiguous and that an insurer is obligated to defend and indemnify underlying claims against an insured. *Hastings Develop., LLC v. Evanston Ins. Co.,* 2017 WL 2923921 (2d Cir. July 10, 2017). (Click here for full article)

Kentucky Supreme Court Declines To Adopt Expansive View Of "Collapse"

The Supreme Court of Kentucky reiterated that "collapse" must be given its literal interpretation for insurance coverage purposes, which requires falling down or breaking down into pieces. *Thiele v. Kentucky Growers Ins. Co.*, 2017 WL 2598494 (Ky. June 15, 2017). (Click here for full article)

New York Court Rules That Anti-Subrogation Doctrine Bars Insurer's Claim Against Another Insurer

A New York federal district court dismissed an insurer's claim seeking reimbursement for settlement payments from another insurer, finding that the claim is barred by the anti-subrogation doctrine. *Ace American Ins. Co. v. American Guarantee & Liab. Ins. Co.*, 2017 WL 2840286 (S.D.N.Y. July 2, 2017). (Click here for full article)

Computer Fraud Coverage Alert:

New York Court Rules That Fraudulent Wire Transfer Losses Are Covered By Liability Policy

As discussed in previous Alerts, courts have rejected policyholder attempts to obtain coverage for cyber-related losses under computer fraud and similar policy provisions. *See Taylor & Lieberman v. Fed. Ins. Corp.*, 2017 WL 929211 (9th Cir. Mar. 9, 2017) (coverage unavailable under computer fraud provision because sending an email, without more, does not constitute an unauthorized "entry into" a computer system) (March 2017 Alert); *Apache Corp. v. Great American Ins. Co.*, 2016 WL 6090901 (5th Cir. Oct. 18, 2016) (computer fraud provision does not cover claims arising out of the transfer of funds to criminal accounts because a fraudulent email was only one part of a chain of events that caused the loss, and thus the loss was not caused "directly" by computer use) (November 2016 Alert); *Universal Am. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 25 N.Y.3d 675 (N.Y. 2015) (coverage for "fraudulent entry" of data is limited to losses caused by unauthorized access into the policyholder's computer system and does not encompass losses caused by an authorized user's submission of fraudulent information into the computer system) (July/August 2015 Alert).

In a decision issued last month, a New York federal district court distinguished these rulings and held that claims arising out of losses caused by a fraudulent wire transfer were covered by "computer fraud" and "funds transfer fraud" provisions. *Medidata Solutions, Inc. v. Federal Ins. Co.*, 2017 WL 3268529 (S.D.N.Y. July 21, 2017).

Medidata, a cloud service provider, used Google's Gmail platform for company emails. Medidata email addresses contained an employee's first initial and last name followed by the domain name "mdsol.com." When Google processed Medidata emails, it compared incoming email addresses with Medidata employee profiles in order to find a match. Once a match was found, Gmail displayed the sender's full name, email address and picture in the "from" field.

In 2014, a Medidata employee (Alicia Evans) received an email purportedly sent from Medidata's president advising her to follow any instructions received from an attorney named Michael Meyer in connection with a potential corporate acquisition. That same day, Evans received a call from a man who identified himself as Meyer and requested a wire transfer. Evans informed Meyer that she needed email confirmation for the transfer from Medidata's president and approval from the vice-president and director of revenue. Evans thereafter made the requested wire transfer after receiving a group email confirming that the transfer should be made. It was later discovered that the emails were sent from an unknown source and altered to appear as if they were sent by Medidata's president. Medidata sought coverage from Federal under provisions relating to computer fraud, funds transfer fraud and forgery. Federal denied coverage, and Medidata brought suit. The court ruled that the policy provided coverage for the wire transfer losses pursuant to the computer fraud and funds transfer fraud provisions.

The computer fraud provision covers loss arising from the fraudulent entry of data into a computer system or change to data elements of a computer system. The court held that the fraud committed upon Medidata fell within this language because the thief embedded a computer code in the spoofed emails to mask their true origin and thus violated the integrity of the computer system. The court distinguished *Universal*, which involved the inputting of fraudulent content by an authorized user. The court also distinguished

Apache, in which the court denied coverage under a similarly-worded computer fraud provision on the basis that the loss was not caused directly by "computer use." There, the court held that an email was only one step in a "muddy chain of events" that led to a fraudulent wire transfer, whereas here, the loss originated with the spoofed email. Finally, the court deemed *Taylor & Lieberman*, which also involved a fraudulent email, inapposite. Unlike the present case, that case involved an email sent from a client, which is not an unauthorized entry into a computer system.

The court also found coverage available under the funds transfer fraud provision. The court rejected Federal's argument that this coverage was not implicated because the transfer did not occur "without Medidata's knowledge or consent," as required by the policy. The court reasoned that although Evans knowingly made the wire transfer on Medidata's behalf, she did so due to fraud and trickery through the email manipulation.

Finally, the court ruled that the forgery provision did not trigger coverage because there was no alteration of a financial instrument. The court declined to rule on whether the spoofed emails containing Medidata's president's name constituted a forgery, explaining that even if they did, the absence of a financial instrument was fatal to coverage under the forgery provision.

Defense Alert:

Massachusetts Supreme Judicial Court Rules That Duty To Defend Does Not Require Insurer To Prosecute Insured's Affirmative Counterclaims

The Massachusetts Supreme Judicial Court ruled that an insurer is not obligated under the duty to defend to fund the prosecution of an insured's affirmative counterclaims in the underlying suit. *Mount Vernon Fire Ins. Co. v. Visionaid, Inc.*, 477 Mass. 343 (2017).

Visionaid tendered to Mount Vernon a wrongful termination suit filed by a former employee. Mount Vernon defended under a reservation of rights, but refused to pay to prosecute a counterclaim against the former employee for misappropriation of funds. In ensuing litigation, a Massachusetts federal district court ruled that Mount Vernon's duty to defend did not require it to fund the prosecution of the counterclaim. The district court further held that the absence of such a duty did not create a conflict of interest with Visionaid such that Mount Vernon was required to pay the costs of independent counsel. The First Circuit concluded that the appeal raised unresolved issues under Massachusetts law and therefore certified questions to the Massachusetts Supreme Judicial Court as to an insurer's duty to fund affirmative counterclaims.

The court ruled that an insurer's contractual duty to defend does not obligate it to prosecute affirmative counterclaims on the insured's behalf. In so ruling, the court relied on the plain meaning of "defend," rejecting Visionaid's argument that it should be understood to include anything that reduces the liability of the insured. The court also dismissed the notion that an insurer may be obligated to pursue a counterclaim when it is "intertwined" with the defense, stating: "Not only is this proposition found nowhere in the language of the contract, it would result in extensive preliminary litigation to determine what claims are sufficiently intertwined."

The court further held that such an obligation does not arise under the common law "in for one, in for all" doctrine, which requires an insurer to defend all claims in a suit if some are potentially covered by the policy.

Coverage Alerts:

Texas Supreme Court Finds That Insurer Is Not Bound By Judgment Against Insured

The Texas Supreme Court ruled that a judgment against a builder was not enforceable against the builder's insurer (notwithstanding the insurer's wrongful refusal to defend) because the judgment was not the product of a "fully adversarial proceeding." *Great American Ins. Co. v. Hamel*, 2017 WL 2623067 (Tex. June 16, 2017).

The Hamels sued their home builder after discovering water damage. The builder was insured under five consecutive one-year policies issued by Great American. Great American refused to defend based on a stucco exclusion in the last policy, which was in effect when the damage was discovered. Great American later conceded that its refusal to defend was wrongful under Texas' "injury in fact" trigger rule. Prior to trial in the underlying case, the Hamels and the builder agreed that the Hamels would not attempt to enforce any judgment against the builder. In addition, the builder executed stipulations that admitted negligence in the construction of the home. Thereafter, a trial resulted in a judgment in the Hamels' favor. The Hamels, as assignees of the builder's claims, sued Great American, seeking to recover for the underlying judgment. A trial court ruled in the Hamels' favor, finding that because Great American had waived its right to control the defense, it was bound by the judgment. An appellate court largely affirmed the decision. The Texas Supreme Court reversed and remanded the matter for a new trial.

Under Texas law, an insurer that breaches the duty to defend is bound by any covered judgment, but only if that judgment results from a "fully adversarial trial." The court explained that a fully adversarial trial occurs when the parties actually and effectively oppose and contest each other's positions. The controlling factor is whether "the insured bore an actual risk of liability for the damages awarded . . . or had some other meaningful incentive to ensure that the judgment or settlement accurately reflects" the damages. The court concluded that this standard was not met because the pretrial agreement had effectively removed the builder's financial stake to contest liability. Although the court declined to issue a bright-line rule, it noted that a pretrial agreement that eliminates the insured's financial risk creates "a strong presumption" that the judgment did not result from an adversarial proceeding.

Eleventh Circuit Holds That Intentional Shooting May Be An "Occurrence" Based On Insured's Subjective Perspective

The Eleventh Circuit ruled that whether an intentional act constitutes an "occurrence" under an insurance policy must be evaluated from the standpoint of the insured. Therefore, an intentional shooting by a non-insured party may be deemed a covered occurrence if it was unexpected and unintended by the insured. *Allstate Prop. and Cas. Ins. Co. v. Roberts*, 2017 WL 2683996 (11th Cir. June 21, 2017).

The coverage dispute arose out of an intentional shooting at the home of Kim Roberts. Her then-husband, Bobby, shot a guest. When the guest sued Roberts for assault, she sought coverage under her homeowner's policy, which defined "occurrence" as "an accident" that causes bodily injury. Allstate sought a declaration that it had no duty to defend because the shooting was not accidental. A Georgia district court agreed. The Eleventh Circuit reversed.

Applying Georgia law, the Eleventh Circuit ruled that whether an accident occurred depends on the perspective of the insured (rather than the tortfeasor). Thus, if the shooting was not foreseeable to Roberts, it may be deemed accidental under the policy. The court therefore vacated the district court decision and remanded the matter for application of the correct legal standard. The Eleventh Circuit took no position as to other possible bases for Allstate's coverage denial, including Bobby's potential status as an "insured person" under the policy.

Finding Policyholder's Notice Insufficient, Tennessee Court Rules That Insurers Need Not Indemnify False Claims Act Settlement

A Tennessee federal district court ruled that insurers were not obligated to indemnify a settlement based on insufficient notice of a

claim. *First Horizon Nat'l Corp. v. Houston Casualty Co.*, 2017 WL 2954716 (W.D. Tenn. June 23, 2017).

Plaintiffs sought coverage for a $212.5 million payment to the Department of Justice ("DOJ") in settlement of a False Claims Act suit. The insurers denied coverage on the basis that the claim was first made prior to the August 1, 2013 – July 31, 2014 policy period and that Plaintiffs failed to provide sufficient notice. The court ruled that an April 2014 settlement offer constituted a claim within the policy period, but that Plaintiffs failed to give appropriate notice under the policy.

The insurers argued that the claim first arose prior to the inception of the 2013-14 policy period as a result of the DOJ's service of subpoenas and a Civil Investigation Demand. The court rejected this contention, finding that those actions did not constitute a claim because they did not contain allegations of a wrongful act. The court similarly held that a May 2013 Presentation by the DOJ did "not quite constitute a 'demand for monetary . . . .relief' under the Policy to be considered a Claim," although it presented a close question. In particular, the court noted that the Presentation stated the elements of the False Claims Act, cited evidence against Plaintiffs and detailed theoretical damages. However, it also described the investigation as "ongoing" and thus "slightly closer to the 'lodging of a grievance' than a 'request to do something under a particular claim of right."

The court ultimately concluded that a claim first arose in April 2014 (during the policy period), when the DOJ issued an email with a $610 million settlement demand. In so ruling, the court deemed irrelevant Plaintiffs' subjective understanding of whether a lawsuit might ensue, explaining that the settlement email was clearly a demand for monetary relief. Having determined that a claim arose in April 2014, the court concluded that the policyholder's May 2014 notice was timely. However, the court ruled that the notice was deficient because it provided only "general, boiler-plate type language" and it failed to include information about the $610 million settlement demand.

Policy Interpretation Alerts:

California Appellate Court Rules That Coverage For Pipeline Explosion Is Barred By Professional Services Exclusion

A California appellate court ruled that a professional services exclusion bars coverage for losses arising out of a pipeline explosion. *Energy Ins. Mut. v. Ace Am. Ins. Co.*, 2017 WL 2953677 (Cal. App. Ct. July 11, 2017).

Kinder Morgan, an owner and operator of oil and gas pipelines, used employees provided by Comforce, a staffing company, for construction of a water supply line. During construction, an excavator struck an unmarked petroleum pipeline, resulting in an explosion that killed and injured several workers. Kinder Morgan sought coverage from its own insurers and from ACE, which insured Comforce under an umbrella policy. ACE denied coverage based on a professional services exclusion and also argued that Kinder Morgan was not an additional insured under the policy. Ruling on cross-motions for summary judgment, a trial court held that the exclusion bars coverage, but that an issue of fact exists as to whether Kinder Morgan was an additional insured. The appellate court affirmed.

The professional services exclusion provides that "[t]his insurance does not apply to any liability arising out of the providing or failing to provide any services of a professional nature." Although the policy did not define the terms used in the exclusion, the court held that the exclusion's meaning is clear because "services of a professional nature"

has a generally accepted meaning – services arising out of employment that involve specialized knowledge, labor, or skill that is predominantly mental or intellectual, rather than physical or manual. The court further held that the activities involved in owning and operating a pipeline, including mapping and marking underground installations, are professional services because they involve specialized knowledge and generally require extensive experience and education. Thus, the court held that the failure to mark the pipeline that exploded falls squarely within the ambit of the exclusion. The court noted that even if some underlying claims do not arise out of professional services, coverage is nonetheless barred because any such claims are "inseparably intertwined" with the excluded professional services claims.

Finally, the court held that neither the additional insured endorsement nor the separation of insureds clause creates coverage. Even assuming that Kinder Morgan was an additional insured under the ACE umbrella policy (an issue in dispute), the separation of insureds clause does not provide coverage for Kinder Morgan because both Comforce and Kinder Morgan engaged in professional services in connection with the pipeline.

Second Circuit Deems Employer's Liability Exclusion Ambiguous

The Second Circuit ruled that an employer's liability exclusion is ambiguous and that an insurer is obligated to defend and indemnify underlying claims against an insured. *Hastings Develop., LLC v. Evanston Ins. Co.*, 2017 WL 2923921 (2d Cir. July 10, 2017).

Evanston issued a general liability policy to Universal Phonics, Inc. ("UPI") that provides coverage for certain Named Insureds, including Hastings, a subsidiary of UPI. When a UPI employee was injured in Hastings' building, he sued UPI, Hastings, and several other companies. Hastings tendered the action to Evanston, which denied coverage based on the employer's liability exclusion. In ensuing litigation, a New York federal district ruled that the exclusion does not bar coverage. The Second Circuit affirmed.

The exclusion provides that there is no coverage for claims arising out of injury to "an employee of the Named Insured arising out of and in the course of employment by any Insured, or while performing duties related to the conduct of the Insured's business." Evanston argued that this language unambiguously bars coverage for injured employees of all listed Named Insureds. In support of this position, Evanston noted that the policy defines "employee" to include "any member, associate, leased worker, temporary worker of or any person or persons loaned to or volunteering services to, any Named Insured." In contrast, Hastings argued that the phrase "the Named Insured" (as opposed to "a Named Insured" or "any Named Insured") creates ambiguity as to the scope of the exclusion. Additionally, Hastings argued that the Separation of Insureds provision (which requires each Named Insured to be treated individually for purposes of determining coverage) supports its contention that the exclusion applies only if the employee is employed by the specific Named Insured that is seeking coverage. Thus, Hastings reasoned, the exclusion does not bar coverage as to claims against Hastings, because the injured worker was an employee of UPI. The Second Circuit agreed, finding the policy language ambiguous under the circumstances.

Property Insurance Alert:

Kentucky Supreme Court Declines To Adopt Expansive View Of "Collapse"

Declining to abrogate state precedent, the Supreme Court of Kentucky reiterated that for insurance coverage purposes, "collapse" must be given its literal interpretation, which requires falling down or breaking down into pieces. *Thiele v. Kentucky Growers Ins. Co.*, 2017 WL 2598494 (Ky. June 15, 2017).

A homeowner sought coverage for termite damage under a policy provision covering "collapse." The insurer denied coverage on the basis that no actual collapse had occurred. The homeowner sought a declaration of coverage, which a Kentucky trial court granted. An intermediate appellate court reversed, and the Kentucky Supreme Court affirmed.

The Kentucky Supreme Court expressly declined to adopt "the more lenient majority rule" under which a structure need not actually collapse or be in imminent danger of collapsing, so long as the damage "substantially impairs" the structural integrity of the building. Instead, the court adhered to the plain meaning of "collapse," finding that it requires a structure to fall down, break or cave in order to invoke coverage under the collapse provision.

Subrogation Alerts:

New York Court Rules That Anti-Subrogation Doctrine Bars Insurer's Claim Against Another Insurer

A New York federal district court dismissed an insurer's claim seeking reimbursement for settlement payments from another insurer, finding that the claim is barred by the anti-subrogation doctrine. *Ace American Ins. Co. v. American Guarantee & Liab. Ins. Co.*, 2017 WL 2840286 (S.D.N.Y. July 2, 2017).

The dispute arose out of an employment-related injury. The underlying defendants (a school district and a contractor) were both insured under various liability and excess policies, some of which were issued by the same insurers. American Guarantee issued policies to Pelham School District and Wager Contracting, while ACE issued a policy only to Wager. The parties ultimately reached a settlement and an interim funding agreement under which American Guarantee contributed $1.5 million and ACE paid $3.5 million. Thereafter, ACE sued American Guarantee, alleging that it was responsible for the entire $5 million. Ruling on the parties' cross motions for summary judgment, the court ruled that American Guarantee was responsible for the full settlement amount.

Under New York's anti-subrogation doctrine, an insurer "has no right of subrogation against its own insured for a claim arising from the very risk for which the insured was covered." The court ruled that the anti-subrogation rule prevents American Guarantee from bringing an indemnity claim as the subrogee of its insured (Pelham) against another of its insureds (Wager) in order to access Wager's coverage under ACE's policy. The court explained that the only way that American Guarantee could shift its share of the settlement to ACE is via a subrogation claim on behalf of Pelham against Wager. But because American Guarantee also insures Wager for at least one of the underlying claims resolved by the settlement, the anti-subrogation rule applies.

The court rejected American Guarantee's attempt to frame the issue as a coverage priority dispute (*i.e.*, that American Guarantee's policy is excess to ACE's policy), explaining:

> It is [ ] a mistake to focus solely on coverage priority as to Wager Contracting, because American Guarantee can only reach that entity (and its other insurance coverage) through an indemnity claim on behalf of one insured, Pelham, against another insured, Wager Contracting – which is the exact route blocked by the anti-subrogation rule.

The court also rejected American Guarantee's argument that the anti-subrogation rule does not apply because the policy justifications underlying the rule (avoiding conflicts of interest and improperly passing losses back to the insured) were not implicated. The court held that the rule applies regardless of policy implications and that in any event, American Guarantee was, in fact, attempting to shift liability to a policyholder that it insured for that very risk (albeit ultimately to another insurer).

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Simpson Thacher has been an international leader in the practice of insurance and reinsurance law for more than a quarter of a century. Our insurance litigation team practices worldwide.

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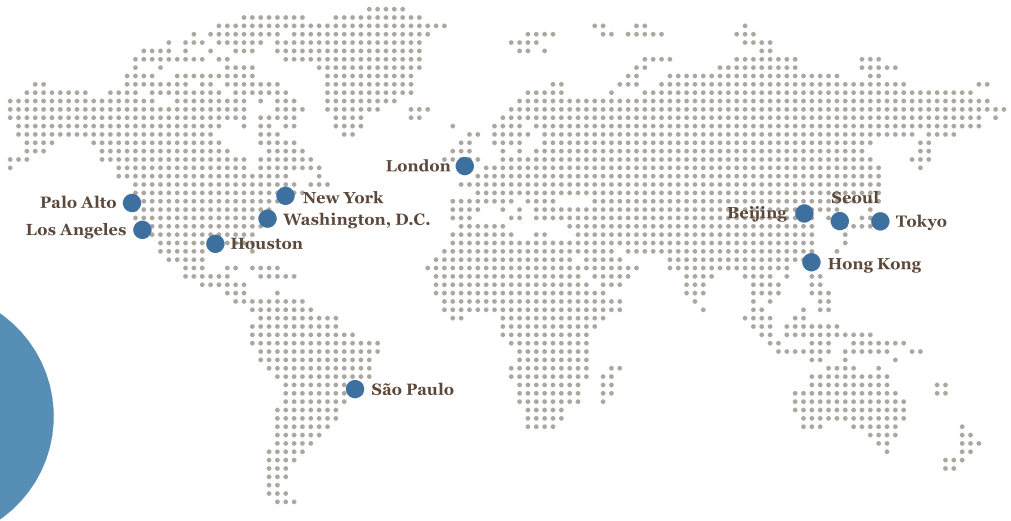

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