2003-04 Survey of New York Law

INSURANCE LAW

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INTRODUCTION

During this *Survey* year, the New York Court of Appeals and other New York Courts have rendered a number of important decisions involving several significant issues of Insurance Law. Most notable among the decisions are several concerning an insured's timely notice of an occurrence or suit to the insurer and whether New York will abandon its "no-prejudice" rule for a requirement that an insurer prove prejudice to sustain a disclaimer of coverage for untimely notice. This *Survey* year also included two opposing jury verdicts in the Southern District of New York in the continuing coverage litigation over the tragic events of September 11, 2001 and the destruction of the World Trade Center (WTC) in the terrorist attack on the United States that was discussed in this *Survey* article in the last two years. This article will focus in depth on these significant cases and others from the state and federal courts in New York.

I. LIABILITY INSURANCE

A. Timely Notice

Without a doubt the most significant and widely contested insurance coverage issue being litigated in New York in the past year has been whether New York will abandon its "no-prejudice" rule in light of the 2002 decision of the Court of Appeals in *Matter of Brandon (Nationwide Mut. Ins. Co.)*.[1] As noted in the last two *Survey* articles [2]

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[1] 97 N.Y.2d 491, 769 N.E.2d 810, 743 N.Y.S.2d 53 (2002).

in *Matter of Brandon* [3] the Court of Appeals created a crack in New York's "no-prejudice" rule for primary insurers when it rejected the insurer's argument that a SUM policyholder's failure to timely submit a summons and complaint (*notice of suit*) vitiated the policy without the insurer demonstrating that it had been prejudiced by the delay.[4]

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[2] Alan J. Pierce, *Insurance Law, 2001-2002 Survey of New York Law*, 53 SYRACUSE L. REV. 673, 684-685 (2003); Alan J. Pierce, *Insurance Law, 2002-2003 Survey of New York Law*, 54 SYRACUSE L. REV. 1241, 1250-1252 (2004).

One of an insured's primary obligations under most liability insurance policies is to provide "timely notice" of an accident or occurrence and of a suit to the insurer. In this
regard, New York has been known far and wide as the "no prejudice" state. Thus, under almost all insurance policies governed by New York law an insured's failure to furnish timely notice an accident or occurrence or notice of a suit (i.e., the summons and complaint) vitiates an insurance contract, and the insurer may rely on this defense regardless of whether it can demonstrate that the insured's failure operated to its prejudice.

Under most liability policies the insured has separate obligations to give notice of an accident or occurrence "as soon as practicable" and to "forward immediately" to the insurer the summons and complaint against the insured.

[3] 97 N.Y.2d 491, 769 N.E.2d 810, 743 N.Y.S.2d 53 (2002).

[4] Lower courts immediately began applying the rule that late notice of a lawsuit against a tortfeasor where the insured was making a SUM claim would not preclude the coverage unless the insurer the language from *Brandon*.

See State Farm Mut. Auto. Ins. Co. v. Sparacio , 297 A.D.2d 284 (2d Dept. 2002); *Banks v. American Manufacturers Mut. Ins. Co.*, 306 A.D.2d 120, 122 (1st Dept. 2003) ("[a]n insured's late notice to the insurer of the pendency of a legal action against the tortfeasor does not vitiate SUM coverage absent a demonstration that the insurer has been prejudiced by the delay.").

Last year's *Survey* article noted that the much anticipated sequel to *Brandon* did not occur in 2003 in *Mark A. Varrichio & Assocs. v. Chicago Ins. Co.*[5] because of a settlement in the action.[6] This *Survey* year, however, produced a number of opinions, from Supreme Court, the Appellate Division, and the Court of Appeals on the continued viability of the "no-prejudice" rule in New York with the possibility of a definite ruling by the Court of Appeals by the time this article is published.

In *Argo Corp. v. Greater New York Mut. Ins. Co.*,[7]the First Department affirmed the dismissal of the insured's complaint for failure to give timely notice of the underlying action. The short memorandum decision contains little if any facts. It simply indicates that the record demonstrates that the summons and complaint in the underlying action was served on the Secretary of State, who forwarded a copy to the insured at the same address where the notice of default in the action was admittedly received approximately one year later. Apparently, there was a certified mail receipt that had been signed by someone at Argo accepting the mailing from the Secretary of State. Argo apparently asserted that it never received the Secretary of State's mailing of the summons and

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[5] 312 F.3d 544 (2d Cir. 2002) (question certified whether New York requires an insurer to demonstrate prejudice to disclaim coverage based on the insured's failure to timely provide notice of suit under a professional liability policy); 99 N.Y.2d 545, 753 N.Y.S.2d 805, 783 N.E.2d 895 (2002) (certified question accepted); 328 F.3d 50 (2d Cir. 2003) (certified question withdrawn); 100 N.Y.2d 527, 760 N.Y.S.2d 761, 790 N.E.2d 1190 (2003) (certified question withdrawn).

[6] Pierce, *supra* note 2, 54 SYRACUSE L. REV. at 1251.

[7] 1 A.D.3d 264, 767 N.Y.S.2d 577 (1st Dep't 2003), *lv. granted* 3 N.Y.3d 602, N.E.2d __, 782 N.Y.S.2d 405 (2004).

complaint and that its first notice of the accident and claim involved was from service of a notice of default in the underlying action.

The First Department held that *Argo* failed to establish that the signature on the certified mail receipt relating to the Secretary of State's mailing of the summons and complaint did not belong to one of their employees or a person authorized to accept on their behalf and therefore Argo was unable to provide an excuse for its failure to comply with the policy's notice provisions. The First Department distinguished *Brandon* by asserting that unlike the situation in *Brandon* "this is not a case where the carrier had prior notice of the claim before the action was commenced."[8]

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[8] *Id.*

I have reviewed copies of the Briefs submitted in the Appellate Division, First Department, which shed some additional light on the facts in the case. The slip and fall accident on property owned by Argo occurred on January 2, 1997. The injured plaintiff acknowledged that he never notified Argo of the accident. On December 27, 1999 the injured party filed suit against Argo and affidavits of service indicate that the summons and complaint was personally served on Argo on February 9, 2000 and by the Secretary of State, but Argo alleged that they never received service of process through either method. Argo never appeared in response to the summons and complaint. A default judgment was entered on January 29, 2001. Argo asserted that it first received notice of the action when it received a copy of the Order granting a default judgment with notice of entry on February 13, 2001. After Argo learned what the action was about and the alleged date of the accident it gave notice to GNY, who disclaimed coverage solely on the grounds of late notice. Argo moved to vacate the default judgment and at a hearing provided testimonial and documentary evidence to establish the procedures it had in place for receipt of legal process and that documents relating to this lawsuit were never received. The motion to vacate was granted and the personal injury action proceeded without prejudice to any of Argo's defenses.

Notably, *Argo* presents an unusual circumstance where Supreme Court in the personal injury action has apparently determined after a hearing that Argo did not properly receive notice of the accident or claim until it received the default judgment, but in the coverage litigation the court has determined, on motion, apparently to the contrary

and concluded that Argo received notice when it was served through the Secretary of State over a year earlier. Since GNY was not a party to the underlying personal injury action it was not bound by the earlier determination that the default should be lifted because Argo did not receive notice of the accident until after entry of the default judgment. This highlights one of the troublesome problems with adhering to a strict "no-prejudice" rule in New York.

In *St. Charles Hosp. & Rehab. Center v. Royal Globe Ins. Co.*,[9] then Supreme Court, and now Appellate Division, First Department Justice James Catterson expanded *Brandon's* "prejudice" requirement to a general liability policy, as opposed to a SUM coverage claim, and to both notice of occurrence and notice of suit, whereas only notice of suit was involved in *Brandon*. In a strongly worded Decision dated April 28, 2004, Justice Catterson ordered Royal, a primary liability insurer, to *indemnify* its insured, St. Charles Hospital, despite a nine month delay in giving *notice of claim and suit*, and clearly stated that the time has come for New York to eliminate the "no-prejudice" exception regardless of the type of insurer.

The facts were largely undisputed. This declaratory judgment action was commenced by St. Charles Hospital against Royal for a defense and indemnification of an underlying action involving a claim for malpractice in the delivery and post-delivery care of then 21-year old Tara Mulholland, who was born on March 16, 1975. In June

[9] ___ Misc.2d ___, ___ N.Y.S.2d ___ (Sup. Ct., Suffolk Co. 2004). The decision appears to be unpublished, but the slip opinion is available at www.nysba.org (click on Sections/Committees; Torts, Insurance & Compensation Law Section; Insurance Coverage).

1994 the Medical Records Department of St. Charles received a letter from the law firm of Black & Black requesting Tara's medical records. Three months later the Medical Records Department received a letter from a different law firm requesting the obstetrical records of Tara's mother. On March 7, 1996 Tara's grandparents and legal guardians commenced the underlying medical malpractice action on her behalf against St. Charles and three doctors employed by the Hospital. At the time of commencement of the malpractice action, neither the Diocese of Rockville Centre (which operated St. Charles), nor St. Charles were insured by Royal; they were self-insured. At the time of Tara's birth, however, St. Charles was named as an additional insured on a $500,000 primary policy and on a $12,000,000 excess policy sold by Royal to the Diocese. The Risk Department Manager for St. Charles forwarded the summons and complaint to the Hospital's attorney, who wrote to Royal about the underlying lawsuit on January 15, 1997, nine months after it had been commenced. The attorney wrote in his letter that "It wasn't until we forwarded a bill to St. Charles that we were advised that Royal should be paying the bill." On March 10, 1997 Royal disclaimed coverage "on the grounds that Royal did not receive notice [. . .] until January 16, 1997, nine months after a lawsuit had been filed." [10]

The underlying malpractice action was settled for $4.3 million dollars before the court in March 2004. St. Charles moved for summary judgment on the grounds that Royal's disclaimer was improper because New York required that Royal must show

[10] Slip op. at 4.

prejudice and that as a matter of law Royal cannot show prejudice. In the alternative, St. Charles argued that it had a reasonable excuse for the delay in giving notice and that there was a triable issue of fact on the reasonableness of its excuse. Royal cross-moved for summary judgment on the ground that St. Charles did not comply with the notice of claim provision and that Royal properly disclaimed coverage because it was not required to show prejudice and that St. Charles' claim of a reasonable excuse was a "fantasy."[11]

Justice Catterson held that "Royal was required to demonstrate prejudice" and that "Royal, as a matter of law, cannot show prejudice."[12] The court began by acknowledging New York's stance as one of two states maintaining a "no-prejudice" standard in insurance law, but observed, after citing and discussing *Brandon*, that "the time has come for New York to recognize what the majority of other states have recognized, namely that the egregious imbalance between insurer and insured needs to be corrected."[13] Royal maintained that the *Brandon* Court did not disturb the traditional "no-prejudice" exception as it applies to primary insurers. The court's response was emphatic:

> Royal has failed to recognize the turning of the tide. Indeed, this Court finds Royal's reasoning oddly oblivious to the demonstrable aversion with which the Court of Appeals has scrutinized the "no-prejudice" rule which allows insurers to "avoid their obligations to premium-paying clients."[14]

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[11] *Id.*

[12] *Id.*

[13] *Id*. at 5.

[14] *Id.*

Justice Catterson then discussed and analyzed the recent decisions in Tennessee and Colorado which rejected the "no-prejudice" rule, which were cited in *Brandon*, as well as the Court of Appeals' prior decision in *Unigard Security Ins. Co., Inc. v. North River Ins. Co.*[15] In discussing *Unigard*, Justice Catterson noted that "New York's Court of Appeals has not newly arrived at this juncture," clearly referring to rejection of the no-prejudice rule.[16]

The court then considered the circumstances of this case and found "that no sound reasons exist for extending the 'no-prejudice' exception to a situation where notice of

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[15] 79 N.Y.2d 576, 581, 594 N.E.2d 571, 584 N.Y.S.2d 290 (1992). In *Unigard*, the Court of Appeals held that the "no-prejudice" rule does not apply to a failure to comply with the prompt notice requirement in a contract of *reinsurance*. The Court concluded that the rationales for New York's no-prejudice rule did not apply to a reinsurer who is not responsible for providing a defense, investigating the claim or attempting to get control of the claim in order to affect an early settlement. *Id*. at 581-583, 594 N.E.2d at 573-574, 584 N.Y.S.2d at 292-293.

Even many courts thought *Unigard* was "the beginning of the end" of the "no-prejudice" rule in New York. *See Matter of Crum & Forster Organization v. Morgan*, 192 A.D.2d 652, 596 N.Y.S.2d 472 (2d Dep't 1993) (refusing to apply "no-prejudice" rule to a dispute between two primary insurers contributing pro rata to uninsured motorist coverage for an insured where one insurer sought contribution from the other; the court found that the insurer claiming untimely notice had to establish prejudice); *American Home Assur. Co. v. International. Ins. Co.*, 219 A.D.2d 143, 641 N.Y.S.2d 241 (1st Dep't 1996) (held that an excess insurer must allege and demonstrate prejudice when asserting late notice of claim or occurrence as a defense against the claim by a co-excess insurer suing for contribution), *rev'd* 90 N.Y.2d 433, 684 N.E.2d 14, 661 N.Y.S.2d 584 (1997).

When the Court of Appeals unanimously and emphatically reversed in *American Home*, however, and specifically held that the limited "prejudice" rule recently adopted by the Court with respect to reinsurers in *Unigard* is inapplicable to excess insurers, this appeared to be the end of any erosion or elimination of the "no-prejudice" rule except for reinsurers in New York. That is, until *Brandon* in 2002.

[16] *Id.* at 6.

legal action served also as notice of claim, and where an investigation of the underlying claim could not have been launched any sooner than twenty-one years after the occurrence."[17] Quite simply, Justice Catterson found that since the earliest date that St. Charles could have provided notice of claim or suit to Royal was March 1996 and this was twenty-one years after the occurrence, Royal had already lost the opportunity to investigate the claim or negotiate a settlement on a timely basis through no fault of its insured. Therefore, the rationales for the no-prejudice rule simply did not apply. In so holding, the court rejected Royal's argument that the 1994 requests for medical records should have prompted St. Charles to notify Royal of a potential claim.[18]

The only "news" from the Court of Appeals this *Survey* year on the "no-prejudice" vs. "prejudice" debate was a little noticed decision in *American Transit Ins. Co. v. Sartor*,[19] which addresses a unique timely notice of suit statute. This case involved a motor vehicle accident between a taxi cab and a motor vehicle, implicating Vehicle & Traffic § 370(4), a statute which requires a taxi owner and operator to provide written notice to its insurer within 5 days of an accident or face a misdemeanor. Interestingly, the injured party, Sartor, notified the insurer of the accident three months after it occurred and requested policy and adjuster information. American Transit never responded to Sartor's notice and request and no one ever notified it that he commenced an action

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[17] *Id.* at 7.

[18] *Id.* at 7.

[19] 3 N.Y.3d 71, 814 N.E.2d 1189, 781 N.Y.S.2d 630.

against the insureds. The issue in the case was whether the statute obligated American Transit to satisfy a default judgment later entered against the insureds.[20]

In reaching its conclusion, the Court reiterated several standard, well-settled principles of insurance law. "Distinct from notice of an accident, an insurer may also demand that it receive timely notice of a claimant's commencement of litigation."[21] Reviewing the language of the policy, the Court found that the insurer's receipt of notice is a condition precedent to its liability. Citing *Security Mut. Ins. Co. of N.Y. v. Acker-Fitzsimons Corp.*,[22] *Brandon*, and *Unigard*, the Court wrote that "[t]he failure to satisfy this requirement may allow an insurer to disclaim its duty to provide coverage."[23] Although the Court did not specifically mention "prejudice," the Court's citation to *Brandon* and *Unigard* suggests that their "prejudice" standard may be applicable here, although the reference to *Security Mutual* adds confusion to the mix. Moreover, substantial prejudice could be inferred from the fact that no one ever notified the insurer of the suit and the Default Judgment that was subsequently taken, although American Transit was aware of the motor vehicle accident and never responded to the notice and request from Sartor's attorney. If the Court applied a prejudice standard it must have found it present because it held that American Transit "properly disclaimed coverage of

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[20] *Id*. at 73-75, __ N.E.2d at __, 781 N.Y.S.2d at 631-632.

[21] *Id*. at 75, __ N.E.2d at __, 781 N.Y.S.2d at 632.

[22] 31 N.Y.2d 436, 293 N.E.2d 76, 340 N.Y.S.2d 902 (1972). *Security Mutual* is most often cited as the leading case for the "no-prejudice" rule.

[23] *Id*.

the default judgment on the ground that it did not receive notice of the federal litigation."[24]

In *Blueridge Ins. Co. v. Jiminez*[25] the Second Department found a question of fact whether the insured in that case had a reasonable, good-faith belief in non-liability which would excuse their delay in providing notice to their insurer 90 days after learning of the accident. Notably, the insureds argued that New York should abandon the "no-prejudice" rule, but the Appellate Division stated that "whether such precedent should be overruled is a matter for the Court of Appeals."[26]

In *Rekemeyer v. State Farm Mut. Auto Ins. Co.*[27] Appellate Division, Third Department granted summary judgment to an insurer and dismissed an insured's SUM claim, holding that the insured did not act with reasonable promptness in notifying her auto insurer of her intent to make a SUM claim without citing *Brandon* or discussing whether *Brandon's* "prejudice" requirement was applicable. The facts are relatively straightforward. On May 8, 1998 the plaintiff was injured when the automobile she was

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[24] *Id.* at 79, __ N.E.2d at __, 781 N.Y.S.2d at 6354. Finally, for a good, albeit abbreviated, discussion of the legal and public policy pro's and con's of abolishing New York's "no-prejudice" rule that was published after *Unigard* and before the Court of Appeals ruled in *American Home*, *see* Alan J. Pierce (*Yes: New York Should Adopt Majority Position*) and Evan H. Krinick (*No: Public Policy Considerations Are Paramount*), *Should 'No Prejudice' Rule be Abolished?,* N.Y.L.J., Jan. 13, 1997.

[25] 7 A.D.3d 652, 777 N.Y.S.2d 204 (2d Dep't 2004)

[26] *Id.* at 652, 777 N.Y.S.2d at 206.

[27] 7 A.D.3d 955, 777 N.Y.2d 551 (3d Dep't 2004), *lv. granted* __ N.Y.2d __, N.E.2d __, __ N.Y.S.2d __ (Sept. 24, 2004).

driving was rear ended. On April 27, 1999 plaintiff commenced a personal injury action against the other driver seeking $1,000,000 in damages. According to the court, as early as July 1999 plaintiff asserted she was suffering from severe and permanent injuries to her left arm and cervical spine. On or about September 27, 1999 plaintiff learned that the other driver's insurance policy provided less coverage than her own bodily injury liability coverage. It was not until March 31, 2000, however, that plaintiff first notified State Farm of her intent to make a SUM claim. On April 10, 2000, the other driver's carrier offered to settle plaintiff's claim for $50,000, the limit of its policy.[28]

There is no indication in the Third Department's decision that any argument was made by the plaintiff that the court should adopt the *Brandon* "prejudice" requirement in this case. Moreover, I find it significant that there is no discussion in the Court's decision whether plaintiff's notice to State Farm of her intent to make a SUM claim on or about March 31, 2000 was actually plaintiff's first notice to State Farm of the accident or of the underlying personal injury action against the other driver which was nearly a year old. It seems extremely unlikely that an insured who was rear ended in an accident in May 1998 would never have contacted her insurance agent or insurance company to put them on notice of the accident or that she would have waited almost a year after commencing the personal injury action to first notify her insurer. Obviously, if the March 2000 notice of intent to make SUM claim was the first notice of the accident to State Farm, it is difficult to imagine a reasonable excuse for a two year delay in providing notice. If, on the other

[28] *Id.* at ___, 777 N.Y.S.2d at 552-553.

hand, State Farm had known about the accident early on, it certainly could have investigated and may well have done so from at least a property damage standpoint. That would seem to make it extremely unlikely that State Farm could satisfy a prejudice standard.

In *Cade & Saunders, P.C. v. Chicago Ins. Co.*[29] Senior District Court Judge McCurn held that the insured law firm and attorneys had a good faith belief in non-liability excusing a delay in giving notice to the insurer. Before doing so, however, Judge McCurn rejected the law firm's argument that the insurer had to show prejudice before disclaiming coverage on the basis of late notice. In discussing *Varrichio*, the court wrote that "[it] does appear, as plaintiff suggests, that the tide may be turning in New York in terms of a showing of prejudice in the context of late notice," but citing a recent Second Circuit decision found that "at least for the time being, the state of the law on the issue of prejudice is unchanged in New York: there is no requirement that an insurer make such a showing when claiming late notice."[30] The court specifically noted that "[t]his District Court is not free to disregard the relevant precedent within the Circuit."

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[29] 332 F.Supp.2d 490 (N.D.N.Y. 2004).

[30] *Id.* at 496-497. Judge McCurn cited *Green Door Realty Corp. v. TIG Ins. Co.,* 329 F.2d 282 (2d Cir. 2003), in which, just 12 days after the certified question was withdrawn in *Varrichio*, the Second Circuit reiterated the "no-prejudice" rule in New York without citing or discussing either *Brandon* or *Varrichio*. The Second Circuit wrote that "[a]bsent a valid excuse, an insured's failure to provide timely notice of a claim to its excess insurer is a complete defense to coverage, *regardless of whether the carrier was prejudiced by the late notice*." *Id.* at 287 (emphasis supplied).

By far, the most significant and controversial decision regarding the no-prejudice rule during this *Survey* year was the First Department's decision in *Great Canal Realty Corp. v. Senecca Ins. Co., Inc.*[31] In a 3-2 decision the court affirmed the denial of Senecca's motion for summary judgment dismissing the complaint on the grounds of late notice, but the decision resulted in three written opinions. The plurality opinion of Justices Catterson and Ellerin, written by Justice Catterson, the author of the *St. Charles'* decision noted above, rejected the no-prejudice rule in favor of the prejudice requirement of *Brandon* in a case involving notice of an accident/occurrence and a general liability policy. Justice Lerner would have affirmed solely on the basis of Supreme Court's decision, specifically that there was a triable issue of fact as to whether Great Canal's delay in notifying Seneca of the underlying accident and claim was timely under the circumstances and whether Great Canal demonstrated the existence of a reasonable and good-faith belief in its non-liability excusing the late notice. The dissent, authored by Justice Marlow and joined in by Justice Tom, would have reversed and granted summary judgment to Senecca on the grounds that an intermediate appellate court it should follow the existing precedent applicable to notice of an accident or occurrence on a general liability policy, namely the no-prejudice rule and not speculate on whether the Court of Appeals would apply *Brandon* to this case, and that Great Canal could not establish a good faith belief in non-liability excusing late notice as a matter of law.

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[31] 2004 NY Slip Op 09419 (1st Dep't December 21, 2004); available at the First Department's web site at www.nycourts.gov/courts/ad1.

The underlying facts are relatively straight forward. Mr. Chong, an employee of a subcontractor, was injured on May 7, 2002 when he fell from a ladder during the course of renovation work on property owned by Great Canal. A few weeks after the accident Great Canal's President, Ms. Lai, was informed about the accident for the first time by a foreman of the general contractor, Well Done Enterprises, who told Ms. Lai that the problem would be taken care of under Well Done's worker's compensation policy which covered Great Canal as an additional insured. Four months later, in September 2002, Great Canal was served with a summons and complaint alleging violations of Labor Law §§ 200, 240, and 241. Ms. Lai immediately notified Senecca and Senecca disclaimed coverage on the basis of late notice.[32]

After Great Canal commenced the declaratory judgment action, Senecca moved for summary judgment, arguing that Ms. Lai was aware of the occurrence for four months before Great Canal notified it. In opposition, Great Canal argued that it gave notice to Senecca immediately upon receipt of the summons and complaint, but did not notify Senecca earlier because of its belief that worker's compensation was the exclusive remedy and because of its good faith belief in non-liability because Ms. Lai did not know more than the basic fact of the accident and had no knowledge of how the accident happened or the nature of the injury until the suit was commenced. The Supreme Court

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[32] *Id*. at *1. The CGL policy issued by Senecca provided that the insured "must see to it that we are notified as soon as practicable of an occurrence or an offense which may result in a claim." *Id*. at *1-2.

denied Senecca's motion, finding a triable issue of fact on whether Great Canal had a valid excuse for the delay in notice given the limited information provided to Ms. Lai.[33]

Justice Catterson's opinion left no doubt about the primary issue in the case, writing that "the Court is confronted with the validity of the no-prejudice exception in New York whereby an insurer can disclaim coverage without demonstrating prejudice when its disclaimer is based on late notice of an occurrence."[34] Justice Catterson began his legal analysis by quoting Justice Cardozo from a breach of contract action that "[t]here will be no assumption of a purpose to visit venial faults with oppressive retribution."[35] Justice Catterson also noted that the Court of Appeals went on to hold in that case that "[s]omething, doubtless, may be said on the score of consistency and certainty in favor of a stricter standard. The courts have balanced such considerations against those of equity and fairness and found the later to be the weightier."[36] Justice Catterson characterized the Court of Appeals' philosophy in *Jacob & Youngs* as "contrary" to the "now *** well-settled law in New York" regarding late notice and the no-prejudice rule.[37]

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[33] *Id*. at *2.

[34] *Id*. at *1.

[35] *Id*. at *2 (quoting *Jacob & Youngs, Inc. v. Kent*, 230 N.Y. 239, 129 N.E. 889 [1921]).

[36] *Id*.

[37] *Id*. at *3.

He also noted that whether an insured has a reasonable good faith belief in non-liability and therefore whether the insured has a duty to give notice to the insurer "are questions which are particularly fact sensitive. Indeed, New York Courts have wrestled with the question in numerous decisions."[38] Justice Catterson noted that the Court of Appeals "has recognized that New York's 'no-prejudice' standard is an exception to the well-established principle of general contract law that a non-breaching party must show that a breach was material, or that it was prejudiced by the breach, before being relieved of its obligations to perform under a contract."[39] Justice Catterson, like the Court of Appeals in *Brandon*, noted that New York "now finds itself in the minority of jurisdictions" enforcing the no-prejudice rule and that as a result insurers in New York have "been granted, wholly through judicial largess, the benefit of a conclusive presumption of prejudice."[40]

Justice Catterson wrote that "[o]ur concern in the instant case, where the time lapse between injury and notice was just four months, prompts us to examine the inequities inherent in granting insurers the benefit of a conclusive presumption of

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[38] *Id*. He noted that the full spectrum could range from the requirement that notice be given every time an injury occurs because of today's "litigious society" as represented by case law on one end of the spectrum and existing case law on the other end of the spectrum that notice is not required for every "trivial mishap." *Id*.

[39] *Id*. at *4 (citing *Matter of Brandon, supra*, 97 N.Y.2d at 496, 769 N.E.2d at 813, 743 N.Y.S.2d at 56 and *Unigard, supra,* 79 N.Y.2d at 581, 594 N.E.2d at 573, 584 N.Y.S.2d at 292 [1992]).

[40] *Id*.

prejudice in derogation of fundamental principles of the law of contracts."[41] Moreover, he wrote that the court need not need to look any further than "the antipathy demonstrated by the Court of Appeals" toward the "no-prejudice" exception in *Brandon* and the fact that the Court in *Brandon* "appeared to applaud two jurisdictions, Colorado and Tennessee, that had recently moved to a prejudice standard ***."[42] He also noted that other jurisdictions that moved to a prejudice standard generally agreed that the condition of timely notice "should not be given greater scope than required to fulfill its purpose" given the "draconian character of forfeiture ***."[43] In this case, Justice Catterson wrote, Senecca did not explain why it deemed the four month period between the accident and receipt of notice of the lawsuit as untimely largely because under the no-prejudice rule it did not need to explain why it considered the notice untimely and that Senecca "may well have disclaimed coverage just 'because it could'."[44]

In response to the dissent, which he wrote "urges strict adherence to precedent ***," Justice Catterson again quoted Judge Cardozo that "[t]he power of precedent, when analyzed, is the power of the beaten track."[45] Acknowledging that "there is a historical reluctance in this jurisdiction to 'inhibit the freedom of contract by finding insurance

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[41] *Id*.

[42] *Id*.

[43] *Id*. (quoting *Great Am. Ins. Co. v. C.G. Tait Const.*, 279 S.E.2d 769, 774 [N.C. 1981]).

[44] *Id*. at *5.

[45] *Id*. (quoting Cardozo, The Nature of the Judicial Process, at 80).

policy clauses violative of public policy ***,' " Justice Catterson wrote that " the time has come for this Court to look at 'the end which ought to be attained' and acknowledge that freedom of contract is a fiction when applied to insurance policies."[46] Justice Catterson referred to both Pennsylvania and Kentucky decisions rejecting the no-prejudice rule in favor of a prejudice requirement to the effect that an insurance contract is not a negotiated agreement, that its provisions are largely dictated by the insurance company to the insured, and that standard form insurance policies are contracts of adhesion and offered to policy holders on a "take it or leave it" basis. The end result of this analysis is that since insurance policies are contracts of adhesion any ambiguity must be liberally construed in favor of the insured.[47] According to Justice Catterson, "[i]n interpreting notice provisions to require automatic forfeiture in the event of non-compliance, New York law ignores that precept."[48] He noted that Great Canal's policy, like most policies, provides no guidance as to the meaning of the phrase "as soon as practicable". Because insurers did not define the term, in 1979 the Court of Appeals concluded that the phrase "as soon as practicable" is an elastic one, and that "soon" is expressly qualified by the word "practicable."[49] In his opinion, Justice Catterson noted a

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[46] *Id*. (quoting *Slayko v. Security Mut. Ins. Co.*, 98 N.Y.2d 289, 295, 774 N.E.2d 208, 212, 746 N.Y.S.2d 444, 448 [2002].

[47] *Id*. at *5-6.

[48] *Id*.

[49] *Id*. (*citing Mighty Midgets v. Centennial Ins. Co.*, 47 N.Y.2d 12, 19, 389 N.E.2d 1080, 1083, 416 N.Y.S.2d 559, 563 [1979]).

number of decisions where extremely short delays in providing notice (including ten days, thirteen days, or fifty-three days) were deemed untimely, but other cases where seven and one-half months, three years, fourteen months, or a year were found timely, and wrote:

> Setting aside the confusion that is produced by decisions disparate enough to hold that a delay of ten days is untimely but a delay of three years is not, there is a more interesting observation to be made about lengthy delays which are adjudicated as "prompt" or "as soon as practicable". The only possible explanation is that jurists and juries alike will go to great lengths to find extenuating circumstances or, in New York, a valid excuse for alleged delays because of the abhorrence of the law for forfeitures.[50]

Addressing *Brandon* and the precise legal issue in this case, Justice Catterson wrote:

> While the *Brandon* Court was not dealing with the precise issues before us, its rationale in concluding that the no-prejudice exception should not apply to disclaimers of late service of legal papers, militates equally toward moving to a "prejudice" standard as to the initial notice requirements. *** Thus, the *Brandon* decision is the clearest signal yet of the Court's acknowledgment of the soundness of the principle followed by the majority of other states, namely, that the egregious imbalance between insurer and insured needs to be corrected. It would appear that the time has come for New York, too, to adopt that principle in furtherance of the foregoing positive public policy goals.[51]

According to Justice Catterson, he and Justice Ellerin "see no reason to extend the 'no-prejudice' exception to allow insurers to disclaim coverage on the basis of late notice of

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[50] *Id*. at *6-7.

[51] *Id*. at *7.

claim where ‘lateness’ is an arbitrary temporal standard applied to a lapse between occurrence and notice, and where contractual rights favor just one party, the insurer.”[52] In a footnote, Justice Catterson wrote that the issue of whether the burden should be on the insurer to prove prejudice or on the claimant to show that the insurer has suffered no prejudice should be decided consistent with the fact that the *Brandon* Court placed the burden of proving prejudice on the insurer.[53]

Justice Lerner concurred in the result but which affirmed the denial of summary judgment, with Justices Catterson and Ellerin, but did so solely on the ground that “questions of fact exist in this matter as to whether plaintiff’s delay was timely and whether plaintiff demonstrated a reasonable belief in its non-liability, thus precluding summary relief.[54]

Justices Marlow and Tom dissented in an opinion by Justice Marlow. As relevant here, the dissent does not express disagreement with Justice Catterson on whether the no-prejudice rule should continue to be the law of New York or whether it should be replaced by the prejudice requirement; the dissent simply takes the position that this change in law must come from the Court of Appeals because as a matter of appellate practice the Appellate Division may not read the “tea leaves” of *Brandon* and decide for itself that the time has come for abandoning the no-prejudice rule. Specifically, Justice

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[52] *Id*. at *7.

[53] *Id*., fn.4.

[54] *Id*. at *8-9.

Marlow wrote that whether the no-prejudice rule should be replaced with a requirement that the insurer prove prejudice "should be adopted as a law of this State is, in my judgment, a decision which I believe inappropriate for this court to make in face of the long-standing, clear and contrary decisional authority from our State's highest court."[55] He further wrote:

> It is my strong view that, as an intermediate appellate court, we must follow the clear and long-standing rule which our highest court laid down decades ago *** and has recently reaffirmed ***.
>
> Contrary to the plurality writing, I believe we ought not act prematurely to change such a fixed precept, simply based on dicta which does not, with any precision, inform us whether the court will, or might, change an important policy, whether any possible rule change will be a change in whole or in part, or further, whether any change will impose a burden on the insured to prove prejudice or on the insured to prove its absence ***.[56]

As noted above, in June 2004 the Court of Appeals granted leave to appeal in *Argo*[57] and in September 2004 granted leave to appeal in *Rekemeyer*.[58] Oral argument on

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[55] *Id*. at *11.

[56] *Id*. at *12.

[57] 3 N.Y.3d 602, __ N.E.2d __, 782 N.Y.S.2d 405 (2004).

the cases is scheduled in February 2005 and a distinct possibility exists that we will have a clear and direct answer to whether New York is going to abandon the no-prejudice rule for a requirement that an insurer, in order to disclaim coverage on the grounds of late notice of occurrence (accident or claim) or failure to timely forward suit papers, will be required to establish prejudice consistent with the vast majority of jurisdictions in the United States. It is entirely possible, however, that there may be no definitive answer on this question despite the Court having granted leave in these two cases. Either way, however, there should be a much clearer path or direction on this issue in New York during the next *Survey* year.

1. The Insured's Good Faith Belief in Non-Liability

As a number of the decisions discussed above involving timely notice demonstrate, there continues to be a divergence of opinion on what constitutes an insured's good faith belief in non-liability that excuses failure to give notice of an accident or occurrence until the insured learns of a lawsuit or claim raising out of that accident or occurrence.

Thus, in *Blue Ridge*[59] the Second Department found a question of fact on good faith belief in non-liability even though the insureds learned that their uncle was injured when he fell on the exterior stairs of their home within two days of the occurrence, but

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[58] __ N.Y.2d __, __ N.E.2d __, __ N.Y.S. __ (Sept. 21, 2004).

[59] 7 A.D.3d 652, 777 N.Y.S.2d 204, *supra*.

did not provide notice to the insurer until suit was commenced three months after the accident. Unfortunately, the opinion contains no additional information regarding the basis for the insured's allegation that he had a good faith relief in non-liability.

Similarly, in *Cade & Saunders*[60] District Court Judge McCurn found, after a trial, that the law firm had a good faith belief that the trial court's denial of their motion to provide disclosure of expert witnesses, and the resulting preclusion of expert testimony, in a personal injury action would not give rise to a legal malpractice claim. The court relied on the facts that the attorneys accepted the case only one month before trial and made diligent efforts to retain experts and provide disclosure, they were unaware that prior counsel had orally agreed to an earlier deadline for disclosure, the relevant statute appeared to permit disclosure at or on the eve of trial, and the clients were closely related to one of the attorneys and never said anything about making a malpractice claim until a year and one-half after the final appellate ruling affirming the jury verdict in favor of the defendant when the attorney received a letter asserting a potential legal malpractice claim on behalf of their prior personal injury client.

In *Great Canal*[61] Justice Lerner agreed with the trial court in his concurring opinion that the insured property owner, through its president, Ms. Lai, had a good faith belief in non-liability because she had been told only that an accident had occurred, but nothing about the nature of the accident or the injury, and that it would be taken care of

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[60] 332 F.Supp. 2d 490, *supra*.

[61] 2004 N.Y. Slip. Op. 09419, *supra*.

by the general contractor's worker's compensation insurance. On the other hand, in dissent, Justices Marlow and Tom found as a matter of law that the insured did not have a good faith belief in non-liability that would excuse the four month delay in giving notice of the accident to Senecca. Justice Marlow wrote:

> Once plaintiff's president was charged with knowledge of the accident and had no reasonable basis to rely on the subcontractor's false representation that it would cover the underlying accident, she was required to give notice as defined by the policies' terms. ***
>
> Based on this record, I perceive no circumstances which would justify a time period more than a brief number of days to notify the insurer. Indeed, no matter how "as soon as practical" or "reasonable" is defined, all plaintiff's president needed was a day or two, with relatively little effort, to consult with a reasonable resource to determine whether she was obligated to notify her insurance carrier of the underlying accident. A mere phone call to her attorney, a call to her insurance broker, or a review of the insurance policies would have been enough for her to realize that notice was required based on a potential claim.[62]

Finally, in *Fischer v. Centurion Ins. Co.*,[63] the court held that plaintiff, who did not notify his insurer of an accident until 15 months after it occurred, failed to demonstrate a reasonable excuse for the delay. The court held it was not reasonable for plaintiff to believe that he would not be liable when, shortly after the accident occurred, he knew that a tenant fell down stairs in his building, and that the tenant required surgery for the injury she sustained. Moreover, the fact that the plaintiff did not timely notify the insurer,

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[62] *Id*. at *10.

[63] 9 A.D.3d 381, 780 N.Y.S.2d 612 (2d Dep't 2004).

despite having timely contacted his insurance broker about the accident and acquiring the defendant's telephone number, was inconsistent with plaintiff's claim of having a good faith belief in non-liability.[64]

B. An Injured Party's Standing to Bring a Declaratory Judgment Action Against the Insurer.

In *Lang v. Hanover Ins. Co.*,[65] the Court of Appeals held that an injured plaintiff does not have standing to bring a declaratory judgment action against a tortfeasor's insurer to test the insurer's disclaimer of coverage before securing a judgment against the tortfeasor. In so holding, the Court of Appeals resolved a split between the First, Third, and Fourth Departments, all of which had previously ruled that a stranger to the policy did not have standing, and the Second Department, which had previously held that the injured plaintiff does have standing to sue the tortfeasor's liability insurer for a declaration of coverage.[66] Interestingly, the Court of Appeals resolved this conflict among the Appellate Divisions without ever indicating that such a conflict existed or that there was any contrary authority from the Second Department.

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[64] *Id*. at 381, 780 N.Y.S.2d at 613.

[65] __ N.Y.3d __, __ N.E.2d __, __ N.Y.S.2d __ (2004), available at the Court of Appeals web site at www.courts.state.ny.us/ctapps.

[66] *See Lang v. Hanover Ins. Co.*, 309 A.D.2d 1123, 766 N.Y.S.2d 915 (3d Dep't 2003), *aff'd* __ N.Y.3d __, __ N.E.2d __, __ N.Y.S.2d __ (2004); *University Garden Apts, L.P. v. Nationwide Mut. Ins. Co.*, 284 A.D.2d 975, 726 N.Y.S.2d 901 (4th Dep't 2001); *Watson v. Aetna Cas. & Sur. Co.*, 246 A.D. 57, 675 N.Y.S.2d 367 (2d Dep't 1998); *Clarendon Place Corp. v. Landmark Ins. Co.*, 182 A.D.2d 6, 587 N.Y.S.2d 311 (1st Dep't 1992).

Lang was injured when he was struck in the eye while playing paint ball fired by a houseguest of the homeowners where the incident occurred. Hanover disclaimed coverage under the homeowner's liability policy on the grounds that the houseguest was not an injured party under the policy. After Lang commenced a personal injury action against the houseguest he learned that the houseguest had filed a Chapter 7 Bankruptcy petitioner. Lang then commenced this declaratory judgment action against Hanover challenging the disclaimer of coverage and sought a declaration that the houseguest was insured under the homeowner's policy. Hanover answered and moved to dismiss the complaint on several grounds, including the fact that Lang lacked standing to sue Hanover directly because he had not yet obtained a judgment in the underlying action.[67] Supreme Court denied the motion to dismiss, but the Appellate Division reversed and dismissed the declaratory judgment action on the grounds that Insurance Law §3420 precludes a direct action by an injured plaintiff against a tortfeasor's insurer until a judgment has been obtained and served on the insurer and remains unpaid for thirty (30) days.

Judge Graffeo, writing for the Court, noted that it is undisputed that the parties to an insurance contract may bring a declaratory judgment action whenever there is an actual controversy concerning the extent of coverage, but that the issue in this case "is whether, and under what circumstances, a stranger to the policy – an injured party who has sued a tortfeasor – can bring a direct action against the tortfeasor's insurance

[67] *Slip Op.* at 2-3.

company for a determination of coverage issues."[68] The opinion notes that at common law "an injured person possessed no cause of action against the insurer of the tort-feasor" and, in fact, that even after obtaining a judgment against a tortfeasor who was insolvent the injured plaintiff could not sue the insurance company directly.[69] Against this common law backdrop, the Court noted that in 1917 the Legislature "remedied this inequity by creating a limited statutory cause of action on behalf of injured parties directly against insurers" that is presently codified at Insurance Law §3420. Notably, Section 3420(b)(1) authorizes "any person who *** has obtained a judgment against the insured *** for damages for injuries sustained or loss or damage occasioned during the life of the policy or contract" to maintain an action against the insurer so long as the injured person serves the insurer with a copy of the judgment with notice of entry and it remains unpaid for thirty (30) days." According to the Court, the statute "therefore grants an injured party a right to sue the tortfeasor's insurer, but only under limited circumstances – the injured party must first obtain a judgment against the tortfeasor, serve the insurance company with a copy of the judgment and await payment for thirty (30) days. Compliance with these requirements is a condition precedent to a direct action against the insurance company ***."[70]

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[68] *Id*. at 3.

[69] *Id*. (*quoting Jackson v. Citizens Cas. Co.*, 277 N.Y. 385, 389, __ N.E.2d __, [1938]).

[70] *Id*. at 5.

In this case, it was undisputed that Lang had not obtained a judgment against the houseguest and therefore lacked standing under the statute to pursue a direct action against Hanover according to the Court. The Court rejected Lang's reliance on CPLR 3001, the statute governing declaratory judgment actions in New York and authorizing the Court to declare "the rights and other legal relations of the parties to a justiciable controversy."[71] Justice Graffeo wrote that "nothing in the language of CPLR 3001 alters the precedent regarding an injured parties' standing to sue a tortfeasor's insurer. Plaintiff has no common-law right to seek relief directly from a tortfeasor's insurer, and the statutory right created in Insurance Law §3420 arises only after plaintiff has obtained a judgment in the underlying personal injury action."[72] The Court also noted that it was undisputed that the bankruptcy discharge obtained by the houseguest does not relieve the insurance company of its obligation to pay damages for injuries or losses, citing Insurance Law §3420(a)(1).

Finally, the Court offered a cautionary note to insurance companies like Hanover who disclaim coverage and thwart efforts to determine the validity of their disclaimer before an underlying action is turned into a judgment. Thus, the Court cautioned insurers that although they may have won this "battle," they could ultimately lose the "war" and be obligated to make substantial indemnity payments when they never had any say in the underlying action. The Court wrote:

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[71] *Id*. at 6 (quoting CPLR 3001).

[72] *Id*. at 6-7.

> Finally, we note that an insurance company that disclaims in a situation where coverage may be arguable is well advised to seek a declaratory judgment concerning the duty to defend or indemnify the purported insured. If it disclaims and declines to defend in the underlying lawsuit without doing so, it takes the risk that the injured party will obtain a judgment against the purported insured and then seek payment pursuant to Insurance Law §3420. Under those circumstances, having chosen not to participate in the underlying lawsuit, the insurance carrier may litigate only the validity of its disclaimer and cannot challenge the liability or damages determination underlying the judgment.[73]

C. Sexual Assault and Intentional Acts Coverage Issues

In *RJC Realty Holding Corp. v. Republic Franklin Ins. Co.*,[74] the Court of Appeals held that, with respect to the policyholder health spa who brought the declaratory judgment action, allegations of an alleged sexual assault by an employee masseur against a client constituted an "accident" within the meaning of the policy and did not fall within the policy exclusions for injuries "expected or intended" or "arising out of *** body massage". Accordingly, the Court held that not only did Republic have a duty to defend the health spa in the underlying action, but that it was obligated to indemnify the spa as well.[75]

RJC is the health spa that was insured by Republic under a policy providing for a defense and indemnification against claims for "bodily injury" caused by an "occurrence;" and "occurrence" was defined by the policy as "an accident, including

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[73] *Id*. at 7-8.

[74] 2 N.Y.3d 158, 808 N.E.2d 1263, 777 N.Y.S.2d 4 (2004).

[75] *Id*. at 161, 808 N.E.2d at 1264, 777 N.Y.S.2d at 5.

continuous or repeated exposure to substantially the same general harmful conditions." The policy also contained exclusions for bodily injuries "expected or intended from the stand point of the insured" or "arising out of *** [b]ody massage other than facial message."[76] The client and her husband brought an action against RJC and the masseur employee alleging that the masseur performed a body massage on her and that she "was the victim of improper sexual contact." The complaint alleged that RJC was liable for negligently hiring and retaining the masseur, and for failing properly to supervise his activities.[77] After RJC notified Republic of the alleged sexual assault and provided a copy of the complaint, Republic disclaimed coverage relying on the definition of occurrence and the two exclusions in question.

On cross-motions for summary judgment in the declaratory judgment action, Supreme Court ruled in RJC's favor and ordered Republic to defend and indemnify RJC in the underlying action. On appeal, the Appellate Division reversed, finding that the "expected or intended" exclusion applied because the complaint alleged "an intentional sexual assault by RJC's employee." The Court of Appeals granted leave to appeal and reversed and reinstated Supreme Court's judgment.[78]

The Court found that whether the alleged sexual assault was an "accident" and therefore an "occurrence" under the policy and whether it was excluded from coverage as

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[76] *Id*. at 162, 808 N.E.2d at 1264, 777 N.Y.2d at 5.

[77] *Id*.

[78] *Id*. at 162-163, 808 N.E.2d at 1264-1265, 777 N.Y.S.2d at 5-6.

"expected or intended from the standpoint of the insured" were both controlled by its prior decision in *Agoado Realty Corp. v. United Int'l Ins. Co.*[79] The Court noted that in *Agoado* it held that an insurer was obligated to defend and indemnify its insured, the landlords of a building, against a claim brought by the estate of a tenant who had been murdered in the building by an unknown assailant because although the murder was obviously intended from the assailant's point of view it was an "accident" from the landlords' point of view. The Court reiterated that in *Agoado* it held that "in deciding whether a loss is the result of an accident, it must be determined, *from the point of view of the insured*, whether the loss was unexpected, unusual and unforseen."[80] The Court wrote that the "only significant difference between this case and *Agoado* is that here the alleged perpetrator of the assault was the insured's employee."[81] Since the Court must assume that the sexual assault occurred it was not an accident from the masseur's point of view and in this case, according to the Court, "the critical question is whether the masseur's expectation and intention in committing the assault should be attributed to his employer, RJC."[82] The Court had little trouble with this issue, finding that "[t]his question is answered in the negative by our decision in *Judith M. v. Sisters of Charity Hosp.* ***."[83]

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[79] 95 N.Y.2d 141, 733 N.E.2d 213, 711 N.Y.S.2d 141 (2000).

[80] 2 N.Y.3d at 163, 808 N.E.2d at 1265, 777 N.Y.S.2d at 6 (quoting *Agoado*, *supra*, 95 N.Y.2d at 145, 733 N.E.2d at __, 711 N.Y.S.2d at __ [emphasis in original]).

[81] *Id.*

[82] *Id.*

[83] *Id.*, *see* 93 N.Y.2d 932, 715 N.E.2d 95, 693 N.Y.S.2d 67 (1999).

The Court noted that in that case it held that a hospital was not vicariously liable under the doctrine of *respondeat superior* for a sexual assault allegedly committed by the hospital's employee because it was clear that the employee departed from the scope of duties of his employment. According to the Court:

> The parties here agree that the policy would cover only an "accident" and would not apply to certain acts "expected or intended" by RJC. When they did so, they could reasonably anticipated that the rules of *respondeat superior* would govern the question of when a corporate entity is deemed to expect or intend its employee's actions.[84]

Turning to the "body massage" issue, the Court found the applicability of that exclusion a closer question, but agreed with Supreme Court's determination. The Court found that the most likely inference from the complaint against RJC was that the alleged sexual assault occurred "during" a body massage. "The insurance policy, however, does not exclude coverage for all alleged conduct during a body massage, but only for 'injury *** arising out of *** [b]ody massage.'"[85] Given the specific language of the exclusion in question, the Court held:

> We think the words of the exclusion are most plausibly read to refer to a bruise or similar injury inflicted on the customer by a massage itself, and not to the emotional or physical injury resulting from a sexual assault by a masseur. At least that is a reasonable reading of the words, and an exclusion in an insurance policy can negate coverage only where it is stated "in clear and unmistakable language [and] is subject to no other reasonable interpretation." (*Continental Cas. Co. v. Rapid-American Corp.*, 80 N.Y.2d 640, 652, 593 N.Y.S.2d

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[84] *Id*. at 164, 808 N.E.2d at 1266, 777 N.Y.S.2d at 7.

[85] *Id*. at 165, 808 N.E.2d at 1266, 777 N.Y.S.2d at 7.

> 966, 609 N.E.2d 506 [1993]). We therefore hold the "body massage" exclusion to be inapplicable here.[86]

D. Waiver and Estoppel

In *General Acc. Ins. Co. of Am. v. Metropolitan Steel Indus., Inc.*,[87] the court held that General Accident could not argue that its "builder's risk" policy provided only first-party coverage for damage to specified property, not third-party liability coverage for breach of contract claims, after it undertook the defense of the underlying action for breach of contract without reserving its right to assert a lack of coverage, and, as a result, the policyholder lost control of its own defense. The court rejected the insurer's argument that estoppel could not be applied to create coverage where none exists, where, as here, the insured was covered by the policy at the time of the loss, although not for the type of loss claimed, and lost control of its defense in reliance upon the insurer having undertaken its defense without a reservation of rights. The insured sufficiently demonstrated that General Accident imposed a posture and strategy on the underlying action that it could not alter, and that its ability to control the defense of the underlying action was otherwise prejudiced by the insurer's delay in disclaiming until that action was well underway.[88]

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[86] *Id*. at 165, 808 N.E.2d at 1266-1267, 777 N.Y.2d at 7-8.

[87] 9 A.D.3d 254, 780 N.Y.S.2d 128 (2d Dep't 2004).

[88] *Id*. at 254, 780 N.Y.S.2d at 128-129.

E. Timely Disclaimer or Denial of Coverage

In an unusual factual setting, the First Department denied summary judgment to the insured in *Bovis Lend Lease LMB, Inc. v. Zurich Ins. Co.* [89] despite an apparent untimely disclaimer of coverage by Zurich under Insurance Law § 3420(d) where the court found issues of act raised whether the insured was trying to trap the insurer into making a late disclaimer.

The coverage action was commenced by a general contractor against Zurich, a subcontractor's general liability insurer, after Zurich refused to accept tender of the claim. The court held that the insurer was on notice of the claim by virtue of its receipt of the claim in its San Francisco office, but the court rejected the insured's argument that the resulting four month delay in disclaiming coverage was untimely under Section 3420(d) as a matter of law. According to the court, the insured's failure to explain why it mailed the letter to Zurich's San Francisco office, even though that office had no connection with the underlying action and the insured's counsel knew that Zurich's New York office was handling the matter, raised an issue of fact whether the insured was deliberately trying to trap Zurich into making a late disclaimer. Moreover, the court found that the reasonableness of Zurich's response to tender of the claim, including whether its San Francisco office should have called the telephone number on the letter to find out more about the claim, is an issue of fact that should be left for trial.[90]

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[89] 9 A.D.3d 269, 780 N.Y.S.2d 129 (1st Dep't 2004).

[90] Id. at 269, 780 N.Y.S.2d at 129-130.

An issue that has often been overlooked is whether a co-insurer seeking contribution from another co-insurer for defense or indemnity payments to or on behalf of their joint insured is entitled to the benefit and protection of Insurance Law §3420(d) where a defense to coverage was not timely raised in a written disclaimer to the insured or the co-insurer.

Until this year the only reported decision specifically addressing this issue was the Fourth Department's decision in *Tops Markets, Inc. v. Maryland Cas.*[91] This year the

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[91] 267 A.D.2d 999, (4th Dep't 1999). There the Fourth Department held that Section 3420(d) does not apply to a co-insurer seeking contribution. The Fourth Department wrote:

> The court determined that the request by Maryland for contribution from Royal was the equivalent of a disclaimer or denial of coverage under Insurance Law §3420(d) and that, because the disclaimer was made more than 2 ½ years after the commencement of the underlying personal injury action, it was untimely as a matter of law. That was error. An insurer has a right to seek contribution from an obligated coinsurer (*see, National Union Fire Ins. Co. of Pittsburgh, Pa. v. Hartford Ins. Co. of Midwest*, 248 AD2d 78, 85, *affd.* 93 NY2d 983). The purpose of Insurance Law §3420(d) is to protect the insured, the injured party "and any other interested party who has a real stake in the outcome" from prejudice resulting from a belated denial of coverage (*Excelsior Ins. Co. v. Antretter Contr. Corp.*, 262 AD2d 124, 127). *That section is inapplicable to a request for contribution between coinsurers.*

Id. at 1000 (emphasis supplied)

Notably, *Tops Markets* is listed in the case annotations to Insurance Law §3420(d) under Note 372 entitled "Contribution between coinsurers, disclaimers" and is summarized as follows: "Section of Insurance Law requiring liability insurer to disclaim coverage as soon as reasonably possible has no application to belated request for contribution between coinsurers."

First Department joined the Fourth Department in holding that Section 3420(d) does not apply in a case involving one co-insurer seeking contribution from another co-insurer in *Realm Natl. Ins. Co. v. Hermitage Ins. Co.*[92] Realm was a workers' compensation insurer seeking contribution from Hermitage, a general liability insurer, for defense and indemnification payments made by Realm on behalf of their insured in a personal injury action by the insured's employee. Hermitage's policy, however, excluded coverage for bodily injury to an employee. Hermitage disclaimed, but only referenced part of the exclusion, and apparently the exclusion was not timely sent under section 3420(d). The court wrote:

> Contrary to plaintiff's argument, defendant's disclaimer was not untimely pursuant to Insurance Law § 3420 (d), nor did defendant otherwise waive reliance upon the applicable exclusionary language. * * * The disclaimer was not rendered ineffective by defendant's quotation of only part of the relevant exclusion, especially since the claim of ineffectiveness is being raised not by the insured but by a coinsurer seeking contribution (*see Tops Mkts. v Maryland Cas.*, 267 AD2d 999, 1000 [1999]).[93]

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[92] 8 A.D.3d 110, 778 N.Y.S.2d 492 (1st Dep't 2004).

[93] *Id*. at 111, 778 N.Y.S.2d at 493-494.

II. AUTOMOBILE POLICIES

A. Additional Personal Injury Protection (APIP) Subrogation Actions

In *Allstate Ins. Co. v. Stein*,[94] the Court of Appeals held that a subrogation action brought by an automobile insurer, Allstate, against a tortfeasor for recovery of additional personal injury protection (APIP) benefits paid to Allstate's insured arises, for statute of limitations purposes, when the accident occurred rather than on the date when the first APIP benefits were paid. In this case, that meant that the insurer's action was time-barred.

The facts in this case demonstrate exactly how complicated a situation can become when APIP benefits are involved. On May 24, 1995 a vehicle operated by Stein struck a vehicle being operated by Walker and injured her. Allstate paid first party no-fault benefits to Walker, which neither Walker nor Allstate could recover them from Stein under Insurance Law §5104(a). Walker's policy with Allstate also provided for APIP benefits for economic loss exceeding "basic economic loss subject to mandatory no-fault coverage." Notably, there is no statutory basis for APIP benefits; they are authorized by 11 NYCRR §65-1.3 and recovery of "APIP benefits from third parties such as Stein are not restricted by the no-fault statute." In August 1996 Walker commenced a personal injury action against Stein alleging that she sustained a "serious injury" under the no-fault law and sought to recover for the same "economic loss" that was covered by the APIP

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[94] 1 N.Y.3d 416, 807 N.E.2d 268, 775 N.Y.S.2d 219 (2004).

endorsement in her Allstate policy. By June 1998 Walker's basic no-fault coverage was exhausted and Allstate started paying APIP benefits to her and therefore became subrogated to a portion of Walker's claim against Stein. By May 2001 Allstate had paid more than $42,000 to Walker in APIP benefits.[95]

In February 2001 counsel for Walker, Stein, and Allstate appeared at a settlement conference before Supreme Court. Walker's counsel stated that Walker and Stein agreed on a $300,000 settlement of the action. The three counsel then made contrary statements regarding the settlement and Allstate's potential subrogation rights to a portion of the settlement. While the Court's opinion goes into great detail, suffice it to say that Stein thought he was getting a complete release as against both Walker and Allstate, Allstate thought it was preserving its subrogation claim against either Walker or Stein, and Walker apparently thought she was going to keep the full $300,000 and would not have to share any of it with Allstate. A few days later, Walker's counsel delivered to Stein's counsel an unqualified general release that was not executed by Allstate. Stein only paid Walker $200,000. With respect to the remaining settlement amount he first offered a Stein $100,000 draft payable to both Walker and Allstate and later commenced an interpleader action. Walker rejected the $100,000 draft and entered a judgment in that amount against Stein, that Stein moved to vacate. Allstate made no effort to recover from Walker any portion of the $300,000 settlement, but in May 2001 commenced this subrogation action. Notably, the action was commenced almost six years after the

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[95] *Id*. at 418, 807 N.E.2d at 269, 775 N.Y.S.2d at 220.

accident occurred, but within three years of when Allstate made its first APIP benefit payment to Walker.[96]

Supreme Court resolved the multi-action dispute by denying the motion by Stein to vacate the $100,000 judgment entered by Walker against Stein on the settlement, dismissing Stein's interpleader complaint, and denying Stein's motion to dismiss Allstate's action on the grounds of the statute of limitations. The Appellate Division, in a 3-2 vote, reversed and dismissed Allstate's action on the grounds that it was barred by the statute of limitations.[97]

According to the Court, Allstate did not dispute the general principles that a subrogation claim is derivative of the underlying claim, that the subrogee possesses only those rights that the subrogor possessed (no more and no less), and that a defendant in a subrogation action is entitled to assert all defenses against the subrogee that could be asserted against the subrogor. Allstate asserted, however, that its right "is not an ordinary subrogation right, but a creature of statute (as implemented by Insurance Department regulation)," and was therefore governed by the statutory right granted it and that the applicable statute of limitations in the case was CPLR 214(2), providing a three year limitation period to recover for a liability "imposed by statute," rather than CPLR 214(5),

[96] *Id*. at 418-420, 807 N.E.2d at 269-270, 775 N.Y.S.2d at 220-221.

[97] *Id*. at 420, 807 N.E.2d at 270, 775 N.Y.S.2d at 221.

which imposes a three year statute of limitations for personal injury actions.[98] The Court had little trouble distinguishing the cases relied on by Allstate because this case

> involves a traditional equitable subrogation, not a liability created by statute. Indeed, no statute even refers to APIP benefits, much less a subrogation claim by an APIP carrier against a tortfeasor. Allstate relies not on a statute but on an Insurance Department regulation, 11 NYCRR 65-1.3, which sets for a form of APIP endorsement which is "approved and promulgated" by the Department of Insurance (§ 65-1.3[a]).[99]

The Court wrote that the regulation "does not create a new right which did not exist at common law," but only declared Allstate's pre-existing, common law rights. The Court specifically noted that on the facts of this case Allstate would have a subrogation claim against Stein even if there was no regulation and even if there was no subrogation clause in its policy under common-law precedent.[100]

Finally, the Court rejected Allstate's argument that having the statute of limitations run from the date of the accident may lead to cases where an insurer's subrogation claim for APIP benefits may be time-barred before the right of subrogation exists (before any payments are made), foreclosing the possibility of bringing suit on the claim. The Court wrote that "this sort of risk is inherent in subrogation" and that if this should occur "the subrogee's remedy is against the subrogor, for conduct that has

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[98] *Id*. at 420-421, 807 N.E.2d at 271, 775 N.Y.S.2d at 222.

[99] *Id*. at 422, 807 N.E.2d at 272, 775 N.Y.S.2d at 223. The cases cited and relied on by Allstate were *Matter of Motor Veh. Acc. Indem. Corp. v. Aetna Cas. & Sur. Co.*, 89 N.Y.2d 214, 678 N.E.2d 1349, 652 N.Y.S.2d 584 (1996) and *Aetna Life & Cas. Co. v. Nelson*, 67 N.Y.2d 169, 492 N.E.2d 386, 501 N.Y.S.2d 313 (1986).

[100] *Id*.

prejudiced the subrogee's right."[101] The Court was not sympathetic to Allstate's argument in this case, writing that its "plight here results from its own failure" to resolve the subrogation claim against Stein as part of the global settlement of the personal injury claim. The Court noted that Allstate did not have to "acquiesce" in the settlement between Walker and Stein at the settlement conference and that it should have followed up on the statements made by its counsel at that conference to recover its $43,000 from the settlement proceeds that Walker received, but instead chose "to bring a time-barred action against Stein."[102]

B. Bodily Injury

In State Farm Mut. Auto. Ins. Co. v. Glinbizzi[103] the court held that "bodily injury" includes mental injuries arising from a zone-of-danger claim. State Farm insured defendant under an auto policy that was in effect when defendant struck and killed a pedestrian who was walking with his son. The son brought a claim alleging a zone-of-danger cause of action to recover for psychological injuries caused by witnessing the accident and his father's resulting death. State Farm commenced this action seeking a declaration that the policy did not cover the son's mental injuries under the policy's

[101] *Id*. at 423, 807 N.E.2d at 272, 775 N.Y.S.2d at 223.

[102] *Id*. at 423, 807 N.E.2d at 272-273, 775 N.Y.S.2d at 223-224.

[103] 9 A.D.3d 756, 780 N.Y.S.2d 434 (3d Dep't 2004).

definition of "bodily injury." Relying on *Lavanant v General Acc. Ins. Co. of Am.*,[104] the court held that the insurer was obligated to provide coverage. The court wrote that State Farm's modifications to the policy's definition of "bodily injury" in light of *Lavanant* did not succeed in defeating coverage. State Farm's policy defined "bodily injury" as "bodily injury to a person and sickness, disease or death which results from it," which was still susceptible to more than one interpretation. In the court's opinion, "[i]t could mean that the sickness, disease or death must inure to the same person who suffered the bodily injury. Alternatively, it could mean, that any sickness, disease or death to any person is covered if it results from bodily injury to the same or a different person."[105] The court concluded that the average insured auto owner would expect that the injuries suffered as a result of witnessing a relative's death while in the zone of danger would be covered under the policy.

C. Uninsured/Underinsured Motorist Coverage

In *Matter of State Farm Mut. Auto. Ins.. Co. v. Eastman,*[106] the court held that the 20-day limitation period for commencing a proceeding to stay arbitration of an uninsured motorist (UM) claim is inapplicable to a claim that the policy was not issued at the time of the loss. The court held that a permanent stay of arbitration of an UM claim should

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[104] 79 N.Y.2d 623, 595 N.E.2d 819, 584 N.Y.S.2d 744 (1992).

[105] 9 A.D.3d at 756, 780 N.Y.S.2d at 436.

[106] 10 A.D.3d 690, 782 N.Y.S.2d 99 (2d Dep't 2004).

have been granted, even though the proceeding for a stay was not commenced within the 20-day deadline under CPLR 7503©) because the auto liability policy did not exist on the date of the accident. Under these circumstances, the court held, it was clear that the parties never agreed to arbitrate any claim arising out of the accident.[107]

In *Matter of Metlife Auto & Home v. Pennella,*[108] the court held that the insurer's cancellation of an auto policy was effective. In a proceeding to permanently stay arbitration of an UM claim, the insured argued that the purported cancellation of his auto policy was invalid because there was no proof that the notice of cancellation was properly mailed. A hearing was held to determine the validity of the cancellation, at which the insured waived live testimony regarding the alleged mailing. The court held that by agreeing to waive live testimony regarding the mailing, the insured waived any challenge to the sufficiency of the evidence on that issue and, therefore, the lower court properly determined that the cancellation notice was mailed and that the policy was cancelled.

In In re United Servs. Auto. Ass'n v. Bertan,[109] the court held that where the policy provided that arbitration of UM claims would take place in the county in which the covered person lived at the time of the accident, the insurer may not be compelled to arbitrate the subject claims in another county. Although the insurer was precluded under CPLR 7503©) from objecting to arbitration on the ground that a valid agreement to

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[107] *Id.*

[108] 10 A.D.3d 726, 782 N.Y.S.2d 119 (2d Dep't 2004).

[109] 10A.D.3d 542, 782 N.Y.S.2d 63 (1st Dep't 2004).

arbitrate had not been made or complied with, it could object to proceeding in a venue other than one agreed upon under the policy.

In *Matter of Karadhimas v. Allstate Ins. Co.,*[110] the court held that the arbitrator on an UM claim exceeded his authority by considering whether there was physical contact with the hit-and-run vehicle. Petitioner claimed a hit-and-run vehicle struck him, which caused him to lose control of his car and hit a utility pole. Petitioner demanded arbitration and the respondent never sought to stay arbitration. The arbitrator dismissed the claim for insufficient evidence of negligence on the part of the hit-and-run vehicle, doubting whether there even was another vehicle. Petitioner then brought this proceeding to vacate the arbitration award on the ground that the arbitrator exceeded his powers in considering whether there was physical contact between the petitioner's vehicle and an unidentified vehicle. The court held that an arbitrator may not decide the question of whether there was contact with a hit-and-run vehicle on the ground that lack of contact constitutes a "contractual coverage defense" and not a "liability defense."[111] The court also held that where the insurers application to stay arbitration is untimely, "[t]he arbitrator may not decide this issue by creating an artificial distinction between contractual issues and liability issues."[112] According to the court this rule applies equally where the insurer fails to move to stay arbitration in a timely manner and where it fails to

[110] 9 A.D.3d 429, 781 N.Y.S.2d 41 (2d Dep't 2004).

[111] *Id*. at 429, 782 N.Y.S.2d at 42.

[112] *Id*.

move to stay arbitration at all. In either case, the carrier waives a determination of contact as a condition precedent to coverage.

D. No-Fault Benefits

In *Matter of New York Cent. Mut. Fire Ins. Co. v. Czumaj,*[113] the court held, in a 3-2 decision, that service of a demand for arbitration of no-fault benefits by Federal Express delivery was jurisdictionally defective because Federal Express is not one of the permitted methods of service set forth in CPLR 7503©) and granted a permanent stay of arbitration. In the dissenters' view, the procedure should have been allowed because it was analogous to personal service by mail under CPLR 312-a, and is also the functional equivalent of registered or certified mail because they provide for accountability and reliability with respect to the mailing and receipt of the demand for arbitration.

In Hausman v. Hoffman,[114] the court held that the "serious injury" threshold was not met where plaintiff failed to demonstrate a total loss of use. Plaintiff was involved in a motor vehicle accident and commenced this action to recover damages for neck and back injuries. Defendant moved for summary judgment on the ground that plaintiff did not sustain a "serious injury" as defined by Insurance Law §5102(d). Plaintiff maintained that he suffered a serious injury as a result of a permanent loss of use of his cervical and lumbar spine and that he was unable to perform substantially all of the material acts that

[113] 9 A.D.3d 833, 780 N.Y.S.2d 254 (4th Dep't 2004).

[114] 9 A.D.3d 822, 780 N.Y.S.2d 826 (3d Dep't 2004).

constituted his usual and customary daily activities for 90 of the 180 days immediately following the accident. With regard to the permanent loss of use category, defendant's physician opined that, although plaintiff had suffered a cervical injury as the result of the accident, the injury was fully resolved at the time of his examination. While plaintiff submitted medical evidence that he sustained a vertebral sprain/strain resulting in pain that is permanent in nature, the court found that he failed to demonstrate that the loss of use of his cervical and lumbar spine was "total," which the court concluded was fatal to his claim.

With respect to plaintiffs allegation of serious injury in the 90/180-day category, defendant's physician's affidavit demonstrated that plaintiffs own history indicated he lost no time from work as a result of the accident. Moreover, plaintiff's testimony at his deposition in response to questioning about what he could not do following the accident, that he could not "come up with anything right off the top of my head," failed to support a claim that he was prevented from performing substantially all of the material acts that constituted his usual and customary daily activities.

In *Aguilar v. Hicks,*[115] the court dismissed a claim for injuries arising out of a motor vehicle accident where plaintiff failed to raise an issue of fact on "serious injury." The court found that while plaintiff's physician appeared to rely on MRIs in concluding that plaintiff "has sustained permanent partial functional impairment of the lumbar spine, spinal roots and knees," he failed to indicate the extent or degree of any resulting physical

[115] 9 A.D.3d 318, 781 N.Y.S.2d 318 (1st Dep't 2004).

limitations. With respect to a scar above his eye, the court found that plaintiff offered no medical evidence as to its severity, and, moreover, upon review of the photographs that plaintiff submitted, the scar does not constitute a "significant disfigurement" within Insurance Law §5102.

III. HEALTH AND DISABILITY BENEFITS POLICIES

In *Matter of Polan v. State of New York Ins. Dept.*,[116] the Court of Appeals held that an insurer did not discriminate against the insured, in violation of the anti-discrimination provision of Insurance Law §4224(b)(2), by providing more extended coverage for physical disabilities than for mental disabilities and in denying her long-term disability (LTD) benefits claim under a group insurance policy.

Under the LTD policy issued to petitioner's employer coverage for physical disabilities extended until the disabled employee reached age 65 or when the disability ceased, but coverage for disabilities caused by "mental and nervous disorders or diseases" is limited to 24 months unless the employee was hospitalized or institutionalized at the end of the 24 month time period, in which case benefits continued until the confinement ended. Petitioner suffers from a chronic psychiatric disability and has been unable to work since March 1994. In February 1995 the insurer approved her claim for LTD benefits retroactive to September 1994, but terminated her benefits in September 1996 because of the 24 month limitation and because she was not confined at

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[116] 3 N.Y.3d 54, 814 N.E.2d 789, 781 N.Y.S.2d 482 (2004).

that time. Petitioner then commenced an action against her employer and the insurer alleging that the 24 month limitation violated Section 4224(b)(2), but Supreme Court dismissed the action, finding that there was no private cause of action under the statute and that it is to be enforced by the Superintendent of Insurance.[117]

Petitioner then filed a complaint against the insurer with the Insurance Department. It rejected her complaint finding that the statute does not mandate equal benefits for mental and physical disabilities, but simply that the same benefits must be afforded to all employees participating in the employer's group plan. Petitioner then commenced this Article 78 proceeding to challenge the Superintendent's determination. Supreme Court denied the petition and dismissed the proceeding and the Appellate Division, with two justices dissenting, affirmed.[118]

The Court first turned to the language of the statute which provides, in pertinent part, that:

> (b) No insurer doing in this state the business of accident and health insurance * * * shall
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> (2) refuse to insure, refuse to continue to insure or limit the amount, extent or kind of coverage *available to an individual*, or charge a different rate for the same coverage *solely because of* the physical or mental disability, impairment or disease, or prior history thereof, *of the insured or potential*

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[117] *Id*. at 56-57, 814 N.E.2d at 790, 781 N.Y.S.2d at 483.

[118] *Id*. at 57-58, 814 N.E.2d at 790, 781 N.Y.S.2d at 483.

> *insured*, except where the refusal, limitation or rate differential is permitted by law or regulation and is based on sound actuarial principles or is related to actual or reasonably anticipated experience.[119]

The Court specifically noted that the statute "prescribes limitations on coverage 'solely because of' a particular disability, rather than limitations on coverage 'for' a particular disability ***."[120] According to the Court, in order to discriminate against an individual "solely because of" a disability the insurer would have to limit "an individual's coverage by reason of that individual's disability. Here, the insured did not adopt a 24-month limitation 'solely because of' petitioner's mental disability; the limitation preceded her disability."[121] The Court found that petitioner was not discriminated against because she was eligible for the same LTD coverage at the same premium as all other employees in the group plan.

The Court noted that the New York statute was similar to anti-discrimination statutes of several other states, including Maine and Texas, and that courts interpreting those statutes declined to require equivalent coverages for mental and physical disabilities.[122] The Court also wrote that "[t]ellingly, the Legislature chose to place the

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[119] *Id*. at 58, 814 N.E.2d at 791, 781 N.Y.S.2d at 484 (emphasis in original).

[120] *Id*.

[121] *Id*. at 59, 814 N.E.2d at 791, 781 N.Y.S.2d at 484.

[122] *Id*.

anti-discrimination provision in Insurance Law article 42, which governs insurers, rather than in article 32, which mandates terms and conditions of insurance policies. *** The extensive list of statutorily mandated benefits in article 32 and the absence of any comparable list in article 42 cuts against petitioner's argument that the Legislature intended Section 4224(b)(2) to require equivalent coverage for physical and mental disabilities."[123]

The Court then turned to the legislative history of the statute and found that it clearly supported the Court's interpretation of the plain language of the statute and its placement in the statutory scheme of the Insurance Law. The Court also wrote that the National Association of Insurance Commissioners Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment, which the New York statute mirrors, provides further support for the Court's interpretation of the statute. In fact, the Court wrote that a Drafting Note to the Model Regulation specifically provides that it "is *not intended to mandate the inclusion of particular coverages*, such as benefits for normal pregnancy, *or of levels of benefits such as for mental illness*, in a company's policies or contracts."[124]

In *Lipton v. UnumProvident Corp.,*[125] the court held that while not liable under ERISA, the administrator of group disability plan owes plan participants a common-law

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[123] *Id*. at 59-60, 814 N.E.2d at 792, 781 N.Y.S.2d at 485.

[124] *Id*. at 61-62, 814 N.E.2d at 793, 781 N.Y.S.2d at 486 (emphasis in original).

[125] 10 A.D.3d 703, ___ N.Y.S.2d ___ (2d Dep't 2004).

duty of good faith in administering plan. The court first held that a cause of action for breach of contract by a participant in a group disability plan against the company that procured the policy was properly dismissed because, although it had procured the group insurance plan for the benefit of its employees and certain brokers, it was not a party to the contract of insurance between the plan participants and the insurer. Second, since it was undisputed that the plaintiff was an independent contractor rather than an employee of the company, the company owed no fiduciary duty to him under ERISA. Third, the court held that in its role as policyholder and administrator of the group insurance plan which it procured for the benefit of both its employees and brokers who cleared trades through the company, however, the company owed plaintiff a common-law duty of good faith in administering the plan and a cause of action for breach of fiduciary duty was properly stated. This common-law duty encompassed an obligation to inform plan participants of the precise date that their eligibility for coverage would terminate. Thus, to the extent that plaintiff's fifth cause of action is based upon allegations that the company failed to inform him that it had terminated its relationship with him for insurance purposes, and/or breached its duty of good faith in administering the plan by providing the insurer with false and inaccurate information about his eligibility status under the plan, it states a cognizable cause of action under New York law.

IV. HOMEOWNERS INSURANCE

Coverage experts are debating whether the asbestos litigation and coverage litigation for asbestos claims in the 1970s through the 1990's maybe finding a successor in mold and insurance coverage for mold claims in the last five years. While there has been increasing coverage litigation in other states there has been very little in New York. This *Survey* year a significant decision on coverage for first party property damages in a Homeowners policy was handed down in *Gallup v. State Farm Ins. Cos.*[126] that could be the lightening bolt for further coverage litigation in New York. In *Gallup*, Northern District Senior Court Judge McCurn found that both the notice provision and the mold exclusion in State Farm's standard homeowners policy were ambiguous and denied its motion for summary judgment.

Plaintiffs purchased a lot and had a new home built on it and moved into the home in October 1999. State Farm issued its homeowners policy to plaintiffs effective on the date of the closing. Beginning in February 2000 all four members of the Gallup family began to experience unique but persistent physical ailments, including but not limited to, fatigue, swollen glands, dark urine, diarrhea, osteopenia, cognitive and neurological problems, respiratory distress, and extensive orthopedic pains. During the winter of 2001

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[126] 2004 WL 1592626 (N.D.N.Y. April 30, 2004), *vacated* 2004 WL 2732127 (N.D.N.Y. September 14, 2004) (as part of a settlement of action). The author and his partner represented the plaintiffs in this action and some of the facts set forth herein are from the briefs and motion papers submitted to the court, but not specifically sset forth in the decision.

(January-March) plaintiffs came to believe that their home was the source of their illnesses and first reported this connection to State Farm. Because plaintiffs' medical ailments continued to worsen, in June 2001 the four family members vacated their home and left all of their personal effects and contents behind because they were a continuing danger to them.[127]

By letter dated October 4, 2001 State Farm disclaimed coverage for plaintiffs' losses. Although State Farm disclaimed coverage, it agreed to send an expert to plaintiffs' home to investigate whether mold was the cause of the family's problems as plaintiffs' then believed. IAQ Technologies made two site visits to plaintiffs' home at State Farm's request in October 2001 and wrote a Report to State Farm regarding its findings. The Report confirmed significant levels of mold in plaintiffs' home, including on the first and second floors, but in particular in the basement furnace room and the basement play room, which had "unusually high" levels of mold in the air samples they collected. The Report also stated on page 2 that "much of the indoor environment in the house has been contaminated from airborne deposition and/or localized amplification (fungal growth)." The Conclusions portion of the Report noted that "the house is not suitable to live in." State Farm issued a second disclaimer letter after receipt of the IAQ Report.[128]

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[127] 2004 WL 1592626 at *1.

[128] *Id.* at *1-2.

The exact source or cause of the mold in the home was not known. In its disclaimer letters State Farm identified three possible sources or events that may have led to presence of mold at plaintiffs' home and set forth the basis for State Farm's disclaimer of coverage for all three events: (1) a burst washing machine hose that allegedly occurred in December 1999; (2) rain water entered the home during construction; and (3) movers allowed the family's possessions and the home's contents to become wet, but moved them into the home anyway.[129]

It was agreed by the parties that the case raised issues of first impression regarding insurance coverage for mold-related losses under first-party property policies under New York law. State Farm's motion for summary judgment explicitly conceded that there was no New York law on point and cited the court solely to two intermediate appellate court decisions from Minnesota and Ohio interpreting and applying mold exclusions in first-party property policies.

Before analyzing the applicability of the "mold" exclusion the court addressed whether plaintiffs failed to give timely notice of the burst washing machine hose in December 1999, thus precluding coverage for any mold-related "loss" sustained by them from this event. State Farm asserted that notice should have been given immediately upon the event, but was not given until October 2001, a delay of almost two years. Plaintiffs asserted that there was a difference between a "loss" and an "occurrence," and that an event such as a burst washing machine hose may be an "occurrence" that

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[129] *Id.*

ultimately led to plaintiffs' losses, but it does not constitute their "loss" under the policy. Plaintiffs asserted that they did not have a duty to notify State Farm of their loss until they "first believed there was a connection between their home and their illnesses[130]. Citing New York decisions on point, the court agreed with plaintiffs' argument that because the term "loss" was not defined by the policy and was "susceptible to more than one meaning" it was ambiguous and there was a question of fact on timely notice.[131]

Turning to the "mold" exclusion, State Farm's policy excluded any "*loss*" that consists of or is directly and immediately caused by "*mold, fungus or wet or dry rot*." However, the exclusion also provided that "we do insure for any *resulting loss* from [mold] unless the resulting loss is itself a Loss Not Insured by this Section."[132] Plaintiffs asserted that (1) it was unenforceable unless State Farm could prove it had been approved by the Superintendent of Insurance; and (2) it was ambiguous thus creating triable issues of fact on coverage[133].

In support of the first argument, plaintiffs relied primarily on an April 3, 2003 Opinion of the Insurance Department regarding mold exclusions which stated that

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[130] *Id.* at *3-4.

[131] *Id.* at *5-6. The court wrote that in the context of this case "loss does *not* have 'a definite and precise meaning, unattended by danger of misconception in the purport of the contract itself and concerning which there is *no reasonable basis for a difference in opinion.'* * * * Indeed, the opposite is true: there is a 'danger of misconception' in State Farm's policy given that 'loss' is not defined therein." (Emphasis in original, citations omitted). *Id.* at *6.

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[133] *Id.* at *7.

"[s]ubject to certain exceptions * * * , all policy forms must be filed with, and approved by, the Superintendent, before they may be used," that "[t]he Superintendent has not approved any mold-related exclusions," and that "the Department has received over one hundred filings restricting mold coverage, [but] the Department has not approved any of them." It also provided that "in light of the scientific uncertainty concerning mold-related damages, the Department has not yet formulated a policy position * * * ."[134] In response State Farm submitted correspondence between it and the Insurance Department allegedly proving that it has Department approval for the mold exclusion at issue in the present case. The court found that plaintiffs had not carried their burden to prove that the exclusion was not approved, but also noted that State Farm did not establish that the exclusion was approved.[135]

Turning to the ambiguity argument, the court had little trouble finding that the exclusion for any "*loss*" that consists of or is directly and immediately caused by "*mold, fungus or wet or dry rot,*" but is not a "*resulting loss*" was ambiguous. The court wrote that "[t]he absence of a definition of loss in the policy requires no further discussion. For the reasons previously discussed, that omission creates an ambiguity. The conclusion does not change simply because the focus has changed from notice to the mold exclusion."[136] In a footnote, the court stated that "[t]his ambiguity is compounded by the

[134] *Id.*

[135] *Id.* at *8.

[136] *Id.* at *9.

language highlighted in the mold exclusion quoted above. * * * Reading the mold exclusion in its entirety, it is inherently circular primarily because nowhere in the policy does it define either "loss," or "resulting" or the phrase "resulting loss."[137]

The court held that "certainly at this juncture it impossible to hold as a matter of law that based upon the mold exclusion State Farm need not provide coverage to plaintiffs. State Farm simply has not met its 'heavy burden' 'of proving that an insurance policy's exclusions clearly and unmistakably apply to the insured's claims.' "[138]

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[137] *Id.*, fn.3.

[138] *Id*. at *9 (quoting *Checkrite Limited Inc. v. Illinois National Ins. Co.*, 93 F.Supp.2d 180, 189 [S.D.N.Y. 2000]).

V. 9/11 INSURANCE ISSUES

In the last two *Survey* articles [139] I have covered in some depth the coverage litigation for the destruction of the World Trade Center (WTC) from the terrorist attack on the United States on September 11, 2001. In 2002 Southern District Court Judge John Martin issued two significant coverage opinions in the consolidated litigation arising out of several actions entitled *SR International Business Ins. Co. Ltd. v. World Trade Center Properties LLC.*[140] and in 2003 in *World Trade Center Properties, LLC v. Hartford Fire Ins. Co.*,[141] the Second Circuit affirmed District Judge Martin's coverage decisions in three related appeals. As relevant here, the Second Circuit affirmed (1) the grant of

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[139] *2001-2002 Survey, supra,* note 2, at 698-704; *2002-2003 Survey, supra*, note 2, at 1265-1271.

In general, since the WTC complex was insured for first party property coverage through approximately two dozen insurers providing primary and increasing layers of excess coverage in the total amount of approximately $3.5 billion "per occurrence," the basic issue in dispute was whether the events of September 11, 2001 constituted one or two "occurrences." The insureds, referred to as the Silverstein Parties, alleged the two plane attacks constituted two "occurrences" and thus there was $7 billion in coverage available, and the insurers argued that the two planes were part of one coordinated attack constituting one "occurrence" and thus only $3.5 in coverage was applicable. The issue was complicated by the fact that as of September 11, 2001 only one of the many insurers that bound coverage on the WTC had actually issued a policy, which required an individualized inquiry to determine the terms of the insurance binders issued by each insurer.

For a more detailed analysis of the prior decisions the reader is referred to the prior *Survey* articles.

[140] *See* 2002 WL 1163577 (S.D.N.Y. June 3, 2002); 222 F.Supp.2d 385 (S.D.N.Y. 2002).

[141] 345 F.3d 154 (2d Cir. 2003).

summary judgment to three insurers, Hartford, Royal, and St. Paul, because "each of the insurers had issued a binder that incorporated the terms of the WilProp Form and that under the WilProp Form's definition of 'occurrence' there was only one occurrence on September 11, 2001" as a matter of law;[142] and (2) the denial of the Silverstein Parties' motion for summary judgment against Travelers because the undefined term "occurrence" in its binder was ambiguous.[143]

In a two-part verdict rendered in April and May 2004 a Southern District jury gave the Silverstein Partners a huge defeat and a partial victory. The only issue in this first trial was whether each of the remaining 12 insurers was governed by the WilProp binder or not. First, it found that nine insurers, with coverage totaling approximately $1.06 billion, were bound by the WilProp form, under which the attacks constituted one "occurrence."[144] The biggest setback for the Silverstein Partners was the jury's finding that Swiss Re, the largest single insurer involved in the litigation at $877.5 million, was governed by the WilProp binder and therefore its limits could not be doubled.[145] Second, it concluded that three insurers, with coverage of approximately $176 million were not

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[142] *Id*. at 166.

[143] *Id.* at 183-186.

[144] *See "Jurors Deal Silverstein Major Setback on WTC*," New York Law Journal, April 30, 2004, at p. 1; "*Silverstein Loses Bid on Largest WTC Insurer*," New York Law Journal, May 4, 2004, at p. 1.

[145] The jury was in its second week of deliberations when it reached its verdict as to all of the insurers except Swiss Re; the jury required five additional days of deliberations to reach a verdict on Swiss Re. *See id.*

governed by the WilProp form and that a second trial would be needed to determine if the attacks and loss constituted one or two occurrences.

The second trial resulted in a verdict in December 2004 completely in favor of the Silverstein Partners and allowing for the recovery of up to $2.2 billion rather than $1.1 billion from the same insurers.[146] The three insurers from the first trial in April 2004 were joined by six other insurers who sat out the first trial because it had already been determined that they were not governed by the WilProp binder. The jury deliberated for three weeks and asked to see testimony from witnesses on both sides who had negotiated the terms of the policies or interpreted them after the attacks. Reportedly, the jury focused on the testimony of an executive at one of the insurers who testified that the terms defining an "occurrence" used in the WilProp binder and its form "could be interpreted differently."[147]

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[146] *See "In Second Round, Jury Finds Two 'Occurrences' at WTC*," New York Law Journal, December 7, 2004, at p. 1.

[147] *See id.*

VI. INSURANCE DEPARTMENT OPINIONS

The State Insurance Department, through the Superintendent, regularly issues Opinions in response to inquiries and requests from both policyholders and insurers. This past *Survey* year the Department received this inquiry: "May a Certificate of Insurance provide obligations, conditions, or coverages not contained within the underlying insurance policy?"[148] The Office of General Counsel responded as follows:

> A Certificate of Insurance is often used as proof that a policy of insurance is in effect. It is merely a document used in business to summarize information about the insurance coverage. It is usually a brief summary of the essential terms, conditions, and duration of the contract of insurance that is in effect between the insured and the insurer. The Certificate of Insurance is not a contract and is not required by statute or regulation. However, the Certificate of Insurance must contain the same information as the insurance policy. *It is not intended to confer on a certificate holder new or additional rights beyond what the insurance policy provides.* Thus, if any provision in the Certificate of Insurance is not contained in the policy and it imposes an obligation or liability not presently existing upon an insurer, such difference would

[148] New York State Insurance Department Opinion, "Certificates of Insurance," February 27, 2004, available at www.ins.state.ny.us/rg040227.htm .

alter, expand, or modify the rights between an insured and the insurer and would constitute a policy form that must be filed with the Superintendent pursuant to N.Y. Ins. Law §2307(b) (McGivney Supp. 2004).[149]

The Opinion is consistent with most court decisions that have addressed the issue of the effect of a Certificate indicating coverage to a Certificate holder that is not present in the policy.[150] The morale of the story is that a Certificate holder should and must demand to see the policy to be sure that whatever coverage she thought was being provided is contained in the policy and she cannot rely solely on a Certificate of Insurance.

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[149] *Id.* The opinion goes on to state that if a broker or agent issued a Certificate that altered the terms of the policy he/she would be in violation of Section 2307(b). *Id*.

[150] *Tribeca Broadway Assocs., LLC, v. Mount Vernon Fire Ins. Co*., 5 A.D.3d 198, 774 N.Y.S.2d 11 (1st Dep't 2004); *Moleon v. Kreisler Borg Florman Gen. Constr. Co.*, 304 A.D.2d 337, 758 N.Y.S.2d 621 (1st Dep't 2003); *Trapani, v. 10 Arial Way Associates*, 301 A.D.2d 644, 755 N.Y.S.2d 396 (2d Dep't 2003); *but see Lenox Realty v. Excelsior Ins. Co.*, 255 A.D.2d 644, 679 N.Y.S.2d 749 (3d Dep't 1998), *lv. denied* 93 N.Y.2d 807, 691 N.Y.S.2d 2, 712 N.E.2d 1245(1999).

CONCLUSION

As in the past, this *Survey* year was highlighted by a number of significant decisions from the New York Court of Appeals, which have been discussed in depth in this article. Unlike past *Survey* years, there were many important decisions from the lower courts in New York, especially on the issue of timely notice by the insured to an insurer of an occurrence or accident and whether New York will finally and completely replace the "no-prejudice" rule a "prejudice" requirement. The issue will almost surely be decided in the coming year and will be reported here next year with the Court of Appeals hearing argument in both *Argo* and *Rekemeyer*.

As in past years we also continue to see a number of insurance issues arriving at the Court of Appeals by way of certification from the Second Circuit Court of Appeals. In addition, once again this year the insurance decisions of the Court of Appeals did not lead to a single dissent, although there were several in the Appellate Division decisions reported here. Dissents in the Appellate Division are especially helpful to the Court of Appeals because they provide the Court with diverse and completing analysis by the thoughtful and scholarly Justices of the Appellate Division. It will certainly be interesting to see how the Court of Appeals reacts to and addresses Justice Catterson's strong opinions in *St. Charles* and *Great Canal* on the "no-prejudice" vs. "prejudice" rule for late notice in *Argo* and *Rekemeyer* in the upcoming *Survey* year.