INSURANCE LAW

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The author also wishes to dedicate this article to Hon. George Bundy Smith and Hon. Albert M. Rosenblatt, Associate Judges of the New York Court of Appeals from 1992 to 2006 and 1998 to 2006, respectively.

INTRODUCTION

During this *Survey* year, the New York Court of Appeals and other New York Courts have rendered a number of decisions involving significant issues of Insurance Law, including several cases that resolve issues of first impression in New York. Notably, however, there are two important changes from last year. First, the Court of Appeals decided only seven cases in the insurance area, a substantially reduced number from the fifteen Court of Appeals cases discussed in last year's *Survey*.[1] Second, there was a dissent in only one of the seven (14%) insurance cases decided by the Court of Appeals, whereas last year there were dissents in 26% of the cases.

Each of the Court of Appeals cases will be discussed in detail. It should be noted that in the seven Court of Appeals cases decided this year, the insurer or the party who was attempting to limit recovery for the policyholder was successful in five, while the policyholders won two. In addition, this article will address a few cases of significance from the State's appellate divisions.

I. HOMEOWNER'S INSURANCE

A. Criminal Acts as "Occurrences" and "Expected or Intended Damages" Exclusions

Last year's *Survey* article discussed at length the 4-1 decision of the Third Department in *Automobile Co. of Hartford v. Cook*, that the insured, who shot and killed an intruder in his house in self-defense, was not entitled to a defense by his homeowner's insurer in a wrongful death action brought by the intruder's estate because the shooting was not an "occurrence" covered under the policy and, in dicta, would fall within the "expected or intended" exclusion.[2]

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[1] Alan J. Pierce, *Insurance Law, 2005-06 Survey of New York Law*, 56 SYRACUSE L.REV. 881, 881-930 (2006).

[2] 21 A.D.3d 1155, 1156-58, 801 N.Y.S.2d 837, 838-40 (3d Dep't 2005), *rev'd*, 7 N.Y.3d 131, 850 N.E.2d 1152, 818 N.Y.S.2d 176 (2006).

Presiding Justice Cardona's dissent in the Appellate Division, however, won the day in the Court of Appeals, which this year reversed and held that the insured was entitled to a defense in a unanimous decision written by Judge Ciparick.[3]

In February 2002, the insured, Cook, shot and killed Richard Barber inside Cook's home.[4] "[T]he two men had known each other for many years, but became involved in a dispute relating to their business relationship."[5] "Barber . . . was approximately three times Cook's size and had previously attacked [him], causing injury to his leg."[6] "On the morning of [the shooting], Barber and another man were . . . hurling objects at [Cook's] house," but "[t]hey left without further incident."[7] When "Barber returned later that day with two other companions," Cook saw them approaching, and "asked a person visiting him to leave because he expected trouble."[8] Cook then retreated into his home, locked his door, and "retrieved a .25 caliber handgun from his bedroom."[9] Barber and his group burst into Cook's home and "began demanding money from Cook while pounding his fists on the kitchen table."[10] Cook "drew his [handgun] and demanded that they leave his house[,]" but when Barber laughed at him, Cook went to his bedroom and retrieved a loaded, 12 gauge shotgun.[11] Cook then went to his living room and stood "at the far end of his pool table[,]" and "again ordered [Barber] to leave the

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[3] *Auto. Co. of Hartford*, 7 N.Y.3d at 136, 850 N.E.2d at 1155, 818 N.Y.S.2d at 179.

[4] *Id.* at 134, 850 N.E.2d at 1153, 818 N.Y.S.2d at 178.

[5] *Id.* at 134, 850 N.E.2d at 1153-54, 818 N.Y.S.2d at 178.

[6] *Id.* at 134, 850 N.E.2d at 1154, 818 N.Y.S.2d at 178.

[7] *Id.* at 134-35, 850 N.E.2d at 1154, 818 N.Y.S.2d at 178.

[8] *Id.* at 135, 850 N.E.2d at 1154, 818 N.Y.S.2d at 178.

[9] *Id.*

[10] *Id.*

[11] *Id.*

house."[12] "Barber started to head toward the door with his companions, [but] he stopped at the opposite end of the pool table, turned to face Cook and told his companions to take anything of value, and that he would meet them outside because he had some business to attend to."[13] Barber then approached Cook "menacingly," and "Cook warned him that he would shoot if [Barber] came any closer."[14] Cook aimed his gun at Barber's navel, which was "the lowest part of Barber's body that was not obscured by the pool table."[15] Then, "[w]hen Barber was about one step away from the barrel of the gun, Cook fired a shot into Barber's abdomen."[16] Later that day, Barber died at the hospital.[17]

While Cook was indicted for intentional and depraved indifference murder, he raised a justification defense during his trial.[18] He was ultimately acquitted on both counts of murder, as well as the "lesser included offenses of manslaughter in the first and second degrees."[19] "The administrator of Barber's estate . . . commenced a wrongful death action against Cook[,]" alleging causes of action that Cook both negligently and intentionally shot Barber.[20] Specifically, the negligence claim alleged that "'injury to the decedent and the decedent's death were caused by the negligence of . . . Cook[,]'" and "that Cook's behavior 'consisted of negligently playing with a loaded shotgun; negligently pointing that shotgun at the abdomen of

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[12] *Id.*

[13] *Id*.

[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] *Id.*

[19] *Id.*

[20] *Id*. at 135, 850 N.E.2d at 1154, 818 N.Y.S.2d at 178-79.

the decedent; negligently discharging that shot gun into the decedent's abdomen; and engaging in unruly behavior at the Defendant's residence on February 20, 2002.'"[21] At his deposition, Cook testified that "'I knew the [shot from the] shotgun would injure Mr. Barber because I had to stop him, but I did not anticipate it killing him.'"[22]

Cook sought a defense and indemnification from his homeowner's personal liability insurer, Automobile Insurance Company of Hartford.[23] Hartford disclaimed coverage, however, on the grounds that "the incident was not an 'occurrence' within the meaning of the policy and furthermore that the injury [to] Barber fell within a policy exclusion . . . , [for] 'expected or intended'" injuries.[24] Hartford "commenced this declaratory judgment action against both Cook and [the estate]" and, following depositions, moved for summary judgment declaring that it was not obligated to defend or indemnify Cook in the wrongful death action.[25] Cook cross-moved for a "declaration that [Hartford] was required to defend and indemnify him in the underlying tort action."[26] Hartford's motion was denied by the Supreme Court, which "granted Cook's cross motion to the extent of declaring that [Hartford] had a duty to [defend] Cook in the . . . action[,]" but the Third Department reversed and declared that Hartford was not obligated to defend or

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[21] *Id.*

[22] *Id.* at 135-36, 850 N.E.2d at 1154, 818 N.Y.S.2d at 179.

[23] *Id.* at 136, 850 N.E.2d at 1154, 818 N.Y.S.2d at 179.

[24] *Id.*

[25] *Id.*

[26] *Id.* at 136, 850 N.E.2d at 1154-55, 818 N.Y.S.2d 179.

indemnify Cook.[27] The Court of Appeals granted leave to appeal, reversed, and reinstated the Supreme Court's Order.[28]

The Court reiterated its well-established rules that an insurer's "duty to defend is 'exceedingly broad'"—much broader than the duty to indemnify—and that "[w]hen an insurer seeks to disclaim coverage on the [] basis of a [policy] exclusion," it has an exceptionally high burden of proof.[29]

Turning to the first issue of whether an "occurrence" is alleged in the wrongful death action, giving rise to policy coverage, the Court noted that the complaint in that action "alleges that Cook negligently caused Barber's death []" and that "[i]f such allegations can be proven, they would fall within the scope of the policy as a covered occurrence."[30] Specifically, Hartford's policy defines "occurrence" as "an accident" and, the Court wrote, it had previously made clear that the term accident "'pertain[s] not only to an unintentional or unexpected event which, if it occurs, will foreseeably bring on death, but equally to an intentional or expected event which unintentionally or unexpectedly has that result.'"[31] The Court noted that

> The fact-finder in the underlying action may indeed ultimately reject the notion that Cook negligently caused Barber's death given the evidence of intentional behavior, but that uncertain outcome is immaterial to the issue raised here—the insurer's duty to defend in an action where it is alleged that the injury was caused by the negligent conduct of the insured.[32]

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[27] *Id.* at 136, 850 N.E.2d at 1155, 818 N.Y.S.2d at 179.

[28] *Id.* at 136, 138, 850 N.E.2d at 1155, 1156, 818 N.Y.S.2d at 179, 181.

[29] *Id.* at 137, 850 N.E.2d at 1155-56, 818 N.Y.S.2d at 179-80.

[30] *Id.* at 137, 850 N.E.2d at 1156, 818 N.Y.S.2d at 180.

[31] *Id.* at 137-38, 850 N.E.2d at 1156, 818 N.Y.S.2d at 180 (quoting Miller v. Cont'l Ins. Co., 40 N.Y.2d 675, 678, 358 N.E.2d 258, 260, 389 N.Y.S.2d 565, 567 (1976)).

[32] *Id.* at 138, 850 N.E.2d at 1156, 818 N.Y.S.2d at 180.

With respect to the policy exclusion for "expected or intended" injuries, the Court wrote that insofar "as an allegation of negligence implies an unintentional or unexpected event, Hartford necessarily has failed to demonstrate that the allegations of the complaint are subject to no other interpretation than that Cook 'expected or intended' the harm to Barber."[33] Thus, the Court found that "Hartford is . . . required to defend Cook in the underlying wrongful death action []" and "[a]s to a duty to indemnify, that determination will abide the trial."[34]

Significantly, consistent with the current Court's general philosophy on deciding only the issues directly before it, the Court issued a narrow and fact-specific decision and declined to resolve a broad, general issue that has divided courts nationally—whether a homeowner's insurance policy provides coverage if an insured is sued for wrongful death when death results from an act of self-defense.[35] The Court simply wrote that "[i]n light of this disposition, it is unnecessary to address the remaining arguments—specifically, whether acts of self-defense are intentional acts precluding coverage under a homeowner's policy."[36] The Court did, however,

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[33] *Id.* at 138, 850 N.E.2d at 1156, 818 N.Y.S.2d at 180. The Court cited, in comparison, its decision in Allstate Ins. Co. v. Mugavero, 79 N.Y.2d 153, 589 N.E.2d 365, 581 N.Y.S.2d 142 (1992) for the proposition that "where the harm caused was inherent in the nature of the acts alleged to be committed by the insured—child sexual abuse—[it] fell within the homeowners' insurance policy's exclusion" for expected or intended injuries. *Auto. Co. of Hartford*, 7 N.Y.3d at 138, 850 N.E.2d at 1156, 818 N.Y.S.2d at 180.

Notably, the Court of Appeals has, to this author's knowledge, only applied *Mugavero* once and similarly held that an insurer is not obligated to defend a policyholder based on an "expected or intended" injury, in Peters v. State Farm Fire & Cas. Co., 100 N.Y.2d 634, 635-36, 801 N.E.2d 416, 416, 769 N.Y.S.2d 195, 195 (2003).

[34] *Auto. Co. of Hartford*, 7 N.Y.3d at 138, 850 N.E.2d at 1156, 818 N.Y.S.2d at 180-81.

[35] Courts in West Virginia and Arizona have found coverage for such acts of self-defense, whereas courts in Michigan and Vermont have concluded that there is no coverage for such acts. *See* Farmers & Mechs. Mut. Ins. Co. v. Cook, 557 S.E.2d 801, 810 (W. Va. 2001) (coverage); Transamerica Ins. Group v. Meere, 694 P.2d 181, 189 (Ariz. 1984) (coverage); Auto-Owners Ins. Co. v. Harrington, 565 N.W.2d 839, 840 (Mich. 1997) (no coverage); Espinet v. Horvath, 597 A.2d 307, 309-10 (Vt. 1991) (no coverage). *See generally* James L. Rigelhaupt, Jr., Annotation, *Acts in Self-Defense as Within Provision of Liability Insurance Policy Expressly Excluding Coverage for Damage or Injury Intended or Expected by Insured*, 34 A.L.R.4th 761 (1984).

[36] *Auto. Co. of Hartford*, 7 N.Y.3d at 138, 850 N.E.2d at 1156, 818 N.Y.S.2d at 180-81.

offer this tantalizing signpost of advice: "[s]uffice it to say that a reasonable insured under these circumstances would have expected coverage under the policy."[37]

The *Cook* decision was applied by the Third Department to a similar fact pattern only one month after *Cook* was decided. In *Merchants Insurance of New Hampshire, Inc. v. Weaver*, the Third Department held that a claim that a flare gun was negligently discharged by the insured was within the embrace of the homeowner's insurance policy despite an exclusion for injury "expected or intended" by insured, and that therefore the insurer was required to defend its insured in an action by a child who was struck by a projectile from the flare gun.[38]

The policyholder's son, Sweeney, "pleaded guilty to attempted assault in the first degree, admitting that he aimed what he knew was a loaded and operable flare gun and fired it at Jacob Weaver and Weaver's friend."[39] "The fiery projectile struck Weaver, causing serious physical injuries, including the loss of his left eye."[40] The insurer disclaimed coverage and "brought this action seeking a declaratory judgment that it owed no duty to either defend or indemnify Sweeney."[41] Supreme Court granted the insurer's motion for summary judgment, "finding both that Sweeney's acts were not an 'occurrence' within the meaning of the policy and that the policy's intentional act exclusion applied because Sweeney intended to cause bodily injury to Weaver."[42]

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[37] *Id.* at 138, 850 N.E.2d at 1156, 818 N.Y.S.2d at 181.

[38] 31 A.D.3d 945, 945-46, 819 N.Y.S.2d 594, 595 (3d Dep't 2006).

[39] *Id.* at 945, 819 N.Y.S.2d at 595.

[40] *Id.*

[41] *Id.*

[42] *Id.*

The Appellate Division reversed "based on the recent decision" in *Cook* because in *Cook* "the definition of an 'occurrence' and the exclusion for intended results language contained in the policy of insurance are identical" to the same provisions in the Merchants policy here.[43] Because, as in Cook, "the complaint alleges that the weapon was negligently discharged by [the] insured[,]" the claim "is within the 'embrace of the policy' [and] the insurer must defend 'even though facts outside the four corners of [the] pleadings indicate that the claim may be meritless or not covered.'"[44] With respect to the "expected or intended" exclusion, the court simply wrote that the insurer was required but failed to satisfy its burden "to show that the allegations of the complaint 'cast that pleading solely and entirely within the policy exclusions, and, further that the allegations, *in toto*, are subject to no other interpretation.'"[45]

The court went on to reject the insurer's argument that the policyholder provided late notice of the occurrence and failed to timely forward the suit papers.[46] The court found that the insured's notice to the insurer of the occurrence "within three months of the alleged incident" was "'as soon as practicable'" as required by the policy ("within a reasonable period of time under all of the . . . circumstances") given that the "unsophisticated insured individuals were preoccupied with the criminal charges" during this period.[47] It was undisputed that the insured was served at prison and did not forward the suit papers to the insurer, but the court rejected the

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[43] *Id.*

[44] *Id.* at 945-46, 819 N.Y.S.2d at 595 (quoting Auto. Ins. Co. of Hartford v. Cook, 7 N.Y.3d at 137, 850 N.E.2d at 1155, 818 N.Y.S.2d at 180).

[45] *Id.* at 946, 819 N.Y.S.2d at 595-96 (emphasis in original).

[46] *Id.* at 946, 819 N.Y.S.2d at 596.

[47] *Id.*

insurer's separate argument on this ground because it had disclaimed coverage before the insured was served and therefore "forwarding the papers would have been a useless act."[48]

Finally, the court then threw in this "bonus" statement that will almost certainly resurrect the "no prejudice" issue that we all thought the Court of Appeals resolved once and for all last *Survey* year: "Lastly, we further find lack of merit in these disclaimer arguments because [Merchants] has demonstrated no resultant prejudice."[49] We will simply have to wait and see if this seemingly innocuous statement reopens the "no prejudice" debate in New York.

II. INSURANCE BROKERS' LIABILITY

In *Hoffend & Sons, Inc. v. Rose & Kiernan, Inc.*,[50] the Court of Appeals reaffirmed the rule of *Murphy v. Kuhn*, limiting the potential liability of insurance brokers to their customers for allegedly failing to obtain coverage that ultimately was necessary.[51] In a unanimous opinion by Judge Rosenblatt, the Court affirmed the dismissal of an action by Hoffend against R&K for failure to obtain a policy that would have covered its loss, in the absence of proof (1) of a specific request for the coverage in question—a prerequisite to the trigger of the common-law duty of a broker either to obtain the coverage that a customer requests or to inform the customer of an inability to do so—or (2) that the policyholder had a "special relationship" with the broker sufficient to impose any additional duties with regard to the procurement of insurance.[52]

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[48] *Id.* at 946, 819 N.Y.S.2d at 596.

[49] *Id.*; *See* Alan J. Pierce, *2004-05 Survey of New York Law: Insurance Law*, 56 SYRACUSE L. REV. 881, 882-87 (2006).

[50] 7 N.Y.3d 152, 851 N.E.2d 1149, 818 N.Y.S.2d 798 (2006).

[51] 90 N.Y.2d 266, 682 N.E.2d 972, 660 N.Y.S.2d 371 (1997).

[52] *Hoffend*, 7 N.Y.3d at 155, 851 N.E.2d at 1150, 818 N.Y.S.2d at 799.

Just as in *Cook*, however, the Court had no occasion to address and resolve an important legal issue raised in the action. Specifically, the Court declined to address whether Hoffend was barred from recovery because "having received and had an opportunity to read the policy, it requested no changes in it."[53] The Appellate Division dismissed the Complaint on the grounds that Hoffend had received the policy at least nine months prior to the loss, and was, therefore, "charged with 'conclusive presumptive knowledge of the terms and limits of [the policy],' thus defeating [its causes of action for negligence and breach of contract] as a matter of law."[54]

Hoffend is an Ontario County company that designs and constructs theatrical stages and rigging equipment globally.[55] In December 1998, "R&K gave Hoffend a written proposal for insurance coverage for one year starting" the following day for two policies.[56] One policy was a "builders' risk policy, provided by [Travelers], to cover property damage to domestic construction projects generally."[57] "The second was a Great Northern 'Foreign Liability Exporters' Package Policy,' to cover general liability, non-owned automobile coverage and workers' compensation for foreign projects[,]" but "[i]t did not cover property damage incurred during construction abroad."[58] Later in December, R&K sent Hoffend's CFO a letter "stating

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[53] *Id.* at 158, 851 N.E.2d at 1152, 818 N.Y.S.2d at 801.

[54] 19 A.D.3d 1056, 1057-58, 796 N.Y.S.2d 790, 791 (4th Dep't 2005); *See* Fiore v. Oakwood Plaza Shopping Cent., Inc., 78 N.Y.2d 572, 585 N.E.2d 364, 578 N.Y.S.2d 115 (1991); Gillman v. Chase Manhattan Bank, 73 N.Y.2d 1, 534 N.E.2d 824, 537 N.Y.S.2d 787 (1988); Level Exp. Corp. v. Wolz, Aiken & Co., 305 N.Y. 82, 111 N.E.2d 218 (1953); Royal Indem. Co. v. Heller, 256 N.Y. 322, 176 N.E. 410 (1931); Metzger v. Aetna Ins. Co., 227 N.Y. 411, 125 N.E.2d 814 (1920).

[55] *Hoffend*, 7 N.Y.3d at 155, 851 N.E.2d at 1150, 818 N.Y.S.2d at 799.

[56] *Id.*

[57] *Id.*

[58] *Id.*

that the Travelers builders' risk policy would cover only property damage arising out of domestic projects" and that "[f]oreign projects . . . should be discussed on a project-by-project basis."[59]

In February 1999, "Hoffend entered into a contract with an Argentine contractor . . . for a construction project in La Plata, Argentina."[60] Hoffend's principal claimed "that he and R&K's [employee,] Mark Nickel[,] discussed the project at a . . . meeting" in December 1998—the same day the broker's first proposal was made—"and that he made it clear to Nickel that the project should be 'covered.'"[61] "In December 1999, R&K gave Hoffend a written insurance proposal for [a renewal] period from December 12, 1999 to December 12, 2000" providing "essentially the same [coverage] as [in] the previous year, but the proposal did not specifically state that foreign coverage under the Travelers [policy] would still have to be negotiated on a project-by-project basis."[62] The Travelers policy "clearly states that it only covered property in the United States, Puerto Rico and Canada."[63] After the policy was issued, Hoffend's CFO and principal "read it and did not contact R & K with any questions or changes."[64]

The loss in question occurred in October 2000 "when a lighting bridge at the project collapsed," and "Hoffend filed claims with both Travelers and Great Northern."[65] "Great Northern agreed to defend and indemnify Hoffend" against third-party claims under a reservation

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[59] *Id.*

[60] *Id.* at 155, 851 N.E.2d at 1150, 818 N.Y.S.2d at 799.

[61] *Id.* at 155, 851 N.E.2d at 1150-51, 818 N.Y.S.2d at 799-800.

[62] *Id.* at 156, 851 N.E.2d at 1151, 818 N.Y.S.2d at 800.

[63] *Id.*

[64] *Id.*

[65] *Id.*

of rights, but "Travelers disclaimed, citing the territorial limitation in its policy."[66] "As a result, the property damage [loss] was not covered by either policy."[67]

Hoffend sued R&K and Nickel, asserting that they "failed to acquire the coverage" it "specifically requested," and that "it had a special relationship with Nickel, who reviewed Hoffend's operations, provided advice regarding insurance, bonding, banking, contracts and product development, and aided Hoffend in creating its business plan and corporate information statement."[68] "The Appellate Division found questions of fact" on both issues, but, as noted earlier, dismissed the action based on the "presumptive knowledge" doctrine since Hoffend read the Travelers' policy.[69] The Court of Appeals affirmed, but did so on the ground that Hoffend failed to raise any questions of fact that it "specifically requested" coverage or had a "special relationship" with R&K.[70]

The Court noted that Hoffend's principal had a "vague at best" recollection of events and "admitted that he could not remember asking for additional coverage for any specific project" in meetings with R&K.[71] In addition, Hoffend's CFO "could not remember ever asking R & K for full coverage for all losses related to" the La Plata project, and admitted that R&K never "represented that the Travelers policy would cover any property losses" in Argentina.[72] Moreover, R&K sent Hoffend a letter in December 1998 stating that the Travelers policy would

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[66] *Id.*

[67] *Id.*

[68] *Id.*

[69] *Id.* at 156-57, 851 N.E.2d at 1151, 818 N.Y.S.2d at 800.

[70] *Id.* at 157, 158, 851 N.E.2d at 1151, 1152, 796 N.Y.S.2d at 800, 801.

[71] *Id.* at 157, 851 N.E.2d at 1151, 818 N.Y.S.2d at 800.

[72] *Id.* at 157, 851 N.E.2d at 1152, 818 N.Y.S.2d at 801.

"'cover [Hoffend's] U.S. projects only' and that foreign coverage [was] open for discussion" and in light of this "unambiguous writing," said the Court, the recollection of Hoffend's principal "'that we are covered' is insufficient to impose liability" because "[a] general request for coverage will not satisfy the requirement of a specific request for a certain type of coverage."[73]

Finally, the Court noted that in *Murphy* the broker handled the insured's "personal insurance needs for [thirteen] years" and was the company's "broker for over three decades[]" and yet it found no "special relationship" sufficient to impose liability.[74] Finding no special relationship as a matter of law here, the Court wrote:

> Hoffend, a sophisticated commercial entity, did not compensate R & K for its insurance advice apart from its payment of premiums, nor did it delegate its insurance decision-making responsibility to R & K. In short, as in any ordinary broker-client relationship, Hoffend told R & K in general what insurance Hoffend had decided to purchase. It did not ask R & K what that insurance should be.[75]

While *Hoffend* reaffirms that a policyholder theoretically may impose liability against a broker for failure to obtain insurance, it also demonstrates once again that this theoretical possibility is very, very difficult to turn into reality.

III. AUTOMOBILE POLICIES

A. Untimely Disclaimer of SUM Coverage by the Insurer

In *New York Central Mutual Fire Insurance Co. v. Aguirre,* the Court once again addressed the question of an insurer's untimely disclaimer of coverage and held that the insurer's nine month delay in disclaiming coverage was unreasonable and that the insureds were entitled to coverage even though they failed to comply with policy conditions for obtaining SUM

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[73] *Id.* at 157-58, 851 N.E.2d at 1152, 818 N.Y.S.2d at 801 (first alteration in original).

[74] *Id.* at 158, 851 N.E.2d at 1152, 818 N.Y.S.2d at 801.

[75] *Id.* at 158, 851 N.E.2d at 1152, 818 N.Y.S.2d at 801.

(Supplementary Uninsured/Underinsured Motorists) benefits under an auto policy.[76] The Memorandum opinion of the Court's majority relied heavily on the Court's 2003 decision in *First Financial Insurance Co. v. Jetco Contracting Corp*., where the Court held that an insurer's unexcused forty-eight day delay in notifying an insured of denial of coverage was unreasonable as a matter of law.[77] However, the dissent by Judge Robert Smith, concurred in by Judge Read, found that the majority's decision "places an unreasonable and unnecessary burden on the insurance company."[78]

The three respondents were allegedly injured in August 2002 while sitting in a car that was struck by another vehicle that was hit and pushed into their parked car by an "unidentified hit-and-run driver" in Queens.[79] New York Central insured the parked car under an auto policy that included SUM coverage of $25,000 per person and $50,000 per accident.[80] The SUM coverage provisions of the policy required that, "*[a]s soon as practicable after our written request, the insured or other person making claim shall give us written proof of claim , . . . upon forms we furnish* unless we fail to furnish such forms within [fifteen] days after receiving notice of claim."[81]

On August 15, 2002—within two weeks after the accident—an attorney representing the injured parties sent a letter to the insurer making a claim under the policy's SUM coverage and

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[76] 7 N.Y.3d 772, 775, 854 N.E.2d 146, 148, 820 N.Y.S.2d 848, 850 (2006).

[77] 1 N.Y.3d 64, 70, 801 N.E.2d 835, 840, 769 N.Y.S.2d 459, 464 (2003).

[78] *Aguirre*, 7 N.Y.3d at 775, 854 N.E.2d at 148, 820 N.Y.S.2d at 850.

[79] *Id.* at 773, 854 N.E.2d at 146-47, 820 N.Y.S.2d at 848-49.

[80] *Id.* at 773, 854 N.E.2d at 147, 820 N.Y.S.2d at 849.

[81] *Id*. (emphasis in original).

enclosed completed applications for no-fault benefits.[82] On September 3, 2002, the insurer sent a letter to the attorney acknowledging receipt of the claim and directed his attention to the proof-of-claim forms provision.[83] The insurer enclosed the forms in the letter, which advised the attorney that "*[w]e require the immediate completion and return of the enclosed Notice of Intention to Make Claim forms*. 'Your failure to cooperate will jeopardize any rights which you may have under this policy for us to make [SUM] payments.'"[84]

In May 2003, the claimants served New York Central with "a request for uninsured motorist arbitration" although they "never filled out and returned the proof-of-claim forms, which asked for information about the accident and claimants' injuries."[85] The insurer then commenced a "proceeding in [s]upreme [c]ourt to stay the arbitration."[86] The supreme court granted the petition to permanently stay arbitration because of the claimants' failure to return completed proof-of-claim forms, holding that this was a "'condition precedent in the policy'" that did not require a timely disclaimer.[87] The appellate division affirmed and, after the Court of Appeals granted leave to appeal, it reversed and dismissed the petition to stay arbitration.[88]

The majority initially noted that insofar as the insurer conceded that "the policy's requirement to fill out and return a proof-of-claim form is an exclusion or a condition of coverage . . . the outcome of this appeal turns on whether New York Central Mutual disclaimed liability or denied coverage 'as soon as reasonably possible' within the meaning of Insurance

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[82] *Id.*

[83] *Id*. at 773-74, 854 N.E.2d at 147, 820 N.Y.S.2d at 849.

[84] *Id.* at 774, 854 N.E.2d at 147, 820 N.Y.S.2d at 849 (emphasis in original).

[85] *Id.*

[86] *Id*.

[87] *Id.* at 774, 854 N.E.2d at 147, 820 N.Y.S.2d at 849.

[88] *Id*.

Law [section] 3420(d)."[89] Citing *Jetco Contracting Corp.*, the majority noted that the "timeliness of an insurer's disclaimer is measured from the point in time when the insurer first learns of the grounds for disclaimer of liability or denial of coverage."[90] The majority wrote that the delay in disclaiming here was "significantly longer" than the forty-eight day delay it held unreasonable as a matter of law in *Jetco*.[91] Because the insurer's September 3, 2003 letter directed the claimants to "immediate[ly]" complete and return the proof-of-claim forms, the insurer expected the "receipt of the completed forms right away, or without substantial loss or interval of time after they were sent."[92] Thus, the majority held,

> the insurer became aware of its basis for denying coverage—that claimants had not completed and returned properly filled-out proof-of-claim forms—at a point in time significantly before June 19, 2003, when it petitioned to stay arbitration. That completed forms were never returned or that the letter did not set a precise deadline for their return does not extend the insurer's time to disclaim or deny coverage, or excuse its delay in doing so.[93]

The dissent construed the majority opinion as holding, "in substance," that the policy requirement that the claimants return completed proof-of-claim forms as soon as practicable "was nullified because the insurance company did not, as soon as possible after as soon as practicable, send claimants a notice that they had failed to send a notice."[94] According to the dissent, "[t]he Catch-22 quality of this holding is too much."[95] In applying Insurance Law section 3420(d), the dissenters "would hold that, where the disclaimer is based on a claimant's

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[89] *Id.*

[90] *Id.* at 774, 854 N.E.2d at 148, 820 N.Y.S.2d at 850 (quoting *Jetco Contracting Corp.*, 1 N.Y.3d at 68-69, 801 N.E.2d at 838-39, 769 N.Y.S.2d at 462-63) (internal quotation marks omitted).

[91] *Id.* at 775, 854 N.E.2d at 148, 820 N.Y.S.2d at 850.

[92] *Id.*

[93] *Id.* (citation omitted).

[94] *Id.* at 775, 854 N.E.2d at 148, 820 N.Y.S.2d at 850 (Smith, J., dissenting).

[95] *Id.* (Smith, J., dissenting).

failure to submit a document in timely fashion, and there is no fixed deadline for the claimant's submission, the time to disclaim does not start running at least until the belated submission arrives."[96]

The dissent found that the insurer "acted reasonably here" in demanding completion and return of the proof of claim forms, and then "wait[ing] to see when and if claimants sent the form in."[97] The claimants' failure to return completed forms "was not an insignificant oversight[,]" wrote the dissent, because

> a proof of claim form enables an insurance company to investigate a claim and to decide whether it is legitimate or not. To permit claimants who have never submitted proof of their claim to recover is to open the door to claims that are spurious or fraudulent. Under today's holding, however, insurance companies cannot use the failure to submit proof of claim as a defense unless they themselves do what the claimant is supposed to do—send a notice before too much time has gone by. I do not think it makes sense to impose this requirement on insurance companies, and I do not think the statute requires it.[98]

In a footnote, the majority responded to the dissent's "Catch-22" analysis by noting that "there is also a certain circularity to the insurer's argument that it could not disclaim as soon as reasonably possible until after it received the filled out proof-of-claim forms."[99] According to the majority, "[t]he simple answer to this conundrum, of course, is for the insurer to set a deadline for return of a proof-of-claim form."[100] The majority also wrote that "if the insurer suspects fraud in this case, it can still fight the claim in the arbitration on this basis."[101]

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[96] *Id.* (Smith, J., dissenting).

[97] *Id.* at 775-76, 854 N.E.2d at 148, 820 N.Y.S.2d at 850 (Smith, J., dissenting).

[98] *Id.* at 776, 854 N.E.2d at 149, 820 N.Y.S.2d at 851 (Smith, J., dissenting).

[99] *Id.* at 775 n.1, 854 N.E.2d at 148 n.1, 820 N.Y.S.2d at 850 n.1.

[100] *Id.*

[101] *Id.*

IV. LIFE INSURANCE

In *Goldman v. Metropolitan Life Insurance Co*. the Court of Appeals held, in three cases joined for argument and decision, that three insurers did not breach the life insurance policies they issued to policyholders where a policy date was set prior to an effective date and the insured, in the first year of the policy, paid premiums for days for which no coverage was provided.[102] The Court reasoned that "an insurance contract that uses the word 'annual' to describe premium payments is [not] ambiguous as to coverage [simply] because the insured, in the first year, receives less than 365 days of coverage."[103]

The facts of each case vary slightly, but the central and dispositive facts arise out of a common pattern. For example, in *Goldman* the plaintiff submitted an application to MetLife on January 30, 2002 for a yearly renewable term life insurance policy and "[o]n May 30, 2002, the policy was delivered and [the] plaintiff paid his annual premium."[104] The policy date set forth in the policy, however, was May 6, 2002.[105] Goldman commenced a class action alleging, inter alia, breach of contract and violations of General Business Law section 349.[106] He asserted that "since he was not covered for the [twenty-four] days between May 6 and May 30, 2002, yet was required to pay for that period of time, there was a breach of contract."[107] He claimed that the term "annual premium" was ambiguous because the average insured would believe that he or she would receive 365 days of coverage when, in fact, because of the "delay from the policy date

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[102] 5 N.Y.3d 561, 567, 841 N.E.2d 742, 743, 807 N.Y.S.2d 583, 584 (2005).

[103] *Id.* at 571, 841 N.E.2d at 746, 807 N.Y.S.2d at 587.

[104] *Id.* at 567, 841 N.E.2d at 743, 807 N.Y.S.2d at 584.

[105] *Id.*

[106] *Id.*

[107] *Id.* at 568, 841 N.E.2d at 743, 807 N.Y.S.2d at 584.

until the date of payment and delivery of the policy, there are fewer than 365 days of coverage in the first year of the policy."[108]

Similarly, in the *Franco v. Guardian Life Insurance Co. of America*[109] case joined with *Goldman*, there was a short gap between the "policy date" set forth in the life insurance contract and the effective date of the policy, which was controlled by when the policy was delivered and accepted by the insured.[110] "Even though it was permitted by the application, the Francos chose not to purchase interim coverage and receive a conditional receipt for temporary insurance to cover the dates between the date of application and delivery of the policy."[111]

Finally, in *Katz v. American Mayflower Life Insurance Co. of New York*,[112] the plaintiff signed an insurance application on July 11, 1997 for a term life policy, and "[t]he policy was issued on September 2, 1997 and delivered on September 24, 1997."[113] On the date of delivery, the plaintiff sent in his initial premium, and his annual premium, as stated in the policy, was to be paid in quarterly installments.[114] Although the "Goldman and Franco policies provide[d] for a [ten] day 'free look' period, the Katz policy allowe[d] for a [twenty] day period in which [Katz] could reject the policy and be refunded any previously paid premiums."[115]

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[108] *Id.* at 568, 841 N.E.2d at 743, 807 N.Y.S.2d at 584.

[109] 13 A.D.3d 292, 786 N.Y.S.2d 307 (1st Dep't 2004).

[110] *Goldman*, 5 N.Y.3d at 568-69, 841 N.E.2d at 744, 807 N.Y.S.2d at 585.

[111] *Id.* at 569, 841 N.E.2d at 744, 807 N.Y.S.2d at 585.

[112] 14 A.D.3d 195, 788 N.Y.S.2d 15 (1st Dep't 2004).

[113] *Goldman*, 5 N.Y.3d at 569, 841 N.E.2d at 744, 807 N.Y.S.2d at 585.

[114] *Id.* at 569, 841 N.E.2d at 744-45, 807 N.Y.S.2d at 585-86.

[115] *Id.* at 570, 841 N.E.2d at 745, 807 N.Y.S.2d at 586.

In all three cases, the Appellate Division, First Department, dismissed the complaint and then granted leave to appeal to the plaintiff to the Court of Appeals.[116] In a unanimous opinion by Judge George Bundy Smith, the Court affirmed in all three cases, finding that "the Appellate Division properly held that the contracts could be interpreted only in one manner and granted the CPLR 3211 motions to dismiss."[117]

The Court noted that in each of the policies at issue there were two options for payment: (1) the policyholders "could pay at the time the application was submitted and receive temporary coverage until the delivery of the policy" or (2) "pay at the time of delivery of the policy and have coverage become effective upon receipt of the first initial premium and delivery of the policy."[118] The plaintiffs in each case chose the second option, which was referred to as the "cash on delivery (C.O.D.) option."[119]

In rejecting the plaintiffs' argument that each of the insurance policies was ambiguous because it would be the "average insured's understanding that an 'annual' premium purchases a full year of coverage[,]" and under these policies the insured receives less than 365 days of coverage in the first year, the Court wrote that the "[m]ere assertion by one that contract language means something to him, where it is otherwise clear, unequivocal and understandable when read in connection with the whole contract, is not in and of itself enough to raise a triable issue of fact."[120]

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[116] *Id.* at 568, 570, 841 N.E.2d at 744, 745, 807 N.Y.S.2d at 585, 586. *See also* Goldman v. Metro. Life Ins. Co., 13 A.D.3d 289, 289, 788 N.Y.S.2d 25, 26 (1st Dep't 2004); *Franco*, 13 A.D.3d at 292, 786 N.Y.S.2d 307; *Katz* 14 A.D.3d at 202, 788 N.Y.S.2d at 20.

[117] *Goldman*, 5 N.Y.3d at 571, 841 N.E.2d at 746, 807 N.Y.S.2d at 587.

[118] *Id.* at 571, 841 N.E.2d at 745-46, 807 N.Y.S.2d at 586-87.

[119] *Id.* at 571, 841 N.E.2d at 746, 807 N.Y.S.2d at 587.

[120] *Id.* (quoting Bethlehem Steel Co. v. Turner Constr. Co., 2 N.Y.2d 456, 460, 141 N.E.2d 590, 593, 161 N.Y.S.2d 90, 93 (1957)) (internal quotation marks omitted).

Here, the Court found, "[t]he application clearly states the terms and conditions of the insurance policy" and "the policy also states when coverage will begin."[121] The Court rejected the plaintiffs' argument that the "Risk Free" periods—the period in the contract which allows the insured to return the policy and receive a refund of any paid premiums—is misleading.[122] To the contrary, the Court found that "[t]he fact that the insured can return the contract does not mean that the contract period would otherwise be covered even without a payment. There is nothing in the 'Risk Free' period suggesting that the coverage will start from the policy date without the payment of a premium."[123]

Having rejected the plaintiffs' breach of contract claim, the Court had little trouble dismissing their unjust enrichment—because there is no such quasi-contract claim where there is an actual contract, and GBL section 349 claims—because there were no deceptive practices by the insurers.[124]

V. LIABILITY INSURANCE

A. Insurer's Timely Disclaimer of Coverage Under Insurance Law § 3420(d)

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[121] *Goldman*, 5 N.Y.3d at 571, 841 N.E.2d at 746, 807 N.Y.S.2d at 587.

[122] *Id.* at 572, 841 N.E.2d at 746, 807 N.Y.S.2d at 587.

[123] *Id.* The Court noted that although there were no New York cases holding that the "risk free" period is misleading, there are

> several lower court cases from foreign jurisdictions that have both rejected premiums based on a policy date versus a coverage date (*see* Semler v. Guardian Life Ins. Co. of Am., Case No. 990637 [2003 Cal. App. Unpub. LEXIS 4461] (Cal. Ct. App. 200[3]); Semler v. First Colony Life Ins. Co., Case No. 984902 (Cal. Super. Ct. 1999); Burstein v. First Penn-Pac. Life Ins. Co., 209 F.R.D. 674 (S.D. Fla. 2002)) . . . [and that] have permitted premiums that are based upon a policy date rather than a coverage date (Life Ins. Co. of the Sw. v. Overstreet, 580 S.W.2d 929 (Tex. Civ. App. 1979); Travelers Ins. Co. v. Castro, 341 F.2d 882 (1st Cir. 1965)).

Id. However, the Court did not find these cases persuasive. *See id.*

[124] *Id*. at 572, 841 N.E.2d at 746-47, 807 N.Y.S.2d at 587-88.

Two years ago, this *Survey* article discussed a case from the First Department decided in that Survey year that joined the Fourth Department in holding that Insurance Law § 3420(d), requiring timely disclaimers of coverage for certain accidents in New York or else the insurer would be precluded from denying coverage based on policy conditions or exclusions, does not apply to claims between insurers.[125] This *Survey* year the First Department reaffirmed this principle in *Bovis Lend Lease LMB, Inc. v. Royal Surplus Lines Insurance Co*.[126]

The case involved the construction of a new building at Columbia University, who hired Bovis to serve as construction manager.[127] In September 2002, Winter, an employee of Millennium Masonry, which was hired by Bovis as a subcontractor on the job, was injured when "he fell from a height."[128] In November 2002, Winter filed suit against Columbia and Bovis, asserting claims based upon negligence and labor law sections 200, 240 and 241.[129] National Union insured Bovis, and Columbia was an "additional insured" under that policy.[130] Royal insured Millennium, and Bovis and Columbia were both named as "additional insureds" under the Royal policy.[131]

On February 28, 2003 National Union wrote a letter to Royal tendering to Royal on behalf of Bovis and Columbia the obligation to defend and indemnify both Bovis and

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[125] *See* Alan J. Pierce, *Insurance Law, 2003-04 Survey of New York Law*, 55 SYRACUSE L. REV. 1163, 1187-88 (2005); Realm Nat'l Ins. Co. v. Hermitage Ins. Co., 8 A.D.3d 110, 778 N.Y.S.2d 492 (1st Dep't 2004).

[126] 27 A.D.3d 84, 806 N.Y.S.2d 53 (1st Dep't 2005).

[127] *Id.* at 86, 806 N.Y.S.2d at 55.

[128] *Id.* at 85-86, 806 N.Y.S.2d at 55.

[129] *Id.* at 86, 806 N.Y.S.2d at 55.

[130] *Id.*

[131] *Id.*

Columbia.[132] National Union hired attorneys to defend Bovis and Columbia while waiting for Royal's response to its tender.[133] On March 3, Royal acknowledged in writing receipt of National Union's tender letter, indicated that it was commencing its investigation of the matter, but neither accepted nor rejected the tender.[134] On March 20, Royal received a copy of the contract between Millennium and Bovis, which contained a full description of the job.[135] On April 8, Royal received a report from its investigator with more details about the job and the accident.[136]

In April, Bovis, Columbia, and National Union commenced this declaratory judgment action against Royal.[137] In late May 2003, Royal sent an "undated letter" to National Union rejecting the tender on the grounds of a "New Residential Work or Products Exclusion" in Royal's policy with Millennium.[138] National Union received the disclaimer letter on May 21, 2003.[139] Royal moved for summary judgment but Supreme Court accepted National Union's argument that section 3420(d) applied to determine Royal's timely disclaimer of coverage as to National Union, its co-insurer, and declared that Royal was obligated to defend and indemnify Bovis, Columbia, and National Union in the Winter action.[140]

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[132] *Id.* at 86, 806 N.Y.S.2d at 55.

[133] *Id.*

[134] *Id.*

[135] *Id.* at 88, 806 N.Y.S.2d at 57.

[136] *Id.*

[137] *Id.* at 87, 806 N.Y.S.2d at 56.

[138] *Id.* at 86, 806 N.Y.S.2d at 55-56.

[139] *Id.* at 86, 806 N.Y.S.2d at 55.

[140] *Id.* at 87, 806 N.Y.S.2d at 56.

The First Department modified the order in a unanimous opinion written by now retired Justice Ellerin, and as modified affirmed the order, but on very different grounds.[141] First, as to Bovis and Columbia, the court found that Royal's disclaimer was not timely.[142] Given that Royal received the Bovis-Millennium contract on March 20 and its investigator's report on April 8, but its disclaimer was not received until May 21—although allegedly issued on May 14—the court found this delay of between thirty-six and sixty days after it has received "sufficient facts" to render a coverage determination "untimely as a matter of law."[143]

Second, the court once again found, consistent with other decisions in New York—including its own prior decisions—that Insurance Law section 3420(d) does not apply to Royal's disclaimer as to its co-insurer, National Union.[144] The Court noted that "[a] review of the statutory language itself demonstrates that another insurer does not fall within the specified categories" and that "[section] 3420(d) was never intended to apply to another insurer. . . ."[145] The First Department noted that other "courts have held that [section] 3420(d) is not applicable to a request for contribution between coinsurers," and rejected Royal's attempt to distinguish these cases as follows:

> The fact that National Union seeks from Royal not contribution but the full defense and indemnity of Bovis and Columbia in the underlying personal injury action does not alter the analysis. National Union's ability to defend and/or indemnify Bovis and Columbia is not affected by a delay in learning of Royal's position. Indeed, National Union apparently has been providing the defense of the underlying action for nearly three years. Whether it seeks contribution or full coverage, National Union is not "within the zone of interest which the statutory

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[141] *Id.* at 94, 806 N.Y.S.2d at 61.

[142] *Id.* at 89, 806 N.Y.S.2d at 58 (citations omitted).

[143] *Id.* at 88, 90, 806 N.Y.S.2d at 57-58.

[144] *Id.* at 93, 806 N.Y.S.2d at 60.

[145] *Id.* at 91, 806 N.Y.S.2d at 58-59.

> requirement of notice to the injured parties seeks to protect" and thus we hold that, insofar as plaintiff National Union is concerned, [section] 3420 (d) has no application, and Royal's disclaimer is not untimely.[146]

The court affirmed, however, because it concluded that Royal had "failed to meet its burden of establishing that [its] exclusion is subject to no reasonable interpretation other than the one it offers."[147] In addition, the court held that "the motion court improperly held that Royal must reimburse National Union for all its defense costs, rather than for those incurred from the date on which Royal received National Union's tender of the underlying lawsuit."[148]

Although *Bovis* appears to simply reaffirm several consistent decisions in New York that section 3420(d) does not apply as to co-insurers, the decision is important because the issue arose in a construction accident scenario involving labor aw sections 200, 240, and 241 where insurance coverage will often be the most important consideration and an untimely disclaimer under section 3420(d) could be devastating for an insurer.

B. The Insured's Right to Counsel of its Own Choosing at the Insurer's Expense

It is a well-established and known rule of law in New York that generally when the insurer agrees to defend the insured, but reserves its rights on the duty to indemnify the insured on one or more causes of action, the insured has a right to select counsel of its own choosing to defend it and the insurer must pay the reasonable expenses of that counsel. To the knowledge of this author, however, most insurers in this circumstance simply assign the defense of the matter to one of its approved defense counsel and do not advise the policyholder of its rights in this regard, and therefore most insureds do not know of this right unless they have private counsel

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[146] *Id*. at 92-93, 806 N.Y.S.2d at 60, (citing Tops Mkts. v. Md. Cas., 267 A.D.2d 999, 1000, 700 N.Y.S.2d 325, 326 (4th Dep't 1999); AIU Ins. Co. v Investors Ins. Co., 17 A.D.3d 259, 260, 793 N.Y.S.2d 412, 413 (1st Dep't 2005); Batchie v. Travelers Ins. Co., 130 A.D.2d 536, 537, 515 N.Y.S.2d 413 (1987)).

[147] *Id.* at 94, 806 N.Y.S.2d at 61 (citation omitted).

[148] *Id*. (citation omitted).

because the rule is judicially made and is not contained in the policy. If the insurer was required to advise the insured of this right in its coverage letter to the insured, this could have a significant effect on who is defending the insured in the liability case.

This issue was squarely addressed in *Elacqua v. Physicians' Reciprocal Insurers*, where the Third Department held, contrary to a prior decision of the First Department, that where there was a conflict of interest because the insurer "took the position that some of the underlying malpractice claims were covered under policy while others were not" the insurer was required to advise the insureds of their entitlement to a defense by an attorney of their own choosing whose fees were to be paid by the insurer because to "[t]o hold otherwise would seriously erode the protection afforded the insureds."[149]

Although the case raises interesting coverage issues, the case is most significant and is reported here because of the issue of an insurer advising the insured of the right to select counsel, and the other issues will not be addressed here. The plaintiffs were "both licensed physicians" and members of a partnership, and all three were insured under malpractice insurance policies issued by PRI.[150] In November 1994, a patient of the partnership who was treated by "a nurse practitioner employed by the partnership" died of cancer, and her husband subsequently "commenced a malpractice action against plaintiffs and [the nurse practitioner]."[151] "Shortly before the trial of that action, the attorney retained by [PRI] to defend [the insureds in that malpractice action] sought an adjournment because he perceived a conflict in his representation. As a [result, PRI] retained individual counsel for each physician and the case proceeded to

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[149] 21 A.D.3d 702, 706-07, 800 N.Y.S.2d 469, 473 (3d Dep't 2005) (citations omitted), *appeal dismissed* 6 N.Y.3d 844, 847 N.E.2d 373, 814 N.Y.S.2d 76 (2006).

[150] *Id.* at 703, 800 N.Y.S.2d at 470.

[151] *Id.*

trial."[152] The complaint was dismissed against the physicians, but "a verdict of nearly [two million dollars] was rendered against the partnership based upon [the employee's] negligence."[153]

PRI refused to indemnify and pay the verdict, taking "the position that its policy did not [provide] coverage since the only liability of the partnership was vicarious [for] its employee."[154] The plaintiffs commenced this declaratory judgment action "seeking money damages for breach of contract" and "a declaration that [PRI was] required to indemnify the plaintiffs" for the verdict.[155]

> Plaintiffs moved for partial summary judgment declaring that [PRI was] liable for the judgment rendered in the underlying malpractice action. Supreme Court granted summary judgment in favor of the partnership finding coverage for the partnership under the policy and . . . that defendant failed as a matter of law to timely disclaim coverage as required by Insurance Law [section] 3420 (d).[156]

"[PRI appealed] from this holding[,] . . . [and the] [p]laintiffs cross-appeal[ed] from that portion of Supreme Court's judgment that '[r]eluctantly' declared, upon constraint of" a prior First Department decision "that [PRI] had no obligation to advise plaintiffs of their right to counsel of their own choosing."[157]

After finding that the policy language upon which PRI relied to disclaim coverage for the verdict is an exclusion from coverage, and that there was a "triable issue" of fact whether PRI timely disclaimed under Insurance Law section 3420(d), the court turned to the "plaintiffs' cross-

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[152] *Id.*

[153] *Id*.

[154] *Id.*

[155] *Id.* at 703-04, 800 N.Y.S.2d at 470.

[156] *Id*. at 704, 800 N.Y.S.2d at 470.

[157] *Id.*

appeal."[158] There was no dispute in the case that because of the insurer's conflict of interest the "plaintiffs were entitled 'to defense by an attorney of [their] own choosing,' whose fees were to be paid by defendant."[159] With respect to the plaintiffs claim that PRI was obligated to advise them of this right, the court held:

> While Supreme Court correctly recognized such entitlement, it held that it was constrained by *Sumo Container Sta. v Evans, Orr, Pacelli, Norton & Laffan*[160] to conclude that defendant had no obligation to advise plaintiffs of this right. We decline to follow that part of the *Sumo* decision. If defendant was obligated to defend plaintiffs in the underlying action and, as the decision in *Pub. Serv. Mut. Ins. Co. v. Goldfarb*[161] makes clear, provide them independent counsel of their own choosing, it follows that defendant was required to advise them of that right. To hold otherwise would seriously erode the protection afforded.[162]

In *Sumo*, the policyholder sued the insurers and attorneys assigned by the insurers to defend it for breach of contract, legal malpractice, fraud, collusion and violation of Judiciary Law section 487.[163] The First Department wrote as follows on this issue:

> The cases relied on by Sumo, while supporting its right to independent counsel at Kemper's expense, do not establish an affirmative duty on defendants' part to advise Sumo of that entitlement. . . .
>
> The record discloses that notice of defendants' conflict of interest was implicit in the correspondence among the parties and was repeatedly given from the inception of the underlying action through the trial, at which Sumo's secretary-treasurer testified that he was aware of Sumo's exposure and right to independent counsel, but that he wanted [the attorney] to proceed.[164]

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[158] *Id*. at 704-06, 800 N.Y.S.2d at 472-73.

[159] *Id*. at 706-07, 800 N.Y.S.2d at 473 (quoting Pub. Serv. Mut. Ins. Co. v. Goldfarb, 53 N.Y.2d 392, 401, 425 N.E.2d 810, 815, 442 N.Y.S.2d 422, 427 (1981)).

[160] 278 A.D.2d 169, 719 N.Y.S.2d 223 (2000).

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[162] *Elacqua*, 21 A.D.3d at 707, 800 N.Y.S.2d at 473.

[163] *Sumo*, 278 A.D.2d at 170, 719 N.Y.S.2d at 224.

[164] *Id.* at 170-71, 791 N.Y.S.2d at 224 (citations omitted).

We now have a clear conflict between the First and Third Departments on this issue, which means that the Court of Appeals will hopefully soon address this issue and resolve it. Unfortunately, because the Third Department's order was non-final, the Court of Appeals dismissed a motion for leave to appeal in *Elacqua* in 2006.[165] While the Third Department could have granted leave to appeal from its non-final order to the Court of Appeals on a certified question under CPLR 5602(b)(1), apparently the parties did not seek leave in this fashion.

Finally, the Third Department did not address *the appropriate remedy* for the insurer's breach of the duty—now recognized by the court—to advise the insured of the right to select counsel to be paid for by the insurer. Both the insurer's duty to advise the insured and the remedy for a violation of this new duty will be significant issues to watch for in the future.

VI. CHOICE-OF-LAW FOR INSURANCE POLICIES

In *Certain Underwriters at Lloyd's, London v. Foster Wheeler Corp.*,[166] the Appellate Division, First Department, held that New Jersey law should apply instead of New York law in determining the amount of excess insurance coverage for defending and paying asbestos-related personal injury claims, on the grounds that the state of the policyholder's "principal place of business takes precedence over the state of incorporation."[167] As a result, Foster Wheeler, which has faced "hundreds of thousands" of lawsuits for manufacturing asbestos-contaminated boilers,[168] will gain millions of dollars in possible insurance coverage, and approximately thirty

[165] Elacqua v. Physicians' Reciprocal Insurers, 6 N.Y.3d 844, 847 N.E.2d 373, 814 N.Y.S.2d 76 (2006).

[166] 822 N.Y.S.2d 30 (1st Dep't 2006).

[167] *Id.* at 36.

[168] *Id.* at 31.

excess insurers who sold Foster Wheeler polices from 1970 to 1982 will provide substantially more coverage than if New York law was applied.[169]

Foster Wheeler was incorporated in New York in 1900 and maintained its principal place of business in New York until 1962, when it relocated to New Jersey, but kept a small office in New York City with one full-time employee.[170] The lawsuits against it have been brought throughout the United States since 1973, and arise out of its design and manufacturing of asbestos containing products which was performed by Foster Wheeler and whose customers purchased the products in question throughout the country.[171]

Foster Wheeler settled with all of its insurers except the thirty insurer-parties in this case, all of whom issued excess liability policies covering various periods between 1970 and 1982 "while Foster Wheeler's principal place of business was in New Jersey."[172] "Almost all of the [ ] insurers are licensed to do business in both New York and New Jersey."[173] Two significant facts were undisputed between the parties. First, that "the underlying asbestos claims are based on injuries that . . . have been suffered continuously over extended periods of time. This makes it necessary to allocate each injury 'horizontally' over the period of its occurrence in order to determine the coverage obligation of each nonsettling insurer."[174] Second, that "New York and New Jersey prescribe different mathematical methods of performing such an allocation."[175] Although not at issue in the case, the court further noted that

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[169] *Id.* at 32-33.

[170] *Id.* at 32.

[171] *Id.* at 32.

[172] *Id.*

[173] *Id.*

[174] *Id.*

> once an allocation is made to each year [horizontally, there is a need] . . . to allocate the loss for that particular year "vertically" among the various layers of insurance purchased for that year, with primary policies paying first within each year. Thus, . . . "the way in which liabilities are allocated to policies in the primary layers will determine when those primary policies are exhausted, and thus when excess layer policies [such as the unsettled policies] are reached, if at all."[176]

According to the court the policies do not provide a method for allocating the losses "horizontally" over time, and the policies do not contain any choice-of-law provisions.[177]

Turning to the competing states' laws on allocation, the court wrote that New York's

> "time-on-the-risk method" that was approved by the Court of Appeals in *Consolidated Edison Co. of N.Y., Inc. v. Allstate Ins. Co.*[178] derives the portion of the total loss allocable to the term of a given policy "by multiplying the [total loss] by a fraction that has as its denominator the entire number of years of the claimant's injury, and as its numerator the number of years within that period when the policy was in effect."[179]

In contrast, New Jersey

> has adopted the method of "proration on the basis of policy limits, multiplied by years of coverage"[180] Under the New Jersey method (which has been referred to as "time-plus-limits"), the proportion of the total loss allocable to the term of a given policy is the ratio of the total coverage purchased (or risk retained) during the term of that policy to the total coverage purchased (or risk retained) during the entire period of the injury's occurrence (excluding any time during which insurance for the risk was unavailable) (*see Carter-Wallace, Inc. v. Admiral Ins. Co.*[181]).[182]

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[175] *Id.*

[176] *Id.*

[177] *Id.* at 32.

[178] 98 N.Y.2d 208, 225, 774 N.E.2d 687, 695, 746 N.Y.S.2d 622, 630 (2002)

[179] *Certain Underwriters at Lloyd's, London* at 32-33 (quoting Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp, 73 F.3d 1178, 1202 (2d Cir.1995)).

[180] Owens-Illinois, Inc. v. United Ins. Co., 138 N.J. 437, 475, 650 A.2d 974, 993 (1994).

[181] 154 N.J. 312, 322-323, 712 A.2d 1116, 1122 (1998).

[182] *Certain Underwriters at Lloyd's, London*, 822 N.Y.S.2d at 33.

It was undisputed that the New Jersey method of allocation "would make tens of millions of dollars more coverage available to Foster Wheeler than would the [New York] method."[183]

The court wrote that "New York's 'center of gravity' or 'grouping of contacts' approach to choice-of-law questions in contract cases, . . . generally dictates that a contract of liability insurance be governed by the law of . . . the location-of-the-risk[,]" but that this "rule obviously cannot be applied without modification in the event the insurance policies in question cover risks that are spread though multiple states. . . . [as is] the case here. . . ."[184] Thus, according to the court,

> [i]n the case of a corporate insured seeking coverage under a policy covering risks in multiple states, the foregoing interests, in aggregate, weigh in favor of applying the law of the insured's domicile, notwithstanding that certain other states (e.g., the states of the insurer's domicile, and where negotiation and contracting occurred) may share, to a lesser extent, in the [governmental interests to be considered].[185]

According to the court,

> [w]hat emerges from the foregoing is that, where it is necessary to determine the law governing a liability insurance policy covering risks in multiple states, the state of the insured's domicile should be regarded as a proxy for the principal location of the insured risk. As such, the state of domicile is the source of applicable law.[186]

The court then held that where, as here, a corporate insured's principal place of business and its state of incorporation are not the same state,

> the state of the principal place of business takes precedence over the state of incorporation . . . [t]reating the state of the principal place of business as the corporate domicile for these purposes, rather than the state of incorporation, is consistent with the view expressed in the Restatement that, "[a]t least with

[183] *Id.*

[184] *Id.*

[185] *Id.* at 34 (citation omitted).

[186] *Id.* at 35.

> respect to most issues, a corporation's principal place of business is a more important contact than the place of incorporation."[187] We look to the state of incorporation for the law governing the corporation's internal corporate governance and its relations with shareholders, not for the law governing the corporation's contractual relationships in general.[188]

The insurers pointed to the five factors cited in section 188 of the Restatement in arguing for New York law, and the parties disputed whether the contracting, negotiation, and payment of premium occurred in New York or New Jersey.[189] The court rejected this reliance on the five factors in section 188, stating:

> As previously discussed, we regard the state of the insured's domicile to be a proxy for the principal location of the insured risk, which, under New York law and Restatement [section] 193, is the controlling factor in determining the law applicable to a liability insurance policy, thereby obviating the need to consider all five Restatement factors. Even if consideration of all five Restatement factors were required, however, we still would conclude that New Jersey law should be applied. Further, we would reach the same conclusion even if, as the nonsettling insurers argue, New York constituted the place of contracting, negotiation, and the insured's performance. This is because the Restatement factors "are to be evaluated according to their relative importance with respect to the particular issue"[190]. Stated otherwise, the choice-of-law analysis is not "a mindless scavenger hunt to see which state can be found to have more contacts, but rather . . . an effort to detect and analyze what interest the competing states have in enforcing their respective rules"[191]. In the case of a liability insurance policy covering risks in multiple states, the state of the insured's principal place of business has a greater concern with issues of policy construction and application bearing on the amount of available coverage than do the states where contracting, negotiation, or payment of the premium happened to occur.[192]

Finally, the insurers argued that under the court's analysis, most of the settling insurers' policies, which were issued before 1962, would be governed by New York law—because Foster

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[187] RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 145 cmt. e (1971)

[188] *Certain Underwriters at Lloyd's, London*, 822 N.Y.S.2d at 36.

[189] *Id.* at 36-37.

[190] RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 188(2)(e).

[191] Fireman's Fund Ins. Co. v. Schuster Films, Inc., 811 F. Supp. 978, 984 (S.D.N.Y. 1993).

[192] *Certain Underwriters at Lloyd's, London*, 822 N.Y.S.2d at 37 (citations omitted).

Wheeler's domicile was clearly New York prior to 1962—and that all the policies covering Foster Wheeler should be governed by one state's law to assure fairness in the allocation process.[193] The court rejected this argument for a "blanket" choice-of-law determination as opposed to a policy specific analysis under the facts in this case:

> In closing, we note that the nonsettling insurers fail to articulate any justification under choice-of-law principles for their argument that we should render a blanket choice-of-law determination for hundreds of different insurance policies issued by dozens of different insurers over several decades. Each policy constitutes a separate contractual transaction, and to treat insurance policies issued at various widely separated points in time, over a span of decades, as one undifferentiated aggregate for the purpose of choosing one state's law to govern them all, would do considerable violence to the principle (relied on by the nonsettling insurers themselves at certain points in their argument) that the contacts on which the choice-of-law determination depends should have been known to the parties at the time of contracting.[194] While there may nonetheless be sound practical reasons to adopt the practice suggested by the nonsettling insurers where the issue cannot be avoided, we find that the settlement of all pre-1962 policies in the case before us obviates any need for us to consider doing so here.[195]

CONCLUSION

The Court of Appeals decided fewer insurance coverage cases this *Survey* year than in years past. Nonetheless, the decisions discussed herein were all significant and resolved, in many cases, issues of first impression in New York. We already know that the Court of Appeals will hear and decide in 2007 an important case to be discussed in next year's article, *BP Air Conditioning Corp. v. One Beacon Insurance Company* in 2007.[196] Notably, in a 3-2 decision, the First Department in *BP Air* applied the Court's decision in *Pecker Iron Works of N.Y. v.*

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[193] *Id.* at 38-39.

[194] RESTATEMENT (SECOND) OF CONFLICT OF LAWS § 188 cmt. e (1971) (a contract "can bear little weight in the choice of the applicable law when . . . at the time of contracting it is either uncertain or unknown").

[195] *Certain Underwriters at Lloyd's, London*, 822 N.Y.S.2d at 41 (citations omitted).

[196] 33 A.D.3d 116, 821 N.Y.S.2d 1, *leave granted* No. M-5078 2006 N.Y. App. Div. LEXIS 15960, at *1 (1st Dep't Dec. 21, 2006).

Traveler's Ins. Co.,[197] and held that a subcontractor was entitled to a defense pursuant to its status as an additional insured under a policy issued to a sub-subcontractor, and that the sub-subcontractor's policy was primary over the subcontractor's own liability policy in the underlying personal injury action.[198] The dissenters asserted that *Pecker* is not controlling because there it was undisputed that the contractor was an additional insured,[199] whereas here "Beacon cannot be declared obligated to defend or indemnify BP unless and until it is determined that its additional insured obligation is triggered. That determination can only be made if the fact finder in the underlying Cosentino action determines that Cosentino's accident resulted from [the sub-subcontractor's] activities."[200]

The courts in New York will certainly decide many other important insurance coverage cases that will require discussion here next year.[201]

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[197] 99 N.Y.2d 391, 786 N.E.2d 863, 756 N.Y.S.2d 822 (2003).

[198] *See generally BP Air Conditioning Corp.*, 33 A.D.3d at 116, 821 N.Y.S.2d at 1.

[199] *Id.* at 138-39, 821 N.Y.S.2d at 17.

[200] *Id.* at 135, 821 N.Y.S.2d at 15 (citation omitted).

[201] Those cases will include Appalachian Ins. Co. v. General Elec. Co., 19 A.D.3d 198, 796 N.Y.S.2d 609 (1st Dep't 2005), *leave granted in part* 6 N.Y.3d 741, 843 N.E.2d 1150, 810 N.Y.S.2d 410 (2005), and Thyroff v. Nationwide Mut. Ins. Co., 460 F.3d 400 (2d Cir. 2006) (certifying questions to the New York Court of Appeals), *certified questions accepted* 7 N.Y.3d 837, 857 N.E.2d 528, 824 N.Y.S.2d 207 (2006).