LB&C

QUARTERLY INSURANCE COVERAGE NEWSLETTER: NEW YORK

A quarterly newsletter from L'Abbate, Balkan, Colavita & Contini, L.L.P. Volume II · Issue I · First Quarter 2009

CASES OF INTEREST BY TOPIC:

ADDITIONAL INSURED COVERAGE

Illinois Nat'l Ins. Co. v. American Alternative Ins. Co., 872 N.Y.S.2d 26 (1st Dep't January 22, 2009) The insurance contract issued by the defendant-insurer to the non-party asbestos abatement subcontractor included as an insured "any person or organization for whom you are performing operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy." Although plaintiff, the general liability insurer for the New York City School Construction Authority, conceded that the contract between the City and the asbestos abatement subcontractor did not contain an agreement whereby the subcontractor was required to secure the City with additional insured coverage, the plaintiff-insurer argued that a provision in the City's bid documents required that the performance of asbestos abatement work "shall be governed by" certain terms and conditions, among which was a requirement that the City be named as an addition insured. According to the Appellate Division, First Department, contrary to the plaintiff's contention, the provision in the bid documents did not constitute an "agree[ment] [between the subcontractor and the City] in writing in contract or agreement that [the latter] be added as an additional insured on [the former's] policy."

David Christa Constr., Inc. v. American Home Assurance Co., 59 A.D.3d 1136 (4th Dep't February 11, 2009) The Appellate Division, Fourth Department, held that a general contractor was entitled to additional insured coverage under its subcontractor's commercial general liability insurance policy, which defined an additional insured as any organization to which the subcontractor "agreed, by written contract, to provide coverage, but only with respect to operations performed by or on behalf of" the subcontractor. According to the Fourth Department, the language of the additional insured provision focused not upon the precise cause of the accident, but upon the general nature of the operation in the course of which the injury was sustained. Since the parties did not dispute that the claimant was employed by the subcontractor and injured while performing construction work for the subcontractor, the Fourth Department held that the claimant was injured while acting "with respect to the operations performed by or on behalf of" the subcontractor, therefore triggering the additional insured coverage for the general contractor under the subcontractor's liability policy. Furthermore, the fact that the claimant's injury may have been caused by the general contractor's negligence was immaterial with respect to the issue of whether the general contractor was entitled to additional insured coverage.

Larry E. Knight, Inc. v. QBE Ins. Corp., 2009 WL 672994 (1st Dep't March 17, 2009) The Appellate Division, First Department, held that since the subcontract at issue did not contain an obligation to procure additional insured coverage for the contractor, it could not be deemed an additional insured under the subcontractor's commercial general liability policy issued by the defendant-insurer. According to the First Department, the contractor's argument that the indemnity provision of the subcontract imported a duty to insure failed because the duty to indemnify is distinct from and does not inherently contain a duty to insure.

NEW YORK BILLS OF INTEREST:

LATE NOTICE BILL EFFECTIVE AS OF JANUARY 19, 2009:

As we have previously reported, on July 21, 2008, Governor David Patterson signed into law a bill reversing New York's longstanding "no-prejudice" rule concerning late notice denials and allowing for direct actions against insurers in certain circumstances. The new law took effect on January 19, 2009, and applies to policies issued or delivered in New York on or after such date and to any action maintained under such a policy.

FEDERAL BILLS OF INTEREST:

On December 29, 2007, President Bush signed into law the Medicare, Medicaid, SCHIP Extension Act of 2007. Section 111 of the Act, the Medicare Secondary Payer Statute, which goes into effect on July 1, 2009, requires workers' compensation, liability, no-fault and self-insurers to notify Medicare of all claims/settlements involving a Medicare beneficiary.

Specifically, the Act sets forth several requirements for insurance carriers and claims administrators as of July 1, 2009, including:

- The insurer must make a specific determination for each claimant under a workers' compensation, liability, no-fault or self-insurance program as to whether the party is a Medicare beneficiary.
- When a claimant is determined to be a Medicare beneficiary, information regarding the claim must be reported to the Secretary of Health and Human Services in order to facilitate coordination of benefits and applicable recoveries.
- Failure to report the claim in a "timely manner" can result in penalties, which among others can include a penalty of $1,000 for each day of noncompliance per

ANTI-SUBROGATION

Romano v. Whitehall Properties, LLC, 59 A.D.3d 697 (2d Dep't February 24, 2009) The Appellate Division, Second Department, held that an assertion of a workers' compensation lien by Travelers Indemnity Insurance Company of America against the settlement of a claim of an employee of its insured, to which Travelers also contributed as the general liability insurer of the insured-employer, did not violate the anti-subrogation rule, since Travelers' obligation to pay the workers' compensation benefits to the employee did not arise under the general liability policy pursuant to which it defended the property owner and general contractor as additional insureds in the employee's negligence action. As such, according to the Second Department, Travelers was not seeking a right of subrogation against its own insured for a claim arising from the very risk for which its insured was covered.

APPLICABILITY OF EXCLUSIONS

Clayburn v. Nationwide Mut. Fire Ins. Co., 58 A.D.3d 990 (3rd Dep't January 15, 2009) Plaintiff-insured brought an action against his parent's homeowners' liability insurer seeking indemnification and satisfaction of an underlying judgment related to a physical altercation in which the insured was involved. The Appellate Division, Third Department, first held that the defendant-insurer could not rely on the policy's criminal acts exclusion, even though the insured pled guilty to harassment, because the insurer failed to include the same in its disclaimer letter. Secondly, the Third Department held that the intentional acts exclusion did not bar coverage, noting that although the insured had intentionally placed his hands upon another person during the altercation, the insured did so in an attempt to subdue that person or ward off an attack, and that the insured did not expect, intend or foresee that the person would be injured through his defensive act.

Nova Cas. Co. v. Cent. Mut. Ins. Co., 59 A.D.3d 777 (3rd Dep't February 5, 2009) Ryan Bennett, who owned and operated a painting business, was hired by homeowners to apply a protective sealant to the cedar wood siding of the exterior of the homeowners' house. The homeowners thereafter claimed that their house was significantly damaged by a fire allegedly caused by the spontaneous combustion of chemicals in the sealant used by Bennett that had collected on drop cloths. The plaintiff, Bennett's insurer, in turn, brought suit seeking a declaration that it was not obligated under the terms of its policy to either defend or indemnify Bennett for the damages caused by the fire. The plaintiff-insurer argued, *inter alia*, that the terms of the policy rendered it exempt from responsibility for any damage "to that specific part of real property on which work is being performed…if the 'property damage' arises out of such work."

The Appellate Division, Third Department, held that the exclusion did not apply to preclude coverage because the homeowners' claim was not that they were damaged as the result of the quality of the insured's work or that the sealant was misapplied to the siding of their home. To the contrary, according to the Third Department, the homeowners' claim was that their home was damaged by a fire caused by the negligent manner in which Bennett and his employees stored materials and equipment used on the job after the sealant had been applied. As such, the Third Department held that Bennett was entitled to coverage and noted that the policy exclusion at issue was designed to apply to those situations where coverage is sought "for contractual liability of the insured for economic loss because the conduct or completed work is not what the damaged person bargained for."

claimant for which the required information should have been submitted.

In sum, the reporting requirements now imposed will enable Medicare to examine settlements, judgments and awards to ensure that conditional payments are identified and reimbursed, and also to determine whether an allocation for related medical expenses is provided. If the settlement does not contain an allocation, Medicare will have the right to recover up to entire amount of the settlement, judgment or award.

CHOICE OF LAW

Lumbermans Mut. Cas. Co. v. RGIS Inventory Specialists, LLC, 2009 WL 137055 (S.D.N.Y. January 21, 2009) The Southern District of New York applied Michigan law to coverage issues where: (i) the insured's principle place of business was located in Michigan; (ii) the excess insurance policy at issue was placed for the insured via the office of its broker, Marsh USA, office in Detroit, Michigan; (iii) Marsh was responsible, through its Detroit office, for the placement of the insured's entire world-wide liability insurance program, include the excess policy; (iv) in negotiating the excess policy, the insured gave instructions to Marsh's Detroit office, which in turn communicated them to its New York office, which, in turn, communicated with the insurer's New York office; and, (v) it was undisputed that the excess policy was delivered to the insured at its Michigan office and that the insured paid premiums under the excess policy in Michigan, with funds drawn from a Michigan bank.

Safeco Ins. Co. of America v. Discover Property and Cas. Ins. Co., 2009 WL 436329 (S.D.N.Y. February 23, 2009) The Southern District of New York held that California law applied to a loss occurring in New York where the insured's principle place of business was located in California and the policy was issued to the insured though a licensed agent in California. Although the insured was not a party to the action and the underlying claim occurred in New York, the Southern District determined that those facts did not change the fact that the policy was issued in California to insure a California risk. Under New York law, "that makes California the state with the most significant contacts to the claim."

Appalachian Ins. Co. v. Riunione Adriatic Di Sicurata, 2009 WL 672111 (1st Dep't March 17, 2009) In an action for a declaratory judgment regarding the plaintiff-insurers' duty to indemnify the insured as a result of the environmental contamination of numerous sites around the country, the defendant-insured was judicially estopped from denying that its principle place of business was New York, for choice-of-law purposes, where it had obtained rulings in previous lawsuits that, in fact, its principle place of business was New York. According to the Appellate Division, First Department, a contract of liability insurance is governed by the law of the state which the insurer and insured understood to be the principle location of the insured risk. However, where it is necessary to determine the law governing a liability insurance policy covering risks in multiple states, the First Department recognized that the state of the insured's domicile should be regarded as a proxy of the principle location of the risk. In this regard, the First Department found that a corporate insured's domicile is the state of its principle place of business. Since the liability policy at issue did not contain choice-of-law clauses and covered risks that were spread through multiple states, the First Department held that the insured, having obtained prior rulings in its favor as to its principle place of business, was judicially estopped from denying the same and New York law therefore controlled with respect to the coverage issues presented.

DAMAGES

Lima v. NAB Constr. Corp., 59 A.D.3d 359 (2d Dep't February 3, 2009) The Appellate Division, Second Department, recognized that where a promisee has its own insurance coverage, recovery for breach of a contract to procure insurance is limited to the promisee's out-of-pocket expenses in obtaining and maintaining such insurance, *i.e.*, the premiums and any additional costs incurred such as deductibles, co-payments and increased future premiums.

Neff v. Auto. Ins. Co. of Hartford, 2009 WL 435297 (S.D.N.Y. February 22, 2009) The Southern District of New York dismissed the plaintiff-insured's claims for punitive damages against the defendant-insurers based upon the fact that the insured's allegations against the defendant-insurers, that their

disclaimers of coverage were without reasonable bases and deliberately made in bad faith, were equivalent to the allegation of breach of contract and insufficient to support a claim for punitive damages. According to the Southern District, the plaintiff did not allege that the defendant-insurers made any misrepresentations or omissions of material fact to support a claim for fraud or that the defendant-insurers breached any other duty independent of their contractual obligations.

DUTY TO DEFEND

American Guar. and Liab. Ins. Co. v. Moskowitz, 58 A.D.3d 426 (1st Dep't January 6, 2009) Plaintiff-insurer sought a declaratory judgment that it was under no duty to defend or indemnify its insured against underlying fraud and racketeering claims. According to the Appellate Division, First Department, the Complaint, which alleged that the insured "is and was an attorney" and "represented" clients, was sufficient to reveal that the underlying claims of fraud and racketeering were predicated on his purported acts or omissions in rendering legal services and, thus, the plaintiff-insurer was required to defend the insured against the claims under its professional liability insurance policy. In addition, the First Department held that the insurer's allegation that the insured had served as the *de facto* in house counsel for his client did not render him an officer, director or employee of the client as to exclude coverage under the professional liability insurance policy. Nor was the allegation that the insured was a member of a criminal enterprise based on his communication with his clients during the course of representation, sufficient enough to place him within the ambit of the criminal acts exclusion of the policy.

Fieldston Property Owners Assoc., Inc. v. Hermitage Ins. Co., 873 N.Y.S.2d 607 (1st Dep't February 26, 2009) Plaintiff, a commercial general liability insurer, brought suit against a directors and officers insurer, seeking a declaration that the defendant-directors and officers insurer was obligated to reimburse it, in whole or in part, for the costs of defending the insured. According to the Appellate Division, First Department, the directors and officers liability insurance policy's "other insurance" clause, which rendered the policy excess if any loss from any claim against the insured was also covered by "any other valid policies prior or current," did not apply unless the loss was insured under both the directors and officers policy and another policy. Thus, where the action against the insured included only a single claim within the insured's general liability policy, together with other claims covered by the directors and officers policy, the "other insurance" clause of the directors and officers policy did not obviate its duty to defend, except as to the single claim within the general liability coverage.

Adami v. C.J. Rubino & Co., Inc., 22 Misc.3d 1133(A) (N.Y.Sup. Kings County March 11, 2009) The Supreme Court of the State of New York, Kings County, held that the third-party defendant-insurer was under no obligation to defend or indemnify its insured-contractor in the underlying action brought by the plaintiff-property owner. According to the Court, since the claims set forth by the plaintiff-property owner arose out of a dispute regarding the defendant-insured's quality of workmanship in repairing the plaintiff's fire damaged property, the Complaint did not contain any allegations that the property damage was caused by an accident or resulted from an "occurrence." In this regard, the Court recognized the well established law that a general liability policy does not insure against faulty workmanship in the work product itself, but rather faulty workmanship in the work product which creates a legal liability by causing bodily injury or other property damage. Finally, the Court noted that even if the claims against the defendant-insured invoked coverage, they would fall within the "your work" and "your product" exclusions of the policy.

LACK OF COOPERATION

State Farm Indem. Co. v. Moore, 58 A.D.3d 429 (1st Dep't January 6, 2009) The Appellate Division, First Department, began its analysis by noting that where an insured deliberately fails to cooperate with its insurer in the investigation of a covered incident as required by the policy, the insurer may disclaim coverage. According to the First Department, the evidence before it demonstrated that the plaintiff-insurer, upon being informed of an accident, promptly commenced a detailed investigation and diligently continued it. In addition to numerous telephone calls being made to the number its insured provided, the insurer sent letters via certified or registered mail to the address provided and submitted evidence that the insured signed for one of the letters. Furthermore, visits were made to the insured's address, upon which his mother maintained that she was unaware of his whereabouts. In light of these unsuccessful efforts by the insurer that were reasonably calculated to obtain the insured's cooperation, the First Department held that the insurer's inference that the insured deliberately chose not to cooperate was compelling and that the insurer's disclaimer of coverage for lack of cooperation was proper.

MISREPRESENTATIONS

Rafi v. Rutgers Cas. Ins. Co., 59 A.D.3d 1057 (4th Dep't February 6, 2009) The Appellate Division, Fourth Department, held that the lower court committed reversible error in charging the jury that defendant-insurer was required to prove that the alleged misrepresentations made by the plaintiff-insureds on their insurance application were intentional in order to prevail on its affirmative defense, seeking to void the insurance policy. According to the Fourth Department, although the misrepresentations made by an insured must be material, they may be innocently or unintentionally made, in which event the insurance policy is void *ab initio*. Thus, the Fourth Department found that the lower court should have charged the jury that, in order to prevail on its affirmative defense, the defendant-insurer was required to submit "proof concerning its underwriting practices with respect to applicants with similar circumstances," in order to meet its burden of establishing that it would not have issued the same policy had the correct information been included in the application.

NOTICE

Kambbousi Rest., Inc. v. Burlington Ins. Co., 58 A.D.3d 513 (1st Dep't January 20, 2009) When an insurance policy requires that an insured notify the insurer of an occurrence as soon as practicable, the insured's noncompliance constitutes a failure to satisfy a condition precedent to coverage; however, if the insured has established an objectively reasonable good-faith belief of non-liability, said belief may excuse the claimed untimely notice. According to the Appellate Division, First Department, the insured diner established, as a matter of law, a good-faith belief in its non-liability for injuries sustained by a woman who fell in the diner's parking lot, excusing the plaintiff-insured's failure to give the defendant-insurer timely notice about the incident, where a woman's husband told the manager of the diner that he should not "worry", that his wife had tripped over her shoelaces, and the couple departed without giving the manager an opportunity to obtain further information.

Tower Ins. Co. of New York v. Jaison Hohn Realty Corp., 874 N.Y.S.2d 91 (1st Dep't March 3, 2009) The Appellate Division, First Department, held that a tenant, who was allegedly injured after falling down the stairwell in her apartment building, did not provide the landlord's insurer with sufficient notice of the accident in order to satisfy her independent right to notify the landlord's insurer under Insurance Law §3420(a)(3). Although the tenant's counsel advised the landlord to notify his insurer of the accident and indicated that if counsel did not hear from the landlord's insurer or legal representative an action would be commenced, the tenant did not attempt to ascertain the indemnity of the landlord's insurer and merely relied on correspondence to the landlord.

PROFESSIONAL LIABILITY COVERAGE

Burkhart, Wexler & Hirschberg, LLP v. Liberty Ins. Underwriters, Inc., 2009 WL 792050 (2d Dep't March 24, 2009) The Appellate Division, Second Department, held that the defendant-professional liability insurer was under no obligation to provide coverage to the plaintiff-insured, a law firm, in connection with an underlying action against the firm by one of its clients alleging claims for "wanton, willful and malicious" breach of fiduciary duty for the firm's misappropriation of the client's confidential information and trade secrets. According to the Second Department, the insuring agreement of the defendant-insurer's policy clearly limited coverage to claims which are caused by "any actual or alleged act, error, omission or personal injury which arises out of the rendering or failure to render professional legal services." Inasmuch as there was no allegation of negligence or malpractice arising out of the insured-law firm's performance, or failure to perform, legal services, the Second Department determined that the claims in the underlying action did not fall within the ambit of the defendant-insurer's professional liability policy.

SUBROGATION

Fasso v. Indep. Health Assoc., Inc., 12 N.Y.3d 80 (Court of Appeals February 24, 2009) Under New York law, the right to subrogation accrues upon payment of a claim or benefits by a first-party insurer to its insured and generally cannot be extinguished by the insured. Once an insurer has paid an insured's claim or benefits and the tortfeasor knows or should have known that a right to subrogation exists, the tortfeasor and the insured cannot agree to terminate the insurer's subrogation rights without its consent, and such an agreement cannot be asserted as a defense to the insurer's cause of action. As such, the Court of Appeals held that the provision of a settlement agreement between the insured-patient and her doctor relating to the patient's medical malpractice claim that purported to bar the insured-patient's medical insurer's equitable subrogation claim for the medical expenses it had paid could not be enforced and did not prevent the patient's medical insurer from proceeding to obtain reimbursement from the negligent doctor. In this regard, the settlement between the injured patient and the doctor was for less than the doctor's total limit of medical malpractice coverage, leaving the patient's medical insurer with a potential source of recovery.

RLI Ins. Co. v. Turner/Santa Fe, 58 A.D.3d 413 (1st Dep't January 6, 2009) While the amount of "soft costs" (delay in opening/business interruption) was still being calculated and had not yet been paid by the plaintiff-insurer to its insured, the owner of a construction site that was damaged by a fire, there was no dispute, according to the Appellate Division, First Department, that the defendant-subcontractors, which were allegedly responsible for the fire, were given notice in the timely filed Complaint that the claims being made were based on the same facts for which plaintiff-insurer had already partially paid for damage to physical property. In this regard, the First Department explained that although the right to subrogation arises upon payment, and the soft costs were not paid until more than three years after the fire (*i.e.* after the three year statute of limitations had run on the subrogation causes of action), the plaintiff-insurer still possessed a contingent right of subrogation for the unpaid claims at the time it commenced the timely action, and the defendant-subcontractors were clearly on notice of that right. To hold otherwise, would create the very circumstances condemned by the Court of Appeals, where 'the insurer may be put in the position, on the one hand, of having to pay the insured substantial sums of money on questionable claims in order to preserve its subrogation rights, or, on the other hand, it may have to forego the opportunity to prepare what might well have proved to be an excellent case against the alleged tort-feasor.'"

Gulf Ins. Co. v. Quality Building Contractor, Inc., 58 A.D.3d 595 (2d Dep't January 13, 2009) Property owners' insurer brought a subrogation action against the general contractor, subcontractors and architectural firm used by the owners for a restoration project to recover property damages. The Appellate Division, Second Department, held that the property owners' contractual waiver of its insurer's right to subrogation barred its insurer's claims against the general contractor because the property damage was sustained as a result of the "work", as defined in the restoration contract between the owner and the general contractor. In addition, the concrete subcontractor was also entitled to the benefit of the property owner's waiver of its insurer's right to subrogation as a consequence of the fact the subcontractor's agreement with the general contractor incorporated the general contractor's agreement with the property owners. However, the architectural firm was not entitled to the benefit of the property owners' waiver of their insurer's right to subrogation because the architectural firm's agreement with the property owners contained no waiver of subrogation and the firm was not a party to the other contracts at issue. To this same extent, the architectural firm's cross-claims for subrogation against the restoration contractors were not precluded, since no waiver of subrogation existed in agreements between the architectural firm and the contractors related to the property damaged caused to the owners' property.

Travelers Indem. Co. v. Zeff Design, 2009 WL 588793 (1st Dep't March 10, 2009) The Appellate Division, First Department held, *inter alia*, that the payment under the plaintiff's homeowners' insurance policy to the insured-homeowner for damage to a party wall during the remodeling of the insured's townhouse, did not bar the plaintiff-insurer's subrogation action against the general contractor and subcontractors of the remodeling project, absent a showing that the plaintiff-insurer paid its insured voluntarily, or that the proximate cause of the loss resulting in the damage to the wall fell within one of the plaintiff-insurer's policy exclusions.

TIMELINESS OF DISCLAIMERS

Roules v. State Farm Ins. Co., 59 A.D.3d 514 (2d Dep't February 10, 2009) According to the Appellate Division, Second Department, contrary to the determination of the lower court, the timeliness of the disclaimer issued by the defendant-insurer did not present an issue of fact. The defendant-insurer made a *prima facie* showing of its entitlement to judgment as a matter of law by demonstrating that only 13 days elapsed between the date that it first learned of the subject accident and the date that it issued its disclaimer of coverage on the ground of late notice. Moreover, the Second Department took note of that fact that in the 13-day interval the defendant-insurer investigated the matter, reviewed its file and unsuccessfully attempted to contact its insured.

Gulf Ins. Co. v. Stradford, 59 A.D.3d 598 (2d Dep't February 17, 2009) The timeliness of a carrier's disclaimer based on its insured's alleged violation of the policy's cooperation clause "almost always presents a factual question, requiring an assessment of all relevant circumstances surrounding the particular disclaimer and cases in which the reasonableness of an insurer's delay may be decided as a matter of law are exceptional and present extreme circumstances."

Essex Ins. Co. v. Oakwood Constr. Corp., 59 A.D.3d 591 (2d Dep't February 17, 2009) Liability insurers are not required to timely disclaim coverage of a claim where the alleged injury for which coverage was sought does not fall within the terms of the policy.

WAIVER OF COVERAGE DEFENSES

NGM Ins. Co. v. Blakely Pumping, Inc., 2009 WL 765042 (S.D.N.Y. March 23, 2009) Under Insurance Law 3420(d), a high degree of specificity is required in an insurer's disclaimer of coverage. An insurer must raise all of the grounds on which it is basing its disclaimer; all grounds not raised are deemed

waived. In addition, failure to timely disclaim coverage precludes the insurer from later successfully disclaiming. However, New York law carefully distinguishes between cases where the specific coverage was never included as opposed to those where coverage was precluded due to an exclusion. In this matter, the plaintiff-insurer issued a general liability policy, which included a standard auto exclusion. However, because the defendant-insured was aware that its business would involve considerable travel on New York roads, it purchased an endorsement, which generally covered auto accidents, except in situations involving the personal vehicles of the insured's officers and employees which were excluded. In light of the fact that the underlying accident, for which the existence of coverage was at issue, involved an employee operating his personal vehicle, the Southern District of New York held that the plaintiff-insurer was obligated to comply with Insurance law § 3420(d) and timely submit a written disclaimer to its insured and the injured claimants. Although the plaintiff-insurer issued a disclaimer of coverage 30 days after having received notice of the accident based upon the "auto" exclusion of its general liability policy, its disclaimer failed to include reference to the applicable exclusion in the Endorsement, which as a result constituted a waiver of the coverage defense. As such, the plaintiff-insurer's subsequent letter issued six months later raising the exclusion in the Endorsement was determined to be invalid. In this regard, the Southern District noted that it appeared that the plaintiff-insurer seemed unaware of its own Endorsement until the claimant's attorney brought the same to its attention.

MISCELLANEOUS

GuideOne Specialty Mut. Ins. Co. v. Yerim, 593 F.Supp.2d 471 (E.D.N.Y. January 15, 2009) The Eastern District of New York held, *inter alia*, that the plaintiff-premises liability insurer unreasonably delayed in waiting at least seven months before amending its Declaratory Judgment Complaint after it learned of the alleged fraudulent nondisclosure in the policy application by the insured that purportedly supported the rescission of the policy. The declaratory judgment action was initially filed for a determination of the insurer's right to disclaim coverage for an injury that occurred while the property was being used by the caterer.

Hernandez v. American Transit Ins. Co., 2009 WL 564579 (2d Dep't March 3, 2009) Plaintiffs brought a direct action against defendant-insurer pursuant to Insurance Law §3420(a)(2) to recover on two unsatisfied judgments entered against its insureds. The Appellate Division, First Department, held that the plaintiffs made out their *prima facie* case by demonstrating that they each had obtained a judgment against the insured-tortfeasors, served the defendant-insurer with a copy of the judgments and awaited payment for 30 days. Since the judgments were, according to the First Department, presumptively valid, the burden was on the defendant-insurer to prove otherwise. The defendant-insurer, however, failed to establish any invalidity in the judgments that would be a defense to enforcement.

New York City Transit Authority v. Clarendon Nat'l Ins. Co., 22 Misc.3d 1131(A) (N.Y.Sup. Kings County March 9, 2009) The Supreme Court of the State of New York, Kings County, held that the plaintiff's claim for additional insured coverage against the defendant-insurer was not time barred since the six-year statute of limitations for a cause of action based on an insurer's alleged breach of a contractual duty to defend accrues only when the underlying litigation brought against the insured has been finally terminated and the insurer can no longer defend the insured even if it chose to do so. According to the Court, in light of the fact that the underlying action had been finally terminated no earlier than July 2003, less than six years before the plaintiff commenced the present action against the defendant-insurer seeking additional insured coverage, the defendant-insurer's claim that the action was time barred was without merit.

LBC&C's INSURANCE INDUSTRY PRACTICE GROUP

LBC&C has extensive knowledge and experience in the insurance industry, and the wide array of services which it provides to the insurance community is a foundation of the Firm's practice. LBC&C is dedicated to achieving the goals of its clients in a professional, cost-effective and timely manner. The Firm's reputation for meaningful analysis, tough advocacy and creative solutions serves clients well for the regulatory and legal challenges which they face in the ever-changing national landscape of the insurance industry.

Insurance companies rely upon LBC&C to draft policies, render coverage opinions, act as monitoring counsel, advise excess carriers and reinsurers, litigate declaratory judgment and "bad faith" actions, and provide auditing services. These services are performed on a nationwide basis and LBC&C attorneys represent their clients' interests in litigation, arbitration and mediation throughout the country. Furthermore, because the law of insurance is evolutionary and dynamic, the Firm provides in-house seminars for underwriting, claims and marketing personnel on developing issues.

Should you have any comments, questions or suggestions in connection with the information provided in this newsletter please contact Richard P. Byrne, Esq., John D. McKenna, Esq. or Jillian Menna, Esq. at (516) 294-8844. You may also wish to visit the Firm's website at lbcclaw.com