LB&C QUARTERLY INSURANCE COVERAGE NEWSLETTER: NEW YORK

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CASES OF INTEREST BY TOPIC

ADDITIONAL INSURED COVERAGE

140 Broadway Property v. Schindler Elevator Co., 73 A.D.3d 717 (2d Dep't May 4, 2010) According to the Appellate Division, Second Department, the plaintiff was not entitled to additional insured coverage under the defendant's Commercial General Liability policy with Zurich American Insurance Company, where the Zurich policy extended coverage to any entity "for whom the named insured ha[d] specifically agreed by written contract to procure bodily injury, property damage and personal injury liability insurance." Although the contract between the plaintiff and defendant required the defendant to purchase several forms of insurance coverage, the contract did not expressly state that the defendant was required to name the plaintiff as an additional insured on its Commercial General Liability policy.

373 Wythe Realty, Inc. v. Indian Harbor Ins. Co., 2010 WL 1930256 (E.D.N.Y. May 11, 2010) 373 Wythe Realty brought action against Indian Harbor Insurance Company seeking a declaration that Indian Harbor had a duty to defend and indemnify Wythe in an underlying state court action. Wythe, the manager of certain premises, retained The Wrecking Group, Inc., to perform demolition and asbestos abatement work. The contract between Wythe and Wrecking required Wrecking to secure additional insured coverage for Wythe, which it did by purchasing a Commercial General Liability policy from Indian Harbor. Wrecking thereafter subcontracted Asbestos Lead & Removal Corporation to remove and dispose of asbestos. Julio Cueva, an employee of Asbestos Lead & Removal, was subsequently injured while performing operations at the premises, resulting in a lawsuit against Wythe and Wrecking. Upon receipt of the underlying *Cueva* action, Wythe tendered its defense and indemnification to Indian Harbor. Indian Harbor denied the tender, claiming that its duty to defend Wythe was not triggered until there was a determination of fault against Wrecking, its named insured. Indian Harbor's position was premised upon the definition of coverage owed to an additional insured under its policy, which provided, in sum, that Wythe was an additional insured "only with respect to liability for 'bodily injury'…caused, in whole or in part, by" Wrecking's acts or omissions or the acts or omissions of those acting on Wrecking's behalf, in the performance of Wrecking's ongoing operations for Wythe. Indian Harbor's argument was founded solely upon the use of the term "caused", which, according to Indian Harbor, meant that Wrecking must be adjudged liable to Cueva before Indian Harbor would be obligated to provide coverage to Wythe.

The Eastern District began its analysis by acknowledging that, under New York law, an additional insured is an entity enjoying the same protection as the named insured. The Eastern District then went on to note that although *BP Air Conditioning v. One Beacon Ins. Group*, 8 N.Y.3d 708 (2007) involved similar facts, the additional insured language at issue in *BP* was the more commonly used "arising out of" as opposed to "caused, in whole or in part, by". In this regard, Indian Harbor argued that the term "caused", in lieu of "arising out of", required a finding of liability against Wrecking. Nonetheless, the Eastern District rejected Indian Harbor's contention, holding that "the duty to defend an additional insured is invoked once a lawsuit alleges that an additional insured is responsible for the conduct of the named insured." According to the Eastern District, since the *Cueva* suit alleged that Wythe and Wrecking were responsible for the unsafe conditions at the premises leading to Cueva's injuries, the claim was "well within the scope of the duty to defend."

Regal Const. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 15 N.Y.3d 34 (N.Y. June 3, 2010) According to the New York Court of Appeals, because a casual connection existed between the injury sustained by a general contractor's employee at a construction site and the general contractor's operations performed for the project's construction manager, the construction manager was entitled to additional insured coverage under the general contractor's Commercial General Liability insurance policy, pursuant to policy language providing additional insured coverage "only with respect to liability arising out of [the insured's] operations." As provided by the Court of Appeals, even if it was the construction manager's employee that painted the joist upon which the injured claimant fell, the general contractor's responsibilities encompassed all demolition and construction work to be done, and the injury was sustained while the claimant, the general contractor's employee, was supervising and giving instructions to a subcontractor regarding work to be performed.

Stellar Mechanical Services of New York, Inc. v. Merchants Ins. of New Hampshire, 2010 WL 2303209 (2d Dep't June 8, 2010) In May 2003, Stellar Mechanical Services of New York, Inc. agreed to perform certain heating, ventilation and air conditioning work for the construction of a building. Stellar thereafter subcontracted certain duct work to Serge Duct Design. The subcontract between Stellar and Serge required Serge to procure additional insured coverage for Stellar. Serge, in turn, procured a Commercial General Liability insurance policy from Merchants Insurance of New Hampshire providing Stellar with additional insured coverage but "only with respect to liability arising out of" work Serge performed for Stellar. Stellar was directly insured by American Empire Surplus Lines Insurance Company.

In July 2003, an employee of another subcontractor was injured while working on the project when he fell through an opening in the roof of the building. In November 2006, the injured employee commenced a personal injury action against certain entities, and thereafter filed an Amended Complaint in August 2005 naming Stellar as a defendant. In February 2006, Stellar demanded that Merchants provide it with a defense and indemnity in the underlying action. Merchants denied coverage, claiming, *inter alia*, that the accident did not "arise out of" the work performed by Serge. In March 2006, a Second Amended Complaint was filed in the underlying action naming Serge as a defendant. Stellar again wrote to Merchants in June 2006, providing a copy of the Second Amended Complaint and again demanding a defense; Merchants, however, refused. American Empire provided Stellar with a defense and eventually settled the underlying action. Stellar and American Empire thereafter commenced an action against Merchants seeking a judgment declaring that Merchants was obligated to defend and indemnify Stellar.

The Appellate Division, Second Department, held, *inter alia*, that Merchants was obligated to provide Stellar with a defense, but only from the time Stellar was served with the Second Amended Complaint including allegations against Serge. In this regard, the Second Department noted that an insurer must defend its insured whenever the allegations of a complaint in an underlying action suggest a reasonable possibility of coverage. With respect to Merchants' duty to indemnify Stellar, however, the Second Department stated that even in cases of negotiated settlements, "there can be no duty to indemnify unless a determination is made that there was a covered loss." In this regard, the Second Department highlighted that Merchants submitted certain evidence supporting a determination that any loss to Stellar was not within the coverage of Serge's policy because Stellar's liability did not "arise out of" work performed by Serge. Specifically, Merchants submitted certain deposition testimony showing that Serge's employees did not create the opening through which the claimant fell and were not responsible for protecting construction workers from falling through the opening.

APPLICABILITY OF EXCLUSIONS

Edmond Massa v. Nationwide Mut. Fire Ins. Co., 2010 WL 2518927 (3d Dep't June 24, 2010) In November 2006, plaintiff David Massa, a college student at the time, threw or pushed an oil drum out of the second story window of a fraternity house. The drum struck and injured another student, who commenced a personal injury action, alleging that Massa was negligent. Massa was also charged with assault in the second degree and plead guilty to disorderly conduct. Massa was an insured under a homeowners' insurance policy issued to his parents by Nationwide Mutual Fire Insurance Company. Nationwide denied coverage in the negligence action based on policy exclusions for intentional and criminal acts. As a result, the Massas commenced an action seeking a declaration that Nationwide was obligated to defend and indemnify them in the negligence action.

The Appellate Division, Third Department, first held, contrary to Nationwide's position, that the intentional acts exclusion, barring coverage for bodily injury "caused intentionally by or at the direction of an insured, including willful acts the result of which the insured knows or ought to know will follow from the insured's conduct", was not applicable. According to the Third Department, because the evidence did not conclusively establish that anyone was directly below the window when plaintiff looked outside, that he saw anyone below, or that he knew of the presence of anyone when he pushed or threw the drum outside, there was a possible basis for a factual determination that, from plaintiff's point of view, it was unexpected, unintended and unforeseen that the drum would strike someone, despite the fact that other interpretations were also possible. With respect to the criminal acts exclusion, barring coverage for injury "caused by or resulting from an act or omission which is criminal in nature and committed by an insured", the Third Department likewise found the same inapplicable. In this regard, the Third Department stated that other than indicating that conduct may fall within the exclusion "regardless of whether the insured is actually charged with, or convicted of a crime", the policy offered no definition or other guidance in determining what conduct was "criminal in nature". This ambiguity, according to the Third Department, was required to be resolved against Nationwide and in favor of the plaintiff.

BAD FAITH

CBLPath, Inc. v. Lexington Ins. Co., 73 A.D.3d 829 (2d Dep't May 11, 2010) This matter arose from an underlying action commenced against CBLPath, Inc. and CBLPath Holdings (collectively "CBL") by Darrie Eason, alleging medical malpractice. At the time, CBL was insured under a medical malpractice insurance policy issued by the defendant Lexington Insurance Company, a subsidiary of American International Group. The policy provided CBL with coverage for medical malpractice liability up to the sum of $1 million per medical incident. CBL timely reported the claim to Lexington, which referred the matter for handling on its behalf to AIG Domestic Claims ("AIGDC"), also an AIG subsidiary. Although Eason's counsel made attempts to open settlement discussions from February 2007 until September 2007, suit was eventually commenced against CBL in October 2007, since AIGDC never made a substantive response to the settlement overtures. The underlying action was settled several months later for $2.5 million, with Lexington paying its $1 million policy limit and CBL paying the balance. CBL thereafter commenced an action against Lexington asserting a single cause of action for breach of the covenant of good faith and fair dealing. The graveman of CBL's Complaint was that AIGDC, which had asserted sole control over the claim, acted in bad faith by refusing to enter into pre-litigation settlement discussions with Eason's counsel. CBL sought actual and consequential damages, including, *inter alia*, injury to its business reputation, lost sales, increased sale expenses, lost profits and lost business opportunities caused by the negative publicity that resulted from the commencement of the underlying action. According to the Appellate Division, Second Department, Lexington was entitled to summary judgment dismissing the claim since CBL failed to raise a triable issue of fact as to whether Eason's counsel made a pre-litigation settlement demand within the policy limits. "[W]hile it may arguably be some evidence of bad faith that AIGDC failed to

enter into pre-litigation settlement discussions with Eason's counsel at the time when CBL's liability was not in doubt and the nature of Easton's injuries indicated her recovery would exceed the policy limit, we are constrained to find that Lexington was entitled to summary judgment because CBL failed to raise a triable issue of fact as to whether Eason made a pre-litigation settlement demand within the policy limit."

Doherty v. Merchants Mut. Ins. Co., 2010 WL 2332098 (4th Dep't June 11, 2010) The plaintiffs, the assignees of Thomas S. Fitzpatrick, the defendant in the underlying personal injury action, commenced an action against Merchants Mutual Insurance Company, alleging that Merchants acted in bad faith by failing to settle the underlying action and thereby exposing Fitzpatrick to personal liability. The plaintiffs had commenced the underlying action against Fitzpatrick seeking damages for injuries Jennifer Doherty sustained when the vehicle she was operating was rear-ended by a vehicle operated by Fitzpatrick. The underlying action went to trial and the jury awarded plaintiffs damages in excess of the coverage that Fitzpatrick had under his auto policy with Merchants. Therefore, plaintiffs brought suit seeking recovery of the difference between the verdict and the policy limit.

The Appellate Division, Fourth Department, began its analysis by recognizing that to prevail in an action seeking damages for an insurer's bad faith refusal to settle an underlying action, it must be established that the insured lost an actual opportunity to settle the action at a time when all serious doubts about liability were removed and the defendant insurer acted with gross disregard for the insured's interests, *i.e.*, it engaged in a pattern of behavior evincing a conscious or knowing indifference to the probability that the insured would be held personally accountable for a large judgment if a settlement offer within the policy limits were not accepted.

In this matter, according to the Fourth Department, it was undisputed that prior to the trial of the underlying action, the attorneys for plaintiffs and Fitzpatrick requested that the defendant settle the matter for the policy limit of $300,000. The Fourth Department recognized, however, that an insurer cannot be compelled to conceded liability and settle a questionable claim simply because an opportunity to do so is presented. In support of its position, the defendant-insurer established that it investigated the claim in the underlying action and arranged for a physical examination of the plaintiff to determine the extent of her injuries and whether they constituted a serious injury. Although the expert retained by the defendant and the plaintiff's treating physician had differing views with respect to the extent of the plaintiff's injuries, the expert determined that plaintiff sustained a moderate, partial, temporary disability. The defendant-insurer's investigation also included a videotape of plaintiff engaged in activities without apparent difficulty, despite her alleged injuries. Furthermore, the defendant-insurer established that it participated in settlement negotiations prior to and during the trial and was actively engaged in the settlement negotiation process. Prior to the trial, the plaintiffs reduced their demand to $250,000 and, during the trial, further reduced their demand to $240,000. The defendant thereafter increased its settlement offer $25,000 to $55,000. In a 5-2 decision, the majority of Fourth Department concluded that the foregoing established that Fitzpatrick did not lose an actual opportunity to settle the claim at a time when all serious doubts about his liability were removed and it was clear that the potential recovery would far exceed the insurance coverage. Merchants was therefore entitled to summary judgment dismissing the complaint against it.

Whiteface Real Estate Dev. and Const., LLC v. Selective Ins. Co., 2010 WL 2521794 (N.D.N.Y. June 16, 2010) The plaintiff-insured brought action against its insurer seeking, *inter alia*, costs incurred in cleaning up a fire loss as well as consequential damages for interest paid on a loan it took out to cover restoration costs and attorneys' fees. The defendant-insurer, in an attempt to refute the claim for consequential damages, relied upon a clause of its policy providing that there would be no coverage for "a 'loss' caused by or resulting from…[d]elay, loss of use, loss of market or any other consequential loss." The Northern District held, however, that the clause was neither legally nor factually conclusive. According to the Northern District, an insurance policy's "exclusion for consequential loss does not bar recovery of consequential damages" resulting from the insurer's breach of the covenant of good faith and fair dealing. In addition, the Northern District stated that a fact finder could conclude that the consequential damages sought by the plaintiff-insured were reasonably contemplated by the parties and were necessary to return the insured to where it would have been had coverage been provided. As such, the Northern District denied the parties' summary judgment motions, unable to determine as a matter of law whether the insured was entitled to consequential damages.

DISCLAIMERS

New York State Ins. Fund v. Mount Vernon Fire Ins. Co., 2010 WL 1292305 (2d Cir. April 6, 2010) The timely disclaimer requirement set forth under Insurance Law 3420(d) does not apply to disputes between co-insurers of the same insured.

Hargob Realty Assoc., Inc v. Fireman's Fund Ins. Co., 73 A.D.3d 856 (2d Dep't May 11, 2010) The Appellate Division, Second Department, held, *inter alia*, that the defendant-insurer was not required to issue a timely disclaimer since its denial of coverage under the additional insured endorsement constituted a denial based upon a "lack of inclusion" rather than "by reason of exclusion", and, thus, the defendant-insurer was not required to deny coverage where none existed. In this regard, there was no coverage under the policy since the additional insured endorsement only afforded coverage to those entities that the named insured was required in a written contract to name as such and there was no such obligation included in the agreement between the named insured and the plaintiff-owner.

ESTOPPEL

Sevenson Envtl. Services, Inc. v. Sirius America Ins. Co., 902 N.Y.S.2d 279 (4th Dep't June 11, 2010) Plaintiffs commenced suit against Sirius American Insurance Company seeking a declaration that Sirius was obligated to defend and indemnify them in an underlying personal injury action. In support of the plaintiffs' argument that they were additional insureds under the Sirius policy, the plaintiffs submitted a Certificate of Insurance reflecting that they were named as additional insureds on a direct, primary and non-contributory basis. They also submitted an additional insured endorsement to the Sirius policy, naming persons or organizations "as on file with the company." In opposition, Sirius submitted an affidavit from an employee of its third-party claims administrator, UTC Risk Management Services, Inc., averring that the named insured's underwriting file did not contain any request or notice to name the plaintiffs as additional insureds on the policy. According to the Appellate Division, Fourth Department, the fact that UTC did not locate any documentation in the named insured's underwriting file was, by itself, insufficient to establish, as a matter of law, that neither Sirius nor one of its agents possessed documentation naming the plaintiffs as additional insureds. In addition, the Fourth Department also held that there was an issue of fact as to whether Sirius was estopped from denying additional insured coverage, even though the certificate expressly provided that it "was issued as a matter of information only and confers no rights upon the certificate holder [and] does not amend, extend or alter the coverage afforded by the policies listed below." The Fourth Department noted that an insurance company which issues a Certificate of Insurance naming a particular party as an additional insured may be estopped from denying coverage to that party where the party reasonably relies on the Certificate of Insurance to its detriment. For estoppel based upon the issuance of a Certificate of Insurance to apply, however, the certificate must have been issued by the insurer itself or by an agent of the insurer. Plaintiffs, according to the Fourth Department, failed to meet their initial burden of establishing that the Certificate of Insurance was, in fact, issued by Sirius or an authorized agent of Sirius.

HOMEOWNERS COVERAGE

Fabozzi v. Lexington Ins. Co., 601 F.3d 88 (2d Cir. April 6, 2010) Under New York law, "date of loss" that commenced the two-year contractual limitations period to commence action against the insurer in a homeowners insurance policy was the date on which the insureds' breach of contract claim against the insurer accrued, rather than the date on which the accident occurred resulting in property damage.

Cragg v. Allstate Indem. Corp., 74 A.D.3d 90 (4th Dep't May 7, 2010) As a matter of first impression in New York, the Appellate Division, Fourth Department, applying Ohio law, held that the defendant-insurer was under no obligation to defend or indemnify its insureds for the wrongful death of an insured person. In this matter, plaintiff's decedent sustained fatal injuries when she drowned in a swimming pool located at the residence of her grandparents, where she resided with her mother. Plaintiff, the decedent's father, did not reside there, and commenced a wrongful death action against the decedent's mother and grandparents. The decedent, mother and grandparents were all insured under a homeowners' policy issued by defendant-insurer, Allstate Indemnity Corporation. Allstate disclaimed coverage to the defendants in the wrongful death action under the policy pursuant to the provisions excluding coverage for "bodily injury to an insured person…whenever any benefit of this coverage would accrue directly or indirectly to an insured person." The decedent's mother defaulted in the wrongful death action and, following an inquest on damages, plaintiff obtained a judgment against her in excess of $100,000 for his pecuniary loss. Plaintiff subsequently commenced a declaratory judgment action against Allstate. The Fourth Department rejected the plaintiff's contention that the derivative nature of his wrongful death action rendered the policy exclusion inapplicable. According to the Fourth Department, "there is no coverage for the simple reason that a homeowners' insurance policy is essentially designed to indemnify the policy holders against liability for injuries sustained by non-insureds." Since indemnification by Allstate on behalf of the decedent's mother would result in receipt by the mother, an insured, of the benefits of the policy in the form of satisfaction of the money judgment obtained against her for the death of her daughter, also an insured, coverage under the policy was excluded.

LACK OF COOPERATION

John Johnson v. GEICO, 72 A.D.3d 900 (2d Dep't April 20, 2010) Under New York law, in order to deny coverage based upon a failure to cooperate, the insurer must show: (1) that it acted diligently in seeking to bring about the insured's cooperation; (2) that the efforts employed by the carrier were reasonably calculated to obtain the insured's cooperation, and (3) that the attitude of the insured, after his cooperation was sought, was one of willful and avowed obstruction.

NOTICE

American Transit Ins. Co. v. Brown, 14 N.Y.3d 809 (N.Y. April 1, 2010) Arthur Brown was involved in a motor vehicle accident with Albertano Batista, American Transit Insurance Company's insured. American Transit acknowledged receipt of Brown's claim and paid for his property damage. Brown subsequently commenced an action against Batista and forwarded a copy of the Summons and Complaint to American Transit at the address included in American Transit's initial acknowledgment letter. Unbeknownst to Brown, however, American Transit had moved its offices. Upon Batista's failure to appear in the action, Brown moved for a default judgment against Batista and proceeded to inquest, resulting in a judgment in the amount of $81,830. Pursuant to Insurance Law 3420(a)(2), Brown served copies of the unsatisfied judgment with notices of entry upon American Transit and Batista, in response to

which American Transit issued a disclaimer, and commenced a declaratory judgment action on the ground that neither Batista nor Brown gave it timely notice of the underlying lawsuit. According to the Appellate Division, First Department, Brown demonstrated a valid excuse for forwarding the Summons and Complaint to American Transit's former address in that he was never notified of its change of address. American Transit's allegation that it had "sent out a post card to claimants and attorneys who had filed any claims against us during that time" was found to be hollow and did not evidence that any specific notification was sent to Brown or his counsel. The dissent, however, opined that the majority placed the burden on the wrong party when it rejected American Transit's statements that it sent a mass mailing announcing the change of address at the time of the move, and that it notified the State Insurance Department and the post office of the change of address, and changed its address on its website and all phone listings. On April 1, 2010, the Court of Appeals overturned the First Department's decision and held that Brown did not provide a valid excuse for his failure to use reasonable diligence in providing American Transit with notice of the underlying action.

The Travelers Indemnity Co. of America v. Southern Gastronom Corp., 2010 WL 1292289 (E.D.N.Y. April 1, 2010) The Eastern District recognized that where the insured is the first to provide notice, and the injured party later gives notice, the injured party's notice is superfluous and the insurer need not disclaim as to the injured party. Where an insured provides notice of an occurrence before an injured party exercises its independent right to notify the insurer of an occurrence, the disclaimer issued to the insured, for failure to satisfy the notice requirement of the policy, will be effective as against the injured party as well. In addition, the Eastern District also held that the plaintiff-insurer's disclaimer based upon late notice, issued twenty-six days after notice of the occurrence was provided, was timely under New York Insurance law 3420(d).

Prince Seating Corp. v. QBE Ins. Co., 73 A.D.3d 884 (2d Dep't May 11, 2010) The plaintiff allegedly provided notice of an underlying claim to its broker rather than, as required by the policy, to its insurer, QBE Insurance Company. As recognized by the Appellate Division, Second Department, it is well settled that, absent some evidence of an agency relationship, timely notice of an accident by an insured to a broker is not effective and does not constitute notice to the insurance company, as a broker is considered to be an agent only of the insured. However, according to the Second Department, the terminology of the QBE policy, including the notice provision, in which the words "we", "us" and "our" referring to "the company providing this insurance", were used to describe who should be notified, was ambiguous. Since QBE was not clearly identified as the party to whom those terms applied, there was an issue of fact as to whether the contract should be interpreted to allow notice to the broker.

MISCELLANEOUS

Richner Communications, Inc. v. Tower Ins. Co. of New York, 72 A.D.3d 670 (2d Dep't April 6, 2010) Under New York law, insurance policies must be read as a whole, and in construing an endorsement to a policy, the endorsement and the policy must be read together, and the words of the policy remain in full force and effect except as altered by the words of the endorsement. An insurance contract should not be read so that some provisions are rendered meaningless. According to the Appellate Division, Second Department, the defendant-insurer established, as a matter of law, that it was not obligated to defend and indemnify the plaintiff in the underlying action since the subject policy contained an endorsement that expressly limited coverage to certain "Designated Premises" shown on the Declarations page of the policy. It was undisputed that, as of the time of the underlying accident, the subject premises was not listed on the Declarations page. The Second Department rejected the contention that the policy was rendered ambiguous by a provision that stated "this insurance applies" to bodily injury "caused by an 'occurrence' that takes place in the 'coverage territory'."

Indemnity Ins. Co. of North America v. St. Paul Mercury Ins. Co., 74 A.D.3d 21 (1st Dep't April 22, 2010) The Appellate Division, First Department, held, *inter alia*, that where an insurer does not take part in settlement negotiations or agree to the settlement of an underlying personal injury action, it cannot later be required to contribute to the resulting settlement. The First Department noted that this is especially true when the insurance policy at issue prohibits its insured from assuming any financial obligation without the insurer's consent.

DRK, LLC v. Burlington Ins. Co., 2010 WL 2572561 (1st Dep't June 29, 2010) As set forth by the Appellate Division, First Department, a "Exclusion-Cross Liability" endorsement, which stated that the subject insurance policy did not apply to any actual or alleged bodily injury to an employee of "any insured", unambiguously excluded coverage even where the injured party was an employee of another insured under the policy. Neither the general "Separation of Insureds" provision contained in the policy, nor the separation of insureds doctrine, rendered the exclusion ambiguous.

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