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QUARTERLY INSURANCE COVERAGE NEWSLETTER: NEW YORK

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CASES OF INTEREST BY TOPIC:

ADDITIONAL INSURED COVERAGE

Mt. Hawley Ins. Co. v. United Staffing Sys. Inc., 30 Misc.3d 1234(A) (N.Y.Sup. New York County February 25, 2011) Madison, LLC, the successor in interest to Madison Equities, was the owner of property in Manhattan. Sapir Realty f/k/a Zar Realty managed the property. United Staffing, a company in the business of providing temporary staffing of personnel on construction projects, including manual laborers, executed a contract with "Sapir Organization" for professional recruiting and temporary services. Sometime thereafter, a United Staffing employee brought suit against the Madison entities, Zar Realty and Sapir Realty seeking to recover damages for bodily injuries he sustained while performing construction services on the Madison property. The Madison entities and Zar Realty (as well as their insurer, Mt. Hawley Insurance Company) commenced this action against National Union Fire Insurance Company, United Staffing's general liability insurer, seeking a declaration that National Union was required to provide additional insured coverage under a blanket endorsement, since the contract between United Staffing and Sapir Realty provided: "Concurrently with its execution and delivery of this agreement, United Staffing shall provide Sapir Organization with a certificate of insurance detailing its general and excess liability insurance policies and coverage information and naming Sapir Organization as an additional insured under those policies." National Union argued that the agreement did not require that additional insured coverage be procured on behalf of the plaintiffs; in response, the plaintiffs argued that "Sapir Organization" was a general reference to the group of the plaintiff-entities and that United Staffing was aware that its personnel was being supplied to the project. The Court, however, found the plaintiffs' argument unpersuasive, since nowhere in the staffing agreement, which was only executed between Sapir Realty and United Staffing, was there reference to the plaintiffs or their subsidiaries. Moreover, the plaintiffs failed to provide an affidavit from any employees with personal knowledge of the staffing services agreement and understandings between Sapir and United Staffing.

ANTI-SUBROGATION

Diaz v. 333 East 66th Street Corp., 80 A.D.3d 652 (2d Dep't January 18, 2011) The anti-subrogation rule, prohibiting insurers from seeking indemnification from their own insureds, did not apply in this matter since there were two distinct and separate insurance policies covering different risks. Contrary to the plaintiff's contention, her status as a stockholder in the subject cooperative corporation did not qualify her as a named insured under the policy issued to the defendant third-party plaintiffs. While section II(1)(d) of the subject policy stated "your stockholders are also insureds, but only with respect to their liability as stockholders," there was no allegation of stockholder liability at issue in the action.

U.S. Underwriters Ins. Co. v. Skyline Dev. Corp., 2011 WL 1045061 (S.D.N.Y. March 17, 2011) On April 25, 2000, Glenn Kenney fell to his death while working for the defendant, Skyline Development Corporation, the general contractor for the renovation of a building in Manhattan. Kenney's estate ultimately brought suit against the owners of the building and the carpentry subcontractor, alleging negligence and violations of N.Y. Labor Law. The owners cross-claimed against the carpentry subcontractor

MERGER OF NEW YORK STATE BANKING AND INSURANCE DEPARTMENTS

The 2011-2012 New York State budget proposal, set forth by Governor Andrew Cuomo, includes a provision to merge the New York State Insurance and Banking Departments. This proposal has generated a substantial amount of attention from insurance companies and banks in New York State.

Scope

The section of the budget addressing the merger combines the New York State Insurance Department and the New York State Banking Department into a single agency – the Department of Financial Services ("DFS").

The DFS will be charged with taking the actions necessary to accomplish the following goals:

(1) foster the growth of the financial industry in New York and spur state economic development through judicious regulation and vigilant supervision;

(2) ensure the continued solvency, safety, soundness, and prudent conduct of the providers of financial products and services;

(3) ensure fair, timely, and equitable fulfillment of the financial obligations of such providers;

(4) protect users of financial products and services from financially impaired or insolvent providers of such services;

(5) encourage high standards of honesty, transparency, fair business practices, and public responsibility;

(6) eliminate financial fraud, other criminal abuse, and unethical conduct in the industry; and

(7) educate and protect users of financial products and services and ensure that users are provided with timely and understandable information to make responsible decisions about financial products and services.

The legislation also grants the DFS the power to conduct investigations, research, studies and analyses of matters affecting the interests of consumers of financial products and services, including tracking and monitoring complaints.

and brought a third-party action against the demolition subcontractor, KJS Construction. Although the owners did not implead Skyline (since they share the same principals), the carpentry subcontractor named Skyline as a third-party defendant. U.S. Underwriters ("USU") issued a general liability policy to KJS, and declined coverage for the owners' third-party action. As a result, KJS defaulted and a judgment in favor of the owners was entered against KJS for $1.35 million. Skyline was defended by its general liability insurer, Investors Insurance Company, which also defended the owners as additional insureds. After the owners were held statutorily liable, Investors and Ohio Casualty Insurance Company, Skyline's excess insurer, settled the underlying action for $1.35 million. Following the settlement, the owners executed an Assignment and Covenant to Limit Execution of the Judgment against KJS, pursuant to which the owners agreed to limit any levy or execution of the default judgment they had obtained to the claims KJS had against USU or any other insurer. Having thus acquired KJS's claim against USU, the owners then commenced an action against USU. USU eventually settled with the owners for $700,000, in exchange for a release. USU then commenced this action against Skyline for reimbursement of the $700,000. In opposition, Skyline invoked, *inter alia*, the anti-subrogation rule, derived from the fact that Skyline's insurer named the owners as additional insureds, defended them in the underlying action and settled the claims against them. As such, Skyline argued that the anti-subrogation rule barred USU's claim. USU argued, in turn, that anti-subrogation was not applicable, contending that it did not issue any insurance policy to Skyline, and that it was not bringing the action as subrogee of Skyline's insurer. Although the Southern District agreed that both of these facts were true, it found that "USU [was] missing the point." According to the Court, it was not anti-subrogation that barred USU in its capacity as the owners' assignee from being indemnified by Skyline, but rather, it was the principle that an assignee has no greater right against a defendant than does his assignor, and is subject to all defenses that could have been asserted against the assignor. Anti-subrogation is a defense that could have been asserted against the owners because the anti-subrogation rule barred the owners from being indemnified by Skyline; because the owners could not bring any claim for indemnity directly against Skyline, they could not assign any such claim to USU.

APPLICABILITY OF EXCLUSIONS

Richner Dev., LLC v. Burlington Ins. Co., 81 A.D.3d 705 (2d Dep't February 8, 2011) The cross-liability exclusion in a Commercial General Liability insurance policy precluded coverage for damages arising out of bodily injury sustained by an employee of any insured in course of his employment. This held true, according to the Appellate Division, Second Department, regardless of the Separation of Insureds policy provision, which provides that the "insurance applies as if each Named Insured were the only Named Insured", since the cross-liability exclusion precluded coverage to "any insured", and not just injuries sustained by the insured's own employees.

385 Third Avenue Assoc., L.P. v. Metropolitan Metals Corp., 81 A.D.3d 475 (1st Dep't February 10, 2011) The cross-liability exclusion in a subcontractor's Commercial General Liability policy barred coverage for a property owner and general contractor, as additional insureds, with respect to injuries sustained by a subcontractor's employee, regardless of whether policy proceeds were sought by way of direct claims by the injured party or by way of their contractual indemnification claims against subcontractor.

Emerson Enterprises, LLC v. Kenneth Crosby New York, LLC, 2011 WL 814422 (W.D.N.Y. March 1, 2011) Under New York law, the pollution exclusion in a lessor's Commercial General Liability insurance policy, which precludes coverage for property damage arising out of any "expected or intended" emission, discharge, seepage, release or escape of

The DFS will oversee both banks and insurance companies, as well as entities covered by regulations to be promulgated in accordance with the new law.

Additionally, the DFS will be charged with oversight responsibility for any other entity selling a financial product or service that is not specifically exempted from the DFS' jurisdiction. Such exempted items will include products or services that are regulated exclusively by a federal agency, regulated for the purpose of consumer or investor protection by another New York State agency, or whose regulation would be pre-empted by federal law.

Structure

The new agency will consist of two bureaus: one for banking and one for insurance. The merger also creates a state charter advisory board, which would work to retain state-chartered banking institutions and to encourage federally-chartered institutions to switch to a New York State charter.

Investigatory and Enforcement Powers

Under the bill, the DFS will have comprehensive investigatory and enforcement powers. The bill creates a financial fraud and consumer protection unit under the Department of State that will be authorized to undertake an investigation if it has reasonable suspicion that any person or entity is engaged in fraud or misconduct under the relevant statutes and regulations. The DFS also will be authorized to conduct adjudicatory proceedings under the State Administrative Procedures Act and to issue subpoenas compelling witnesses to attend hearings.

Additionally, the DFS will be authorized to penalize violators of the financial fraud and consumer protection rules with civil fines of up to $5000 per offense for violations of statutory provisions and up to $2500 for violations of regulations promulgated by the DFS. These penalties are in addition to any other civil or criminal sanctions that regulated entities face. (The blanket civil penalty for general violations of the Insurance Law has been increased from $500 to $1000.)

Whistleblower Provision

Finally, the merger bill includes a whistleblower provision that will insulate from civil penalties and civil causes of action of "any nature," persons who, in good faith, supply information about suspected violations of the Banking or Insurance Laws.

any waste or pollutant, barred coverage for the overflow of pollution residue from a drywell onto surrounding land due to rain or melting snow. The pollutant was intentionally dumped into the dry well, which had been constructed on the property for the purpose of dispersing the same into the ground, and no additional cause of contamination had been identified.

Essex Ins. Co. v. Grande Stone Quarry, LLC, et al., 918 N.Y.S.2d 238 (3d Dep't March 3, 2011) The Appellate Division, Third Department, held that an endorsement to the Commercial General Liability insurance policy issued to the defendant-insured which expanded the automobile exclusion, did not exclude coverage for claims by an operator of an all terrain vehicle (ATV) who was injured on the insured's property. Although the endorsement expanded the scope of the exclusion to include activities of "any insured" with regard to certain vehicles, including ATVs, the endorsement was ambiguous as to whether it expanded the exclusion to include use of vehicles by third-parties.

DISCLAIMERS

United Nat'l Ins. Co. v. Scottsdale Ins. Co., 2011 WL 839397 (E.D.N.Y. March 4, 2011) The Eastern District confirmed, *inter alia*, that an insurance company is not subject to the timely disclaimer provision contained in Insurance Law 3420(d) where no coverage exists under the policy. In this regard, New York law draws a distinction between denials based on policy exclusions and denials based on lack of coverage in the first instance. In the former situation, the policy covers the claim, but for applicability of the exclusion and, therefore, a timely notice of disclaimer is required. In the latter, the claim is not within the ambit of the policy and, therefore, mandating coverage on the basis of an insurer's failure to serve a timely notice of disclaimer would be to create coverage where none previously existed.

Chelsea Village Assoc. v. U.S. Underwriters Ins. Co., 2011 WL 1046204 (1st Dep't March 24, 2011) Contrary to the plaintiff's contention, the defendant-insurer's denial of coverage was not rendered "invalid" by the fact that its first disclaimer, issued on April 30, 2007, incorrectly stated that the policy did not provide coverage to the plaintiff, when it, in fact, was an additional insured. In holding the disclaimer was valid, the Appellate Division, First Department, noted that in addition to the incorrect statement in the April 20, 2007 letter, the defendant also asserted several other grounds for denying coverage, including an applicable exclusion. In a May 17, 2007 follow-up letter, the defendant-insurer correctly indicated that the plaintiff was an additional insured, while reiterating the other grounds for the denial of coverage. Thus, rather than changing its position to rely on a ground not previously raised, the May 17, 2007 letter merely retracted one of the grounds originally set forth.

NOTICE

SP&S Assoc., LLC v. Ins. Co. of Greater New York, 80 A.D.3d 529 (1st Dep't January 25, 2011) The receipt of service of a personal injury Summons and Complaint by the Secretary of State, the insured-plaintiff's designated agent, was held by the Appellate Division, First Department, as constituting receipt by the insured-plaintiff itself. The fact that the insured did not actually receive a copy of the Summons due to its failure to keep its address current with the Secretary of State, did not excuse its noncompliance with the notice requirements of the policy. As notice was not provided until a Motion for Default Judgment was filed some five months after service, the defendant-insurer was entitled to disclaim coverage on late notice grounds.

Lobosco v. Best Buy, Inc., 80 A.D.3d 728 (2d Dep't January 25, 2011) The Appellate Division, Second Department, held that the proffered excuses by an insured and additional insureds that they did not provide prompt notice to the defendant-insurer based upon their belief that the accident would not result in a claim because the plaintiff's injuries appeared to be minor and he had filed a workers' compensation claim (as an employee of the insured), were not reasonable in view of the fact that both the insured and the additional insureds were aware that the plaintiff had sought medical treatment for his injuries.

Hanover Ins. Co. v. Prakin, 81 A.D.3d 778 (2d Dep't February 15, 2011) While an injured party has an independent statutory right under New York Insurance Law 3420 to provide an insurance carrier with notice of an accident in satisfaction of the notice requirement of a policy, the injured party has the burden of proving that he or she, or counsel, acted diligently in attempting to ascertain the identity of the insurer, and thereafter expeditiously provided notice. In this matter, the Appellate Division, Second Department, held that injured party-defendants failed to explain their seventh month delay in notifying the plaintiff-insurer, despite uncontroverted evidence that they were informed of the plaintiff-insurer and the existence of an effective policy seven months prior.

American Home Assurance Co. v. BFC Const. Corp., 81 A.D.3d 545 (1st Dep't February 22, 2011) The named insured's forwarding of a Summons and Complaint in a personal injury action to the defendant-insurer constituted timely notice of the claim on behalf of the additional insureds, since the interests of the named insured were not adverse to the interests of the additional insureds at the time notice was provided. In addition, the insurer's delay in disclaiming coverage, after it knew or should have know of the purported bases for the disclaimer based upon exclusions in its policy, were unreasonable as a matter of law, and thus ineffective.

Sitnick v. Travelers Ins. Co., 918 N.Y.S.2d 489 (1st Dep't March 22, 2011) The Appellate Division, First Department, held that issues of fact exist as to the reasonableness of the plaintiff-homeowner's proffered excuse for providing untimely notice of a claim, *i.e.*, that he was unaware that the policies covering his New York home also provided coverage for an incident that occurred at a restaurant in New Jersey, in which a third-party claimed to have suffered personal injury at the hands of the plaintiff-homeowner's minor son. In sum, the First Department found that there was a question of fact as to whether the plaintiff-homeowner acted with due diligence by immediately providing notice to the defendant-insurer upon his receipt of a letter from the injured party's attorney advising him to contact his insurance carrier.

NUMBER OF OCCURRENCES

Bausch & Lomb, Inc. v. Lexington Ins. Co., 2011 WL 833252 (2d Cir. March 11, 2011) The plaintiff, Bausch & Lomb, Inc. ("B&L"), appealed an award of summary judgment entered in favor of its defendant-insurer, Lexington Insurance Company, on B&L's claims for a declaration that Lexington was obligated to defend and indemnify B&L in numerous actions brought by consumers of certain saline solution as the self-insured retentions to three umbrella policies were met. Specifically, B&L contended that the lower court erred in concluding, as a matter of law, that the policies did not group consumer exposures to the saline solution into one occurrence. The Lexington policies provided that "occurrence means…an accident, including continuous or repeated exposure to substantially the same general harmful conditions. All such exposure to substantially the same general harmful conditions will be deemed to arise out of one occurrence." B&L contended that the second sentence of the definition specifically grouped together consumer injuries arising from the same general harmful condition of

exposure to the saline solution. The Second Circuit disagreed, holding that nothing in the provision "precisely indentifies" the operative incident as exposure to a particular product. In addition, the Second Circuit noted that New York courts tend to interpret such a provision as, at most, combining exposures emanating from the same location at a substantially similar time. Following this standard, the saline solution incidents did not constitute exposure to the same general conditions because they involved different times, locations and circumstances. As a result, Second Circuit turned its attention toward the "unfortunate events" test, under which the Court found that the incident giving rise to liability was exposure to the defective product, not the manufacturer or sale of the product. In this regard, when determining if multiple incidents arise from a single occurrence or multiple occurrences, the unfortunate events test analyzes "whether there is a close temporal and spatial relationship between" or "the same causal continuum" for the incidents giving rise to the injuries. According to the Second Circuit, the saline solution incidents shared few commonalities, differing in "when and where exposure occurred, how long or how often plaintiffs used [the saline solution], and what intervening agents or factors existed." As such, B&L was not entitled to coverage under the Lexington policies prior to exhausting the aggregate Retained Limits.

PRIORITY OF COVERAGE

United States Fire Ins. Co. v. Knoller Companies, Inc., 80 A.D.3d 692 (2d Dep't January 18, 2011) With regard to priority of coverage, the additional insured coverage provided under one subcontractor's Commercial General Liability policy to the general contractor and property owner, was primary, and thus concurrent with coverage provided under another subcontractor's policy to those same additional insureds, requiring both, as co-insurers, to defend, and if necessary, indemnify the additional insureds in the underlying personal injury action brought by the injured employee of yet another subcontractor.

Fieldston Property Owners Ass'n, Inc. v. Hermitage Ins. Co., Inc., 16 N.Y.3d 257 (Court of Appeals February 24, 2011) According to the Court of Appeals, the duty to defend under a Commercial General Liability insurance policy providing coverage for "injurious falsehood" claims against an insured in two underlying actions was found to be primary, not entitling the general liability insurer to contribution from the insured's Directors and Officers Liability policy toward the cost of defending the actions, even though the D&O insurer would ultimately have an obligation to indemnify the insured for a greater proportion of the claims, if successfully prosecuted. In this regard, the D&O policy provided that its coverage was excess where any loss arising from any claim made against the insured was insured under any other valid policies, included defense costs in its definition of "loss".

PROFESSIONAL LIABILITY COVERAGE

CPA Mut. Ins. Co. of American Risk Retention Group v. Weiss & Company, 80 A.D.3d 431 (1st Dep't January 4, 2011) The Appellate Division, First Department, held that the unambiguous prior knowledge exclusion, entitling the plaintiff-insurer to disclaim coverage for "any Interrelated Acts or Omissions" that the defendants "believed or had a basis to believe might result in a 'Claim'" before the effective date of the policy, applied, since the evidentiary record established that the defendants, prior to the policy's effective date, had knowledge of numerous facts pertaining to a fraudulent scheme undertaken by their clients, which involved or implicated defendants as well. The defendants' subjective belief that they were not facing a claim in connection with the fraud committed by their clients did not warrant a different result.

Gladstein & Isaac v. Philadelphia Indem. Ins. Co., 918 N.Y.S.2d 92 (1st Dep't March 8, 2011) The allegation in the underlying Complaint that plaintiffs' law firm negligently hired and supervised an attorney who purportedly made sexual advances to a client, fell within the type of errors and omission coverage provided by defendant's professional liability insurance policy. While it was questionable whether the allegations fell within the policy definition of "Personal Injury", the Court held that they did fall within the policy's definition of a "Wrongful Act".

RECOVERY OF FEES

Lauder v. OneBeacon Ins. Group, LLC, 2011 WL 488711 (N.Y. Sup. New York County January 21, 2011) Under New York law, if an insured prevails when "placed in a defensive posture" (*i.e.*, sued) by an insurer seeking to relieve itself of its defense obligations under a policy, the insured may recover attorneys' fees necessarily incurred as a result of its defense of such an action. However, when an insured commences its own declaratory judgment action to settle rights to a defense under a policy, attorneys' fees incurred by the insured are not recoverable. Although there have been limited instances where New York courts have allowed an insured that took the affirmative step of commencing a declaratory judgment action against an insurer to recovery attorneys' fees, - *e.g.*, where the defendant-insurer places the plaintiff-insured in a defensive posture by requiring the declaration of a separate coverage issue based upon a new theory, for example, a counterclaim based upon an entirely separate theory or coverage issues, the Court held that such circumstances were not presented in this matter. In sum, the Court held that the Motion to Dismiss filed by the defendant-insurer, OneBeacon, in response to the First Amended Complaint filed by the plaintiff-insured, Estee Lauder, seeking a dismissal on the ground that Lauder failed to provide timely notice of a claim, was not tantamount to an affirmative action, *i.e.*, a counterclaim, but was a defense against an element of Lauder's *prima facie* case, to wit: that Lauder satisfied a condition precedent to coverage. "Lauder was never placed in the position of that of a defendant, who was forced to debate facts different from those necessary for Lauder to make out its *prima facie* case for coverage."

RESCISSION

Sirius American Ins. Co. v. Burlington Ins. Co., 81 A.D.3d 562 (1st Dep't February 22, 2011) Burlington Insurance Company established that the Commercial General Liability policy it issued to its insured, KJS Construction, Inc., was void *ab initio* on account of material misrepresentations made by KJS in the application process to procure insurance. An underwriting representative from Burlington averred, *inter alia*, that Burlington would not have insured risks associated with KJS undisclosed demolition work, particularly where such work was being performed in a building which exceeded four stories in height. The representative's statements were corroborated by internal underwriting documentation, including evidence of a standard exclusion that precluded recovery for bodily injury arising from demolition work in buildings exceeding four stories.

Am. Gen. Life Ins. Co. v. Salamon, 2011 WL 976411 (E.D.N.Y. March 16, 2011) The plaintiff-insurer commenced this action against the defendant-insureds seeking, *inter alia*, to rescind an insurance policy it had issued. The defendant-insureds argued that because the plaintiff-insurer continued to accept premium payments following its discovery of alleged misrepresentations in the application, as well as after announcing its intention to rescind the policy and filing this action, it ratified the policy and waived its right to rescind the policy. In response, the plaintiff-insurer argued that (1) it could not have ratified the policy without an intention to do

so, and (2) it did not waive its right to rescind the policy because it "inadvertently" accepted the premiums from the defendant-insureds. The Eastern District of New York recognized that, under New York law, waiver is the voluntary and intentional relinquishment of a known right, requiring evidence of a clear manifestation of intent, which cannot be inferred. Intent is established if the insurer had sufficient information regarding the grounds for rescission, but chose to not exercise its right to rescind. In particular, where an insurer accepts premiums after learning of an event allowing for cancellation of the policy, the insurer waives the right to cancel or rescind. The rationale behind this principle is that an attempt to both accept premiums and reserve the right to rescind a contract is unenforceable for lack of mutuality and timeliness. Accordingly, the Eastern District found that the plaintiff-insurer waived its right to rescind the policy because it had sufficient information that there were misrepresentations in the application, yet continued to accept payments after discovering those misrepresentations.

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