LB&C

QUARTERLY INSURANCE COVERAGE NEWSLETTER: NEW YORK

A quarterly newsletter from L'Abbate, Balkan, Colavita & Contini, L.L.P. Volume I · Issue II · Second Quarter 2008

FEATURED DECISION:

Preserver Ins. Co. v. Ryba, 2008 WL 2338635 (June 10, 2008) On May 17, 2003, a New Jersey construction worker, Arthur Ryba, employed by subcontractor East Coast Stucco Construction (Stucco Construction), fell from scaffolding while performing construction work at premises owned by the general contractor, Joaquim Almeida ("Almeida"), in Orangeburg, New York. At the time of the alleged occurrence, Stucco Construction, a New Jersey company, maintained a Workers' Compensation and Employers Liability policy issued by Preserver Insurance Company ("Preserver"), also of New Jersey. The policy was both underwritten and delivered in New Jersey. Despite Stucco Construction's agreement to provide Almeida with additional insured coverage, it failed to do so.

As a result of the paraplegia he sustained from the fall, Ryba commenced an action against Almeida, asserting causes of action for common law negligence and violations of various sections of the New York Labor Law. In light of Ryba's "grave injury" and Stucco Construction's contractual obligations, Almeida commenced a third-party action against Stucco Construction, asserting causes of action for common-law indemnification/contribution, contractual indemnification and breach of contract for failure to procure additional insured coverage.

Thereafter, Preserver commenced a declaratory judgment action, seeking the following relief: (1) Preserver sought a declaration that it had no duty to defend Almeida's cause of action for contractual indemnification or for breach of contract for failure to procure insurance; (2) Preserver argued that it had no duty to defend or indemnify Stucco Construction against Almeida's cause of action for common law indemnification because Ryba's accident occurred in New York, and was not necessary or incidental to Stucco Construction's work in New Jersey; and, (3) Preserver argued that if it must provide employers' liability coverage, it would be limited to $100,000 as provided by its policy.

In response, Northern Assurance Company, Almeida's homeowners' insurer, cross-moved for summary judgment on all three bases, contending that Preserver was time-barred under Insurance Law 3420(d) from disclaiming coverage, and that the Preserver policy was limitless as to the amount of employers' liability coverage.

The New York Court of Appeals began its analysis by noting that the Preserver policy was a standard form Workers' Compensation and Employers' Liability contract, mirroring the format of similar policies issued in both New York and New Jersey.

In reversing the decisions of both lower courts, the Court of Appeals held that under Section 3420(d) of the New York Insurance Law, when a liability policy is "delivered or issued for delivery in this state, [if] an insurer shall disclaim liability or deny coverage for death or bodily injury…it shall give written notice as soon as reasonably possible." As the Court noted, however, it was undisputed that the policy was actually delivered in New Jersey, by a New Jersey insurer, to a New Jersey insured. Based upon these factors, the Court held that despite the language of 3420(d), the policy was not "issued for delivery" in New York. In this regard, the Court stated that a policy is "issued for delivery" in New York, if it covers both insureds and risks located in the state. Although the Preserver policy included New York as an "Item

PENDING BILLS OF INTEREST IN THE NEW YORK LEGISLATURE:

FEATURED BILL:

Both houses of the New York legislature have passed a bill that would, in part, reverse New York's longstanding "no-prejudice" rule and allow for direct actions in certain circumstances.

In sum, Senate Bill 8610 and Assembly Bill 11541 (collectively, the "Bill") would prohibit insurers from denying a claim based upon untimely notice absent a showing of prejudice and would allow underlying claimants to maintain direct declaratory judgment actions, in certain circumstances, against the tortfeasor's insurer in personal injury and wrongful death cases where the insurer has denied coverage based upon untimely notice. Such a suit would be permitted, unless within sixty (60) days following the insurer's denial, the insured or insurer initiates an action to declare the rights of the parties under the insurance policy, and names the injured person as a party to the action.

The Bill provides that in any action in which an insurer alleges that it was prejudiced as a result of a failure to provide timely notice, the burden of proof shall be on:

(1) the insurer to prove that it has been prejudiced, if the notice was provided within two (2) years of the time required under the policy; or

(2) the insured, injured person or other claimant to prove that the insurer has not been prejudiced, if notice was provided more than two (2) years after the time required under the policy.

The insurer's rights shall not be deemed prejudiced unless the failure to timely provide notice materially impairs the ability of the insurer to investigate or defend the claim.

An "irrebuttable presumption" of prejudice shall apply if, prior to notice, the insured's liability has been determined by a court of competent jurisdiction or by binding

3.C" state on its "Information Page," thereby covering risks located in New York, the Court recognized that Stucco Construction was a New Jersey company, with its only office located in New Jersey, and, therefore, it could not be said that that insured was located in New York. Thus, because the policy was neither actually "delivered" nor "issued for delivery" in New York, Preserver was not required by Insurance Law 3420(d) to make a timely disclaimer. Furthermore, since the policy explicitly excluded coverage for any liability assumed under a contract, the Court held that Preserver was under no obligation to defend nor indemnify Stucco Construction for the contractual indemnification or breach of contract claim. The Court noted that even if the policy were "issued for delivery" in New York, Preserver would still not have been barred from denying coverage for Almeida's breach of contract claim since Insurance Law 3420(d) requires a timely disclaimer only for denial of coverage for "death or bodily injury."

Finally, despite the clear $100,000 limitation on coverage, Northern requested that the Court interpret the policy to require Preserver to provide unlimited employers' liability coverage "as if the policy were underwritten in New York." Northern's position rested first on the fact that New York was included on the policy's "Information Page" as an Item 3.C. state, and second on the provision of "Part Three – Other States Insurance," which provided that if work began in a 3.C. state, then "all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page." In short, according to Northern, being listed as a 3.C. state was the same as being listed as a 3.A. state, and Stucco Construction was entitled to coverage as if the policy were underwritten in New York. In response, the Court determined that Northern misapprehended the plain language of the policy, as well as New York law which requires that insurance policies provide unlimited employers' liability coverage in New York. According to the Court, including New York as "a 3.C. state…means what the policy says it means: that if an accident occurs in such a state, all provisions of the policy will apply. This includes the stated limitation of coverage for employers' liability insurance to $100,000 per accident."

PRIORITY OF COVERAGE:

Bovis Lend Lease LMB, Inc., v. Great American Ins. Co., 2008 WL 1063608 (1st Dep't April 10, 2008) The Appellate Division, First Department, held, with respect to the priority of coverage in a wrongful death action, that the coverage afforded the construction manager and owner by the umbrella liability policy of the subcontractor that employed the decedent was excess to the construction manager's and owner's own primary insurance. In addition, the First Department also held that the construction manager's and owner's additional insured coverage under the subcontractor's umbrella policy was excess to their coverage under the primary insurance maintained by the general contractor that retained the subcontractor. The First Department reached these conclusions notwithstanding the terms of the underlying subcontract, which required the subcontractor to make all of the insurance it provided to the construction manager and owner applicable on a primary basis, without contribution by the construction manager's and owner's own insurance. The First Department reasoned that an umbrella or excess liability policy "should be treated as just that," and not as "a second layer of primary coverage, unless the policy's own terms plainly provide for a different result. To hold otherwise would, we believe, merely sow uncertainty in the insurance market." Furthermore, we note that the First Department recognized that although the construction manger's and owner's primary carriers could potentially seek recovery as subrogees via a claim of contractual indemnification, that possibility did not effect priority of coverage among the applicable policies arising from the terms of the same.

arbitration; or if the insured has resolved the claim or suit by settlement or other compromise.

The Bill also requires an insurer, upon receipt of a written request by an injured person, within sixty days of receipt of the written request, to confirm to the injured person in writing whether the insured had a liability insurance policy in effect with the insurer on the date of the alleged occurrence, and to specify the liability insurance limits of the coverage provided under the policy.

In addition, to the extent the injured person or other claimant fails to provide sufficient information to allow the insurer, in the exercise of reasonable diligence, to identify a liability insurance policy that may be relevant to the claim, the insurer shall within forty-five (45) days of receipt of the written request, advise the injured person in writing and identify the additional information needed. Within forty-five (45) days of receipt of the additional information, the insurer shall provide the information required.

If signed into law by the Governor of New York, the Bill will take effect on the one hundred eightieth (180^{th}) day after it has become a law, and shall apply to policies issued or delivered on or after such date and to any action maintained under such a policy.

INSURED'S DUTY TO MITIGATE DAMAGES:

Murray v. New York City Transit Authority, 2008 WL 1902444 (N.Y. Sup. App. Ter. April 7, 2008) In a personal injury action commenced against defendant New York City Transit Authority ("NYCTA"), the plaintiffs claimed to have sustained bodily injuries as a result of an accident in a subway station. NYCTA impleaded its contractor, Kosangeo Construction ("Kosangeo"), and subcontractor, Navillus Tile, Inc. ("Navillus"), which were performing renovation work in the station at the time of the accident. The underlying action was ultimately settled for $25,000. Thereafter, NYCTA moved for summary judgment against Navillus in Civil Court, seeking reimbursement of attorney's fees, based upon Navillus' breach of contract to procure insurance. In this regard, Navillus' had agreed in its contract with Kosangeo to provide both Kosangeo and NYCTA with additional insured coverage. Navillus did not dispute the fact that it had failed to procure insurance pursuant to the terms of the contract, but instead noted that under the prime contract between NYCTA and Kosangeo, Kosangeo was obligated to name NYCTA as an additional insured under its liability policy with Royal Insurance Company ("Royal"), and claimed that NYCTA was required to mitigate damages by looking first to Royal for coverage. In response, the Court concluded that NYCTA did not have an obligation to exhaust all possible means of obtaining insurance coverage, including commencing a declaratory judgment action against Royal to ascertain whether there was coverage, before being made whole for the damages resulting from Navillus' breach of contract and failure to procure insurance.

PROFESSIONAL LIABILITY COVERAGE:

Citak & Citak v. St. Paul Travelers Co., Inc., 2008 WL 1882660 (S.D.N.Y. April 28, 2008) Plaintiffs, Citak & Citak, a law firm, and attorneys Donald and Burton Citak (collectively, the "Citaks") brought an action seeking a declaratory judgment of their rights under an insurance policy issued by St. Paul Travelers Co., Inc. ("St. Paul"). The Citaks had purchased a legal malpractice policy from St. Paul for the period from April 2006 through April 2007. The St. Paul policy did not apply to "'[c]laims' arising out of any error, omission, negligent act or 'personal injury' occurring prior to the inception date of this policy if any insured prior to the inception date knew or could have reasonably foreseen that such error, omission, negligent act or 'personal injury' might be expected to be the basis of a 'claim' or 'suit.'"

On November 3, 2006, Stuart and Carina Marton filed an action against the Citaks claiming legal malpractice. St. Paul declined coverage on the basis that the Citaks "knew or could have reasonably foreseen that this matter might be expected to be the basis of a claim prior to April 28, 2006 [the inception date of the policy]."

The *Marton* action alleged that the Citaks' legal malpractice damaged the Martons in their pursuit of an arbitration award against a contractor. Prior to the filing of the *Marton* action, Stuart Marton filed a complaint with the Department Disciplinary Committee of the First Judicial Department of the Supreme Court of the State of New York ("DDC") summarizing the alleged malpractice of the Citaks. The *Marton* action alleged that the Citaks received a copy of the DDC complaint on or about December 2005, but no later than January 27, 2006. The Citaks informed St. Paul of the Martons' potential claim after the inception date of the St. Paul policy, when a DDC mediator informed the Martons that they were free to pursue a malpractice action.

The Southern District began its analysis by recognizing that when determining whether an insured is on notice of a potential claim, courts use an objective reasonableness standard. According to the Court, upon receipt of the DDC complaint, which occurred no later than January 27, 2006, the

Citaks knew that Stuart Marton had filed a disciplinary grievance asserting various allegations of malpractice, and therefore, should have reasonably foreseen that their actions might have led to a malpractice claim. As such, St. Paul's motion to dismiss was granted.

INSURED'S RIGHT TO INDEPENDENT COUNSEL:

Elacqua v. Physicians' Reciprocal Insurers, 2008 WL 2277860 (3rd Dep't June 5, 2008) Relying on the Court of Appeals decision in *Public Serv. Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d at 392, 401 (1981), the Third Department held that where an insurer is obligated to provide coverage for some of the claims asserted against an insured, but not for others, the insured is entitled to be represented by an attorney of his or her own choosing at the expense of the insurer. The Third Department then indicated that where such potential conflict exists between an insurer and the insured, the insurer has an *affirmative obligation* to inform the insured of his or her right to select independent counsel at the insurer's expense.

According to the Third Department, the partial disclaimer letters sent by the defendant-insurer to its insureds failed to inform them that they had the right to select independent counsel at the defendant-insurer's expense, instead misadvising the plaintiffs that they could retain counsel to protect their uninsured interests "at their own expense." The Third Department determined that this practice was certainly "likely to mislead a reasonable consumer acting reasonably under the circumstances," and, therefore, constituted a deceptive practice under General Business Law § 349.

ADDITIONAL INSURED COVERAGE:

Kassis v. Ohio Cas. Ins. Co., 2008 WL 1914956 (4th Dep't May 2, 2008) The Appellate Division, Fourth Department, rejected the plaintiff Joseph Kassis' contention that he was an additional insured under the defendant-insurer's Commercial General Liability policy by way of a Blanket Additional Insured Endorsement. The endorsement provided, in relevant part, that the term defining "who is an insured…is amended to include as an insured any person or organization who you are required to name as an additional insured on this policy under a written contract or agreement." Pursuant to the property lease agreement executed between Kassis and Kassis Superior Sign Co., Inc. ("Superior Sign"), the defendant's insured, Superior Sign, was required to procure coverage for the "mutual benefit" of Kassis and Superior Sign, but did not specifically require that Superior Sign name Kassis as an additional insured. According to the Court, the policy expressly provided that the written contract or agreement require that Kassis be named as an additional insured, which was not in fact an obligation in the lease agreement. As such, Kassis was not entitled to additional insured coverage.

One Beacon Ins. v. Great Am. Ins. Co. of New York, 2008 WL 1969750 (3rd Dep't May 8, 2008) A golfer slipped and fell on a newly constructed deck at the club house owned by Saratoga National Golf Club, Inc. ("Owner"). The golfer thereafter commenced suit to recover for his injuries, which included allegations against contractors involved in a project at the site. In response to the golfer's suit, plaintiff, One Beacon Insurance ("One Beacon"), which insured the Owner, commenced a separate action against Great American Insurance Company of New York ("Great American"), seeking a declaration that the Owner was an additional insured under the Great American liability policy issued to D&B Building, Inc. ("D&B"), the subcontractor who built the deck on which the golfer fell. The Great American policy provided additional insured coverage for the Owner so long as D&B's operations were ongoing at the time of the occurrence. While the parties agreed that the Owner's additional insured coverage under the Great American policy was dependant upon whether D&B was still engaged in operations on the Owner's project at the time of the occurrence, they disputed

whether D&B's operations were completed. The Appellate Division, Third Department, held that although there was evidence in the record that the deck had been constructed and was in use before the accident, the deposition testimony of D&B's President and a punch list prepared by the project architect established that there was remaining work to be performed by D&B at the time of the accident. According to the Third Department, this evidence was sufficient to support the lower court's finding of a material question of fact as to coverage and a denial of Great American's Motion for Summary Judgment seeking to dismiss the Complaint and Cross-Claims.

Castro v. New York City Transit Auth., 2008 WL 2246070 (1st Dep't June 3, 2008) Although it was claimed that the third-party defendant breached its contractual duty to procure additional insured coverage, the Appellate Division, First Department, held that the third-party defendant did in fact procure such coverage. In this regard, the fact that the third-party defendant's insurer disclaimed coverage on the ground that the claim did not arise out of its insured's "work," was not tantamount to a failure, on the third-party defendant's part, to procure the requisite coverage. According to the Court, the third-party defendant did fail, however, in one respect, in that it procured additional insured coverage with a per-occurrence limit of $1 million, rather than the $2 million called for in the parties' contract. Thus, the Court held that to the extent the plaintiff's claim exceeded the $1 million policy limit, the third-party defendant would remain potentially liable on the breach of contract claim.

NOTICE OF DISCLAIMER:

The Cincinnati Ins. Companies v. Sirius Am. Ins. Co., 2008 WL 1914952 (4th Dep't May 2, 2008) The Appellate Division, Fourth Department, held that Sirius America Insurance Company ("Sirius") did not violate Section 3420(d) of the New York Insurance Law when it failed to issue its notice of disclaimer directly to C.O. Falter Construction Corp. ("Falter"), Buffalo Sewer Authority ("Buffalo Sewer") and the City of Buffalo Water Division ("Buffalo Water"), all of which had insured status under the Sirius policy, explaining that Sirius had complied with the statute by sending the notice of disclaimer to plaintiff, Cincinnati Insurance Companies, the primary insurance carrier for Falter, Buffalo Sewer and Buffalo Water.

MUTUAL MISTAKE:

The Scotts Co., LLC v. ACE Indem. Ins. Co., 2008 WL 1946732 (1st Dep't May 6, 2008) Pursuant to a settlement agreement and release entered into in December 2000, plaintiff, in exchange for $325,000, released the defendants from any and all past, present and future claims under insurance policies, whether known or unknown, issued by defendants. Four and a half years after executing the agreement, plaintiff commenced an action to rescind the agreement, claiming that the policy chart prepared by its own agent, upon which the plaintiff relied, contained a visual error that gave the impression that the total amount of primary coverage available under the implicated policies was $16 million. However, the difference between the primary coverage that was depicted on the policy chart and the amount actually available was $64 million. The Appellate Division, First Department, recognized that there was no legitimate dispute that the agreement was entered into by two sophisticated commercial entities, that there was no deceptive or high pressure tactics, that there was no fine print in the unambiguous agreement, and that there was no disparity between the plaintiff and defendants in experience or bargaining power. In addition, the negotiations took place over a 21 month period, the plaintiff was advised by legal counsel and had retained a consulting firm that assists policyholders in resolving complex insurance claims. The plaintiff, according to the First Department, was "free to walk away from the negotiations at any time and litigate its differences with the defendants in the United States District Court

for the Southern District of New York, where a declaratory judgment action by the defendants was pending." As such, the Court held that the plaintiff's claim of procedural unconscionability failed as a matter of law. Nor, contrary to the plaintiff's contention, did the disparity in exchanged value, *i.e.* the release of $80 million in insurance coverage for $325,000, demonstrate substantive unconscionablility, since the disparity in the amount of coverage the plaintiff believed it was releasing, *i.e.* $16 million for $325,000, was itself, according to the First Department, substantial, and yet, the plaintiff, after 21 months of negotiations, agreed to the exchange.

In addition, plaintiff's claim of mutual mistake also failed as a matter of law. In this regard, the First Department noted that the plaintiff admitted that its agent prepared the policy chart based on its review of the insurance policies, rather that on any information provided by the defendant-insurers. The Court did note, however, that even assuming there was a mistake, the mistake did not go to the foundation of the agreement. "The stated purpose of the agreement was to fully and finally terminate the parties' relationship as insurer and insured under the policies. The nature of the agreement thus remains intact irrespective of the policy limits. In fact, although in the agreement the policies were identified by number, policy period and issuing company, the policy limits were not even mentioned. Moreover, under the agreement, plaintiff released an unknown number of policies with unknown limits. In any event, it does not avail plaintiff to invoke even a material mistake to avoid the consequences of its own negligence. Plaintiff could have easily ascertained the limits of the policies by reading the policies. Instead, it assumed the risk of proceeding based upon second-hand information presented to it by its own agent."

LACK OF COOPERATION:

Country-Wide Ins. Co. v. Henderson, 2008 WL 1054957 (2d Dep't April 8, 2008) On April 8, 2005, Wendy Henderson was involved in an automobile accident with a vehicle owned and operated by Kessel Pierre Charles. At the time of the accident, Henderson's vehicle was insured by Country-Wide Insurance Company ("Country-Wide") and Charles' vehicle was insured by Travelers Indemnity Insurance Company ("Travelers"). On May 23, 2005 and May 25, 2005, after an inability to contact Charles, Travelers wrote to Charles informing him that it was disclaiming coverage due to his failure to cooperate with Travelers' investigation. Travelers then sought a judicial declaration that its disclaimer was valid. The sole evidence presented by Travelers to the lower court in support of its non-cooperation disclaimer was an affidavit from an investigator within its Special Investigations Unit, who had no personal knowledge of the efforts made to locate Charles. The affidavit merely recited the apparent efforts of an unnamed investigator and attached copies of letters to Charles from a claims representative. The affidavit was based entirely upon hearsay evidence with no proof that it fell within any exception to the hearsay rule. As such, the Appellate Division, Second Department, held that the affidavit was inadmissible and failed to provide a sufficient basis for the lower court to determine the validity of Travelers' disclaimer. According to the Second Department, Travelers failed to demonstrate that it fulfilled the following requirements necessary to disclaim coverage: (1) it acted diligently in seeking to bring about the insured's cooperation, (2) its efforts were reasonably calculated to obtain the insured's cooperation, and (3) the attitude of the insured, after its cooperation was sought, was one of willful and avowed obstruction. While the affidavit of the Travelers' investigator correctly provided the surname of the insured as "Pierre Charles," the correspondence from the claims representative and Department of Motor Vehicles and Board of Elections search requests in both New York City and Nassau County, incorrectly gave "Kessel" as the surname. Under such circumstances, the Second Department held that it could not be said that the efforts employed, even if diligently undertaken, were reasonably calculated to bring about Pierre Charles' cooperation. In

conclusion, the Second Department explained that mere efforts by the insurer and mere inaction on the part of the insured, without more, are insufficient to establish non-cooperation as "the inference of non-cooperation must be practically compelling."

Allstate Ins. Co. v. Gardander, 2008 WL 2390065 (2d Dep't June 10, 2008) In affirming the lower court's decision, the Appellate Division, Second Department, held that the insurer was justified in disclaiming coverage because of the insured's failure to cooperate in the defense of an action against him. Under the circumstances of the case, where there was no cooperation by the insured, the insured could not be located after a diligent search, and there had been misrepresentations made by the insured when applying for insurance, a breach of the cooperation clause was found. In addition, the Second Department determined that inasmuch as the driver of the insured's vehicle supplied the police with a nonexistence address, the insurer's failure to serve a separate disclaimer on the driver did not render the original disclaimer ineffective.

STANDING:

Azad v. Utica Nat'l Ins. Group, 2008 WL 2210296 (2d Dep't May 27, 2008) The plaintiff's right of action against the defendant-insurer was held subject to Insurance Law § 3420, as the plaintiff was not a named insured under the liability policy issued by the defendant-insurer. Since the plaintiff was not an insured and did not obtain a judgment against the insured that remained unsatisfied for 30 days, the plaintiff lacked standing to maintain direct causes of action against the defendant-insurer.

SPOLIATION OF EVIDENCE:

Gen. Sec. Ins. Co. v. NIR, 50 A.D.3d 489 (1st Dep't April 22, 2008) Restaurant insurer, as restaurant's subrogee, brought a negligence action against the installer of the restaurant's fire sprinkler system and the system's inspector, seeking to recover for fire damage, and alleging that the sprinkler system was defective and/or not properly inspected. The Appellate Division, First Department, held that the defendants' spoliation argument was properly rejected by the lower court. According to the First Department, the defendants had an opportunity to inspect the fire-damaged premises on several occasions, and did so. The plaintiff-insurer had promptly notified the defendants of its intention to seek indemnification and the plaintiff-insurer had also advised the defendants that the sprinkler system would be disassembled, expressly requesting that the defendants respond so a mutual date for disassembly and inspection could be arranged. The defendants' principal acknowledged receiving the insurer's correspondence, however, there was no assertion or evidence in the record that the defendants ever responded. As such, the First Department found that it could not be concluded that the premature disposal of the sprinkler gave the plaintiff-insurer an unfair advantage over the defendants.

RESCISSION:

Precision Auto Accessories, Inc. v. Utica First Ins. Co., 2008 WL 2314503 (4th Dep't June 6, 2008) The plaintiff-insured sought to recover under its policy of insurance with the defendant-insurer after its place of business was totally destroyed by fire. Following an investigation, the defendant-insurer notified plaintiff that it was not entitled to coverage for the loss and that it was rescinding the policy from its inception based on allegedly material misrepresentations made in the plaintiff-insured's insurance application with respect to the plaintiff's claims history. The Appellate Division, Fourth Department, rejected that plaintiff's contention that the defendant-insurer was not entitled to rely on any misrepresentations in the policy application

because they were the result of the negligence of the defendant-insurer's alleged agents. The Fourth Department held, *inter alia*, that the plaintiff was bound by the misrepresentations in the application, inasmuch as "the signer of a contract is conclusively bound by it regardless of whether he or she actually read it." Furthermore, according to the Fourth Department, the insured "has a duty to review the entire application and to correct any incorrect or incomplete answers." In addition, the Fourth Department noted that an insurance broker is generally considered to be an agent of the insured. To establish that the broker was acting as the insurer's agent, there must be evidence of some action on the insurer's part, or facts from which a general authority to represent the insurer may be inferred. Although the insurance agency that bound that coverage may have been an agent of defendant-insurer, the broker who completed the application was hired by the plaintiff-insured and was, therefore, was an independent contractor with no connection with the defendant-insurer.

SUBROGATION:

Continental Cas. Co. v. Am. Home Assurance Co., 2008 WL 1752231 (S.D.N.Y. April 14, 2008) The Southern District explained that in a subrogation suit brought by an insurer, the insured is not always a necessary party. A partial subrogation case is one in which the insurer has only paid for part of the insured's loss, and the insurer brings a claim against a third-party for the amount the insurer paid. In such instances, both parties may reasonably be considered necessary; otherwise, the insurer and insured might not be available in a single suit. However, if an insurer has paid the entire loss suffered by the insured, the insurer is the only real party in interest, and there is no concern that complete relief cannot be granted in a single action.

PERSONAL AND ADVERTISING INJURY:

47 Mamaroneck Ave. Corp. v. Hartford Fire Ins. Co., 2008 WL 1823487 (2d Dep't April 22, 2008) Plaintiff-insured argued that allegations of "wrongful eviction and/or wrongful entry" made against it by its tenant, Rent-A-Center, Inc. ("RAC"), were covered under the "personal and advertising injury" section of its general liability policy. The Appellate Division, Second Department, held that the defendant-insurer was not obligated to provide coverage to the plaintiff-insured as a result of the fact that the definition of "personal and advertising injury" in the policy distinguished between "person" and "organization," *i.e.* defamation of a "person or organization" was included in the definition, while the wrongful eviction and wrongful entry was limited to "the right of private occupancy of a room, dwelling or premises that a person occupies." Since RAC was not a natural person, any invasion of its leasehold was not covered by the definition of "personal and advertising" injury.

ANTI-SUBROGATION:

ELRAC, Inc. v. Russo, 2008 WL 2346134 (N.Y. Sup. Nassau County. June 10, 2008) Automobile rental companies are required to provide their lessees with primary insurance coverage up to the minimum liability limits provided by statute. Self-insurers, like the plaintiff, are not exempt from this requirement. Pursuant to the anti-subrogation rule, an insurer generally has no right to subrogation against its own insured for a claim arising from the very risk for which the insured was covered. This rule applies even where the insured has expressly agreed to indemnify the party from whom the insurer's rights are derived. The Appellate Division, First Department, held that, the anti-subrogation rule notwithstanding, a car rental company may enforce the indemnification clause in its rental agreement, but only to the extent its liability exceeds the statutory minimum amount of insurance it is required to maintain.

Ins. Corp. of New York v. Cohoes Realty Associates, L.P., 2008 WL 879295 (3rd Dep't April 3, 2008) A fire occurred at a premises owned by the defendant, resulting in damage to business property used by a tenant. At the time of the fire, the defendant-owner was an additional insured under the tenant's Commercial General Liability policy with the plaintiff-insurer, but was not an additional insured under the tenant's business owners' property coverage, also issued by plaintiff-insurer. Defendant-owner argued that given its status as an additional insured under the tenant's Commercial General Liability policy, the plaintiff-insurer was barred by anti-subrogation principles from seeking reimbursement for the damages paid to the tenant under the business owners' policy. The Appellate Division, Third Department, held that since the tenant's Commercial General Liability insurance did not cover the subject loss, and the owner was not added to the business owners' policy as an additional insured, the anti-subrogation rule was inapplicable.

NOTICE:

Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Connecticut Indem. Co., 2008 WL 2342121 (1st Dep't June 10, 2008) Where notice to an excess carrier is at issue, the focus is on whether the insured reasonably should have known that the claim against it would likely exhaust its primary insurance coverage and trigger its excess coverage, and whether the delay between acquiring that knowledge and giving notice to the excess carrier was reasonable under the circumstances.

Tudor Ins. Co. v. RAL Industrial, Inc., 2008 WL 977195 (E.D.N.Y. April 9, 2008) In an action by plaintiff-insurer, Tudor Insurance Company ("Tudor"), seeking a declaration that it had no obligation to defend and/or indemnify its insured, defendant RAL Industrial, Inc. ("RAL"), the United States District Court, Eastern District of New York, held that Tudor established as a matter of law that RAL failed to provide timely notice of the occurrence within a reasonable period of time, as required by the Tudor policy, because over eight months elapsed from the date of the occurrence until Tudor first learned of the accident. In addition, the Eastern District noted that even had timely notice been provided, Tudor would have still prevailed because the policy excluded coverage for "bodily injury to an employee, temporary worker…or contractor…of the insured…arising out of the course of employment by or performing services for the insured."

Tower Ins. Co. of New York v. Lin Hsin Long Co., 2008 WL 895747 (1st Dep't April 3, 2008) Under Insurance Law §3420(a)(3), an injured party has an independent right to notify an insurance carrier of an accident. However, an injured party is required, in order to rely upon Insurance Law §3420(a)(3), to demonstrate that he or she acted diligently in attempting to ascertain the identity of the insurer, and thereafter expeditiously notified the insurer. The undisputed fact that the injured party's counsel never requested that the insured identify its insurance carrier, nor undertook additional efforts to identify the carrier, compelled the Appellate Division, First Department, to concluded that the injured party did not exercise reasonable diligence. In addition, it was also undisputed that the insurer did not receive direct notice from the injured party. The belated notice the insurer received was supplied by the insured when it or its broker forwarded to the insurer the injured party's Complaint. As such, since the injured party did not assert her own right to provide notice, but rather relied on the insured to do so, the First Department determined that her rights were derivative of the insured's. Thus, the insurer was entitled to summary judgment based upon the fact that there were no triable issues of fact existing regarding whether the insured or the injured party provided timely notice of the accident to the insurer.

HOMEOWNERS' COVERAGE

Kantrow v. Sec. Mut. Ins. Co., 2008 WL 808953 (2d Dep't March 25, 2008) The Appellate Division, Second Department, held that the defendant-insurer had no obligation to provide coverage to the plaintiff-insured in an underlying action brought against the insured by third-parties, which claimed to have been injured by the sexual acts of the plaintiff-insured's son. The Second Department noted that the defendant-insurer's policy expressly excluded coverage for "bodily injury…caused intentionally by or at the direction of any insured," as well as for child abuse or sexual abuse, regardless of whether the claims were made directly, indirectly or derivatively as sounding in negligence. Thus, despite the fact that the underlying action couched its allegations against the plaintiff-insureds in negligence, coverage was excluded.

VOLUNTEER DOCTRINE:

Atl. Specialty Ins. Co. v. Gold Coast Developments, Inc., 2008 WL 974411 (E.D.N.Y. April 8, 2008) Subrogation allows an insurer to stand in the shoes of its insured and seek indemnification from third parties whose wrongdoing has caused a loss for which the insurer is bound to reimburse. However, an insurer which pays a loss for which it is not liable thereby becomes a mere volunteer, and is not entitled to subrogation, in the absence of an agreement therefor. Nevertheless, the volunteer doctrine is not automatic, and an insurer does not forfeit the right to recover simply because it settled non-covered claims. In particular, an insurer is not a volunteer when it makes a good-faith payment under a reasonable belief that such payment is necessary to protect itself.

MISCELLANEOUS:

Tr. of Princeton Univ. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 2008 WL 2277830 (1st Dep't June 5, 2008) The Appellate Division, First Department rejected the defendant-insurer's contention that the subject policy's $5 million sub-limit for claims that seek equitable relief applied to claims arising from the same underlying occurrence that sought relief based on tort and contract principles, as it relied on a strained construction of the terms of the policy. In addition, the First Department also rejected the defendant-insurer's contention that the policy's "insured verses insured" exclusion applied to claims brought against the insured entities by individual insureds acting in their individual capacities.

233rd St. P'ship, L.P. v. Twin City Fire Ins. Co., 2008 WL 2344740 (1st Dep't June 10, 2008) In reversing the lower court's decision, the Appellate Division, First Department, held that the lower court erred in basing its determination that the defendant-insurer's policy was excess solely on the wording of the policy, and that its coverage was subject only to the payment of a deductible and, therefore, the policy was not a true excess policy, but rather a primary policy that, under certain circumstances, purports to shift losses to other available insurance.

Marsala v. Travelers Indem. Co., 2008 WL 1748286 (2d Dep't April 15, 2008) Plaintiff was struck by a truck owned by 3-D Transport of South Jersey ("3-D") and driven by its employee. After obtaining a default against 3-D and the employee driver, plaintiff brought suit against the defendant-insurer seeking to recover the unsatisfied judgment. The defendant-insurer cross-moved seeking a dismissal of the action, claiming that the subject policy did not provide coverage to 3-D or the employee driver. The Appellate Division, Second Department, held that the insurer failed to establish its entitlement to summary judgment due to its failure to conduct an "exhaustive search" of the tortfeasor's names in the insurer's records.

NAICC, LLC v. Greenwhich Ins. Co., 857 N.Y.S.2d 723 (2d Dep't May 20, 2008) The Appellate Division, Second Department, found that the lower court correctly determined that certain provisions in a commercial liability policy issued by the defendant-insurer to the plaintiff-insured which pertained to "Loss Conditions" were ambiguous and that, construed against the defendant-insurer, the provisions required the defendant-insurer to reimburse the plaintiff for guard services retained to protect the subject property after a fire that was the covered cause of loss. According to the Second Department, contrary to the defendant-insurer's contention, the record did not establish that, after the fire, the property was valueless as a matter of law and that there was, therefore, nothing on the site to protect from further damage.

Desir v. Nationwide Mut. Fire Ins. Co., 2008 WL 1823427 (2d Dep't April 22, 2008) The Appellate Division, Second Department, held that the insurer was under no obligation to provide its insured with coverage in an underlying action involving an alleged assault, regardless of the fact that there were negligence causes of action included in the underlying complaint. According to the Second Department, the assault in the underlying action was an intentional act, which did not constitute an "occurrence"" within the meaning of the policy issued by the insurer, which defined ""occurrence" as a "bodily injury…resulting from an accident, including continuous or repeated exposure to the same general harmful conditions." In addition, the Second Department noted that coverage for the insured's conduct would also be barred by the exclusionary clause for intentional acts.

Cont'l Cas. Co. v. AON Risk Servs. Cos. Inc., 2008 WL 895944 (1st Dep't April 3, 2008) The Appellate Division, First Department, held that plaintiff-insurer's claims against defendant-broker for failing to deliver to their non-party insured the terms and conditions of its insurance policy were properly dismissed for failure to state a cause of action. "While an insurance broker sometimes acts as an agent for the insurer so that its acts are treated as the acts of the insurer," according to the First Department, there was no evidence of any action on the plaintiff-insurer's part from which it could infer that the plaintiff-insurer entrusted the defendant-broker with delivering the policy documents or authorized the defendant-broker to represent the insurer for any other purpose. Nor was there any evidence that the defendant-broker exercised discretionary functions on the plaintiff-insurer's behalf or possessed superior expertise on which the plaintiff-insurer relied so as to give rise to a fiduciary duty.

Kaufmann v. Leatherstocking Coop. Ins. Co., 2008 WL 2369925 (3rd Dep't June 12, 2008) Generally, insurance agents are not liable for actions other than obtaining insurance coverage for their insureds, unless a special relationship has been established between the parties.

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 have relied 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