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QUARTERLY INSURANCE COVERAGE NEWSLETTER: NEW YORK

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CASES OF INTEREST BY TOPIC:

ADDITIONAL INSURED COVERAGE:

Marcos Mennis v. Commet 380, Inc., 2008 WL 4346320 (1st Dep't September 25, 2008) A lease agreement required the tenant to procure insurance on the landlord's behalf as a primary insured. The Appellate Division, First Department, held that the tenant satisfied this requirement by procuring insurance that named the landlord as an additional insured. More importantly, the First Department held that the tenant's insurer was obligated to defend the landlord as an additional insured in an underlying action which was brought by a construction worker whom the tenant had hired to perform certain work on the premises. In this regard, the First Department based its decision on the fact that the lease agreement required the tenant to make all repairs and undertake full maintenance of the premises, and that the additional inured coverage provided under the tenant's policy therefore protected against the type of risk and injury in the underlying action.

AGENCY AGREEMENTS:

Fidelity and Guar. Ins. Underwriters, Inc. v. Jasam Realty Corp., 540 F.3d 133 (2d Cir. August 26, 2008) The United States Court of Appeals for the Second Circuit recognized that to the extent a broker acts within the scope of an agency agreement it has with an insurer, any knowledge or information the broker has with respect to the insured, *e.g.*, information regarding the insured's business, properties, claims, etc., may be imputed to the insurer, even if the broker does not timely communicate the information to the insurer.

ANTI-SUBROGATION:

Pesta v. City of Johnstown, 53 A.D.3d 338 (3d Dep't July 17, 2008) Plaintiff, an employee of third-party defendant, Peter Luzzi & Brothers Contracting, was injured while working on a road paving project that Luzzi had agreed to perform for the defendant, the City of Johnstown. Specifically, the plaintiff sustained injuries when he was struck by a dump truck owned by Luzzi and operated by another employee of Luzzi. At the time of the accident, Luzzi was insured by Harleysville Insurance Company under three policies: a Commercial General Liability policy, a Commercial Automobile policy, and a Commercial Umbrella policy. As per the contact between Luzzi and the City, Luzzi also purchased an Owners and Contractors Protective Liability policy from Harleysville that named the City as an insured.

After the plaintiff commenced action against the City, the City brought a third-party action against Luzzi seeking common-law indemnification. The City then moved for summary judgment on its indemnification claim and Luzzi cross-moved to partially dismiss the third-party action to the extent of available coverage under the Harleysville policies, under a theory of anti-subrogation.

The Appellate Division, Third Department, began its analysis by recognizing that under New York law it is well settled that an insurer has no right of subrogation against its own insured for a claim arising from the very risk for which the insured was covered. The Third Department pointed out that the anti-subrogation rule, however, does not apply when an exclusion in a policy renders the policy inapplicable to the loss. In this regard, the Third

PENDING BILLS OF INTEREST IN THE NEW YORK LEGISLATURE:

LATE NOTICE BILL SIGNED INTO LAW:

As previously reported in our Second Quarter 2008 Newsletter, both houses of the New York legislature had passed a bill that would, in part, reverse New York's longstanding "no-prejudice" rule and allow for direct actions in certain circumstances. On July 21, 2008, this key bill was signed into law by Governor David Patterson.

In sum, New York law will now prohibit insurers from denying a claim based upon untimely notice absent a showing of prejudice and will allow underlying claimants to maintain direct declaratory judgment actions, in certain circumstances, against the tortfeasor's insurer in property damage, 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 new law will take effect on January 19, 2009, and shall apply to policies issued or delivered in New York on or after such date and to any action maintained under such a policy.

Department held that coverage was excluded under both the Commercial General Liability policy (auto exclusion) and Commercial Auto policy (co-employee exclusion) and, as such, the Commercial Umbrella policy was also held not to apply. Finally, The Third Department held that the anti-subrogation rule did not apply in light of the fact that the Owners and Contractors Protective Liability policy only named the City as an insured.

BAD FAITH:

Vitrano v. State Farm Ins. Co., 2008 WL 2696156 (S.D.N.Y. July 8, 2008) Plaintiff-insured brought action against defendant-insurer seeking compensatory and punitive damages allegedly arising out of defendant-insurer's failure to pay a first-party claim under a renters insurance policy. The plaintiff-insured asserted several causes of action against the defendant-insurer, including breach of contract, unjust enrichment, breach of implied warranty, fraud, breach of good faith and fair dealing, and bad faith refusal to settle a claim. The defendant-insurer moved to dismiss the action for failure to state a claim. The United States District Court, Southern District of New York, held that the only claim with merit was that for breach of contract.

According to the Southern District, all of the plaintiff-insured's causes of action rested solely on the defendant-insurer's alleged failure to honor the insurance policy, which is a claim for breach of contract. In this regard, the Southern District noted that under New York law: (1) the plaintiff-insured's claims for fraud and breach of implied covenant of good faith and fair dealing did not provide a distinct cause of action because they rested on the same allegations as the breach of contract claim; (2) where there is an enforceable contract governing the particular subject matter, claims based on quasi-contract theories like unjust enrichment do not provide a distinct basis for recovery; (3) New York law does not recognize an independent cause of action for bad faith denial of insurance coverage; and (4) the failure to pay a claim cannot provide a basis for a claim of punitive damages in the absence of egregious conduct on the part of the insurer that is actionable as an independent tort that that is directed at the insured and is part of a pattern of behavior aimed at the public generally.

CHOICE OF LAW:

Appalachian Ins. Co. v. Gen. Elec. Co., 2008 WL 2840354 (New York County, July 17, 2008) The first step in any case presenting a potential choice of law issue is to determine whether there is an actual conflict between the laws of the jurisdictions involved. Once an actual conflict is identified, a choice of law analysis is warranted. It is well settled that in a contract dispute, New York's choice of law rules require courts to apply the law of the state with the most contacts with the contract, often referred to as the "center of gravity" or "grouping of contacts" test. This test determines which state has the most significant relationship to the transaction and the parties. There are five factors to consider in determining the "center of gravity" for a contractual dispute: (1) the place of contracting; (2) the place of negotiation of the contract; (3) the place of performance; (4) the location of the subject matter of the contract; and (5) the domicile or the place of business of the contracting parties.

Where the choice of law analysis concerns an insurance contract, the principal location of the insured risk is the primary factor in determining the governing law. However, in this matter, the Court directed that the state of the insured's domicile be regarded as a proxy for the principle location of the insured risk as the insured risk was located in several states. As such, the state of the insured's domicile was found to be the source of the applicable law.

Liberty Surplus Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 20 Misc.3d 1128(A) (New York County, August 4, 2008) The Supreme Court held that the rule that the insured's principle place of business is proxy for location of risk when there are multi-state risks only focuses on the primary insured, and does not consider the principle place of business of additional insureds, which do not have the same participation in the original negotiation for the coverage, a touchstone consideration in connection with the rule.

DUTY TO DEFEND:

State Farm Fire and Cas. Co. v. Whiting, 53 A.D.3d 1033 (4th Dep't July 3, 2008) The Appellate Division, Fourth Department, held that the lower court properly granted the cross-motion of the plaintiff-homeowner's insurer seeking summary judgment declaring that it had no duty to defend or indemnify in an underlying action, which alleged that the defendant-insured assaulted Evan Lang while Lang was attending a party at the defendant-insured's home. The Fourth Department agreed with the lower court that the incident at issue was not an "occurrence" within the meaning of the policy, and disagreed with the dissent's reliance on Automobile Ins. Co. of Hartford v. Cook, 7 N.Y.3d 131 (2006), in finding that the duty to defend was triggered.

The majority noted that the policy defined "occurrence" as "an accident," and that an incident is an occurrence and/or accident, if "from the standpoint of the insured," the incident resulting in injury was "unexpected, unusual and unforeseen." The majority highlighted the fact that the defendant-insured testified at his deposition that he intended to hit Lang and that Lang "could be hurt from the punch." In this regard, the majority distinguished Cook, wherein the insured shot and killed an intruder in his home and where the insured testified at his deposition that he knew the victim would be injured, but did not anticipate that the victim would be killed. As such, the majority concluded that since there was no view of the evidence before it to support a conclusion that the result of the defendant-insured's intentional act of punching Lang in the face "accidentally or negligently" caused Lang's alleged injuries, the plaintiff-insurer's duty to defend was not triggered, irrespective of the fact that the Complaint included allegations of negligence.

Medrano v. State Farm & Cas. Co., 863 N.Y.S.2d 480 (2d Dep't September 2, 2008) On March 8, 2003, the plaintiff in the underlying action, a teacher's aide, was monitoring students in the cafeteria when a food fight broke out. The defendant in the underlying action, Robert Filer, threw a garbage can into the air, which struck the aide and injured her. The aide commenced a personal injury action alleging that Filer negligently, carelessly and recklessly caused her injuries. At the time of the injury, Filer's parents were insured under a homeowner's insurance policy issued by the defendant-insurer. The defendant-insurer denied coverage for the claims asserted against Filer stating, *inter alia*, that the alleged incident did not qualify as an "occurrence," which is defined in the policy as an accident, and that the policy contained an exclusion for bodily injury that either was expected or intended by the insured or was the result of willful and malicious acts of the insured. However, the Appellate Division, Second Department, held that the defendant-insurer failed to demonstrate its entitlement to judgment as a matter of law since it did not show that the allegations of negligence in the Complaint fell wholly outside coverage or within a valid policy exclusion. Furthermore, the Second Department held that the allegations of negligence in the Complaint implied an unintentional or unexpected event which potentially gave rise to a covered claim.

NOTICE:

23-08-18 Jackson Realty Assoc. v. Nationwide Mut. Ins. Co., 53 A.D.3d 541 (2d Dep't July 8, 2008) The Appellate Division, Second Department, recognized that there are situations in which timely notice furnished by one insured may be deemed timely notice by another. Where two or more insureds are defendants in the same action, notice of the "occurrence" or of the lawsuit provided by one insured will be deemed notice on behalf of both when their interests are united or where there is no adversity between them.

1700 Broadway Co. v. Greater New York Mut. Ins. Co., 863 N.Y.S.2d 434 (1st Dep't September 16, 2008) The Appellate Division, First Department, held that the plaintiff, an additional insured under the defendant-insurer's policy, could not rely on the timely notice provided by the named insured because the plaintiff-additional insured had an interest adverse to the named insured from the moment the underlying action was filed, which named both the additional insured and named insured as defendants. According to the First Department, this adversity was confirmed when the additional insured and named insured filed cross-claims against each other.

J.J.J. Properties Inc. v. The Travelers Indem. Co., 2008 WL 2735865 (S.D.N.Y. July 7, 2008) The plaintiff-insured, J.J.J. Properties, Inc., brought an action for money damages and a declaratory judgment action against the defendant-insurer, Travelers Indemnity Company. JJJ was incorporated in 1987 by Joseph A. Simonetti, his brother Gerard Simonetti and their father, Joseph C. Simonetti. Simonetti, his brother and father each owned one-third of the outstanding shares of JJJ until the father's death in 2005, at which time his shares passed to his wife. JJJ's sole business was the ownership of certain real property. JJJ's sole tenant of the premises was American Minutemen Sewer and Drain Service, Inc., another business incorporated by the Simonetti family. In 1992, Simonetti became American Minutemen's sole shareholder and he ran the company's day-to-day operations until 2002, at which time he promoted Scott Hernandez to manager. Travelers issued a Commercial General Liability policy to JJJ for the period June 23, 2003 to June 23, 2004.

On December 6, 2003, Walter Louissant, an American Minuteman employee, was allegedly injured while working. Louissant informed Hernandez of the injury in April 2004. Hernandez, in turn, informed Simonetti of the injury the same month. Simonetti instructed Hernandez to file a workers' compensation claim, which Hernandez did. On September 12, 2006, JJJ received a letter from counsel for Louissant stating that Louissant would be pursuing a personal injury claim against JJJ. On September 14, 2008, Simonetti contacted Travelers to report Louissant's injury. By letter dated October 3, 2006, Travelers denied coverage on the ground that JJJ had failed to provide timely notice. Travelers argued that Simonetti's knowledge of Louissant's injury could be imputed to JJJ. In response, JJJ argued that Simonetti was merely a shareholder and had no role in its management or operations. Travelers, in turn, submitted evidence indicating the Simonetti was the President of JJJ during the time period in question. Simonetti contended that his father operated JJJ until shortly before his death in 2005.

The Southern District held that Simonetti's relationship to JJJ during the relevant time period was unclear from the record and that if, as JJJ argued, Simonetti had no involvement in the company beyond his ownership of one-third of its shares, then his knowledge of Louissant's injury would not be imputable to JJJ. If, however, as Travelers asserted, Simonetti was the President of JJJ at the time he learned of Louissant's injury, then his knowledge would be imputed to JJJ, and the notice to Travelers would be untimely, unless JJJ could establish some other excuse for the delay.

Cicero v. Great Am. Ins. Co., 53 A.D.3d 460 (1st Dep't July 29, 2008) In an underlying personal injury action against Western Beef, Inc., for injuries sustained by the plaintiff, Lydia Cicero, when she slipped and fell in its supermarket, a preliminary conference order directed Western Beef to disclose "the existence of *any* insurance agreement…" Thereafter, Zurich North American, Western Beef's primary insurer, responded that, at the time of the plaintiff's accident, Western Beef was insured by Zurich under a policy that had a single limit of coverage of $1 million. Almost four years later, on the eve of trial, Western Beef's broker notified Zurich that Western Beef had $25 million in excess coverage with Great American. Counsel for Zurich notified counsel for the plaintiff, who promptly gave notice to Great American pursuant to Insurance Law § 3420. Great American denied coverage on late notice grounds. Thereafter, the plaintiff instituted a direct action against Great American seeking judgment that its notice to Great American was timely, as authorized by Insurance Law §3420.

The Appellate Division, First Department, held that while, ordinarily, whether the plaintiffs acted diligently in ascertaining the identity of Western Beef's insurer or insurers would present an issue of fact, under the circumstances, where Western Beef affirmatively misled plaintiff as to even the existence, let alone the identity, of its excess insurer, and failed to cooperate with Zurich in its attempts to ascertain whether there was any excess coverage, plaintiffs' efforts were sufficient, and the notice given by them shortly after they learned of the excess coverage and Great American's identity was timely as to them under Insurance Law 3420.

PRIORITY OF COVERAGE:

Tishman Const. Corp. of New York v. Great Am. Ins. Co., 53 A.D.3d 416 (1st Dep't July 8, 2008) In an action by a subcontractor's employee seeking recovery for bodily injuries, the Appellate Division, First Department, held that the Commercial Umbrella policy issued to the subcontractor-employer provided a final tier of coverage, and could not be invoked on behalf of the general contractor prior to exhaustion of its own Commercial General Liability policy, even though the general contractor was an additional insured under the subcontractor-employer's primary liability policy. The First Department noted that the Umbrella policy issued to the subcontractor-employer provided excess coverage, even though the Umbrella policy's "other insurance" clause indicated that it was not excess as to any policy that was specifically written to be excess of the Umbrella policy. In this regard, the general contractor's policy contained an "other insurance" clause stating that it was excess over any other policies. The First Department based its position on the fact that the general contractor's policy was truly a primary policy, having a significantly higher premium for a lower amount of coverage.

PROFESSIONAL LIABILITY COVERAGE:

Executive Risk Indemn., Inc. v. Pepper Hamilton LLP, 2008 WL 4308148 (1st Dep't September 23, 2008) The law firm of Pepper Hamilton, LLC and one of its members, W. Roderick Gagne, appealed a decision by the lower court denying them coverage under three excess Professional Liability insurance policies. The lower court precluded coverage under two of the policies because of the "prior knowledge" exclusion and, as to the third, held that the insurer was entitled to rescission. The policies were issued by different insurers.

The Appellate Division, First Department, began its review by stating that the two-step analysis set forth in Coregis Ins. Co. v. Baratta & Fenerty, 264 F.3d 302 (3rd Cir. 2001), should be used to determine whether the "prior knowledge" exclusion applied. The Coregis standard first evaluates the subjective question of whether the insured had knowledge of the relevant

facts, and second, the objective question of whether a reasonable lawyer would foresee that those facts might be the basis of a claim.

According to the First Department, while the evidence before it strongly suggested that the defendants' subjectively either believed or feared that the firm might be subject to professional liability claims as a result of the conduct by the firm's client, the subjective belief of the firm, that a suit may ensue based upon the client's misconduct, was not enough. The firm's knowledge of its client's actions, and of its own legal work related to the client's operations, may have provided subjective evidence, however, the First Department went on to state that it did not locate anything in the record before it constituting objective evidence permitting a reasonable professional to conclude that the firm itself did anything that would subject it to suit or other claim. The First Department concluded that there was no wrongful conduct on the part of the firm established as a matter of law so as to entitle the insurers to summary judgment declaring that the firm knew or should have known that a claim might be made against the firm.

With respect to the claim for rescission by one of the three excess insurers, the First Department stated that an insurance policy may only be rescinded due to a misrepresentation in the application when the subject matter of the misrepresentation is material to the risk and the applicant knew of the falsity and made the misrepresentation in bad faith. The evidence relied upon by the third insurer, however, only illustrated, according to the First Department, that the firm knew of the client's misconduct and believed that the firm might be subject to lawsuits brought by parties injured by the client's actions. The question of whether the firm gave false answers on its renewal application and whether any such false answers were given in bad faith were questions of fact and could not properly be determined as a matter of law in the context of summary judgment. In addition, the First Department noted that even if it were to accept that the information omitted truly constituted information that was required by the renewal application, the insurer failed to establish, as a matter of law, that if it had been informed of the client's misconduct and the firm's concern about being subject to suit as a result, it would have handled the renewal application differently. In this regard, the affidavit of an underwriter asserting that had the information been disclosed, the renewal application would have been handled differently, was not, by itself, sufficient to satisfy the insurer's burden.

The Yale Club of New York City, Inc. v. Reliance Ins. Co. in Liquidation, 863 N.Y.S.2d 415 (1st Dep't September 2, 2008) At issue before the Appellate Division, First Department, was whether a letter received by an "insured" constituted a "claim" within the meaning of a claims-made insurance policy. The plaintiff was the named insured under two "claims-made" policies issued by Lloyds and Reliance Insurance Company, providing directors and officers liability coverage for the years ending on November 23, 1993 and November 23, 1994. In August 1993, while plaintiff was insured under the Lloyds policy, it received a letter from an attorney representing certain waiters and other employees of the plaintiff-insured, who alleged to have been "deprived tips and bonuses." The letter requested information to enable compliance with counsel's stated "obligation to make a reasonable inquiry into the facts before a filing pleading with the courts." There was no evidence before the First Department that the plaintiff ever notified Lloyds about the letter. In February 1994, after coverage under the Reliance policy had commenced, the attorney instituted an action on behalf of the employees against the plaintiff-insured. The plaintiff-insured notified Reliance the following month. Reliance disclaimed coverage in April 1994, on the grounds that the August 1993 letter constituted notice of a claim.

The First Department began its analysis by noting that the operative issue before it was to determine the meaning to be ascribed to the word "claim," a term that Reliance conceded was undefined in the policy. According to the

First Department, the failure of the Reliance policy to provide any definition of "claim" presented an ambiguity that must be construed against the insurer. The First Department held, in sum, that the letter was insufficient to state a claim because it did not make any demand for payment nor did it advise that legal action would be forthcoming. "Counsel's letter to the plaintiff falls far short of a demand for money or services, or even the expression of a present intent to initiate legal proceedings. Any action that might have been contemplated in pursuit of the employees' claim was implicitly conditioned upon the outcome of counsel's investigation of its merit. Thus, the letter received by plaintiff is not an assertion of a legally cognizable damage…a type of demand that can be defended, settled and paid by the insurer."

DISCOVERY:

AIU Ins. Co. v. TIG Ins. Co., 2008 WL 4067437 (S.D.N.Y. August 28, 2008) The United States District Court, Southern District of New York, concluded, *inter alia*, that documents included on a reinsurer' privilege log that did not contain legal communications between the reinsurer and either its in-house counsel or outside coverage counsel were not privileged. After reviewing the withheld documents *in camera*, the Southern District noted that a majority of the documents reflected draft language and general revisions recommended by the reinsurer's in-house counsel. In this regard, the Southern District noted that the changes reflected on the drafts appeared to be stylistic and structural changes only. The handwritten notations did not appear to provide or request legal advice and there was no particularized evidence addressing any of the notations on the draft documents. In addition, the Southern District noted that many of the withheld documents were e-mails that merely copied the reinsurer's in-housel counsel, which did not seek legal advice, and therefore were not privileged. Furthermore, other documents provided to in-house counsel, including updates of the reinsurer's investigation, were considered "business communications" and were likewise found not to be privileged. According to the Southern District, "a document will not become privileged simply because an attorney recommended its preparation, if it contains merely business-related or technical communications between corporate employees."

The Southern District also recognized that the application of the work-product doctrine to an insurance company's claims file has been particularly troublesome because it is the routine business of insurance companies to investigate and evaluate claims. Thus, courts have held that documents in a claims file created by or for an insurance company as part of its ordinary course of business are not afforded work-product protection. In this regard, the Southern District stated that "because it is difficult to determine precisely when the possibility of litigation becomes sufficiently definitive to be considered 'anticipated', courts frequently presume that documents prepared by or for an insurer prior to a coverage decision are prepared in the ordinary course of the insurer's business and are not afforded work-product protection. This presumption may be rebutted if the insurer demonstrates with specific competent proof that it possessed a 'resolve to litigate' when the documents were created."

The Southern District held that the reinsurer's argument, that it had a resolve to litigate only seven days after it opened a claims file, failed because, "to make such a categorical ruling would bar production of all the documents [the reinsurer] was seeking to withhold on the basis of work-product, among other reasons." Thus, rather than determine that the work-product doctrine applies based on categorical presumption, the Southern District held that the better course of action was to engage in a fact-specific inquiry to determine whether each document was created in anticipation of litigation.

MISCELLANEOUS:

Garcia v. Konkul, 20 Misc.3d 139(A) (N.Y. Sup. App. Ter. July 10, 2008) The mere fact that a plaintiff does not understand the English language is insufficient to set aside a release since the plaintiff is presumed to know its contents and to have assented to its terms. New York law has consistently held that an individual that cannot speak English must make a reasonable effort to have an agreement made clear to him. While proof that the reader of an agreement "misrepresented the nature of the document" may relieve a non-English speaking party from its obligations, a plaintiff will be required to demonstrate that the representative of a defendant-insurer read the release to him and misrepresented the nature of its contents to him. Thus, in the absence of establishing fraud, duress or some other wrongful act by insurer, plaintiff is deemed to be conclusively bound by the release.

Fienberg v. Marsh USA, Inc., 2008 WL 4299933 (1st Dep't September 23, 2008) The Appellate Division, First Department, upheld the decision of the lower court finding that the broker was a released party within the broad, but unambiguous, definition of "Agent" contained in a release that settled a class action lawsuit against an insurer and noted that, in the absence of other arguments concerning the applicability of the release, the lower court correctly ruled that it conclusively barred all of the plaintiffs' claims.

Dana Woolfson LMT a/a/o Tania Rega v. Gov't Employees Ins. Co., 862 N.Y.S.2d 794 (New York County, August 6, 2008) This case stems from an underlying accident that occurred on July 31, 2006. The policy covering the accident was issued after April 5, 2002 and, therefore, was subject to the Superintendent of Insurance's regulations that all policies issued after April 5, 2002 contain a Mandatory Personal Injury Protection Endorsement, which requires that claims be submitted to insurers within 45 days after service is rendered. The plaintiff stipulated that she failed to submit her claims to the defendant-insurer within the 45 day requirement and that the defendant timely denied the claims. However, the plaintiff asserted that it was the defendant's burden to produce the policy in order to establish that the policy actually contained the Endorsement. The defendant-insurer, in turn, contended that because the Endorsement was mandatory under the new regulations, it applied whether or not the policy actually contained it, and so it was not necessary to produce the policy. The Court agreed with the insurer and found that the introduction of the policy at trial was not necessary to prove that it contained the mandatory Endorsement.

LBC&C's INSURANCE INDUSTRY PRACTICE GROUP

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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