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QUARTERLY INSURANCE COVERAGE NEWSLETTER: NEW YORK

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CASES OF INTEREST BY TOPIC:

ADDITIONAL INSURED COVERAGE

Kassis v. Ohio Cas. Ins. Co., 2009 WL 1789223 (Court of Appeals June 25, 2009) In reversing the decision of the Appellate Division, Fourth Department, the Court of Appeals held that Joseph Kassis was an additional insured under the defendant-insurer's Commercial General Liability policy by way of a Blanket Additional Insured Endorsement. The endorsement extended coverage to "any person or organization whom [the named insured is] 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, as landlord, and Kassis Superior Sign Co., Inc., as tenant, the defendant's insured, Superior Sign, was required to procure coverage for their "mutual benefit", but did not specifically require that Superior Sign name Kassis as an additional insured. According to the Court, the intent and meaning of the term "mutual benefit" became clear when juxtaposed with the language of the other insurance provisions of the lease agreement, entitling Kassis to additional insured coverage under the defendant-insurer's policy.

West 64th Street, LLC v. Axis U.S. Ins., 2009 WL 1586749 (1st Dep't June 9, 2009) The defendant-insurer established that the Blanket Additional Insured Endorsement to its policy did not provide coverage as it was only implicated when the insured was required by written contract to name a person or organization as an additional insured, and that the contract did not have such terms. The additional documentary evidence submitted by the plaintiff, including a Certificate of Insurance issued the same day as the accident giving rise to the underlying personal injury action, did not otherwise confer coverage.

Balyszak v. Siena College and United States Volleyball Association, Inc., 2009 WL 1687685 (3rd Dep't June 18, 2009) The plaintiff sustained injuries when a referee's platform upon which he was standing collapsed during a volleyball tournament being held at Siena College. The defendant, United States Volleyball Association, Inc. (and others), had contracted with Siena to hold the tournament at the college and entered into a Facility Rental Agreement, which required the Association to indemnify Siena for all claims for injury to person or property and to furnish a Certificate of Insurance naming Siena as an additional insured on the Association's liability policy. The Association subsequently provided Siena with a Certificate of Insurance from its insurers, third-party defendants, American Specialty Insurance Services, Inc. and United States Fidelity and Guaranty Company, reflecting that Siena was an additional insured, but only with respect to the negligence of the Association at the tournament. After plaintiff commenced an action against Siena and the Association seeking damages for the bodily injuries he sustained, Siena, in turn, asserted cross-claims against the Association for indemnity and breach of contract. The insurers refused Siena's request for a defense and indemnification, prompting Siena to file a third-party action against them seeking coverage as an additional insured, as well as pursuant to the "contractual liability" provision of the insurance policy.

The Appellate Division, Third Department, held that since the agreement between Siena and the Association provided that the Association would indemnify Siena against all claims and demands for injury to any person or property occurring on or about the leased facility premises, Siena was entitled to indemnification from the Association, regardless of Siena's negligence. In addition, when considering the duty to defend, the Third Department held that it

FEDERAL LEGISLATION OF INTEREST:

Section 111 of the Medicare, Medicaid, SCHIP Extension Act of 2007, the Medicare Secondary Payer Statute, went into effect on July 1, 2009, now requiring workers' compensation, liability, no-fault and self-insurers to notify Medicare of all claims/settlements involving a Medicare beneficiary.

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

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

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

was clear from the record that Siena was named as an additional insured, which gave rise to a duty to defend since "it is axiomatic that the duty to defend is exceedingly broad."

APPLICABILITY OF EXCLUSIONS

Pioneer Tower Owners Ass'n v. State Farm Fire & Cas. Co., 12 N.Y.3d 302 (Court of Appeals April 30, 2009) The New York Court of Appeals held that the "earth movement" exclusion of the defendant-insurer's property policy did not exclude coverage for the damage sustained to the plaintiff-insured's building as a result of excavation work being performed on adjacent property. In reaching its determination, the Court noted that there were a number of other state and federal court decisions (although not binding upon the Court) wherein it was held that similar exclusions were not applicable to losses caused by excavation, and further noted that there was no applicable case law applying the earth movement exclusion to intentional earth removal.

Atlantic Balloon & Novelty Corp. v. American Motorist Ins. Co., 62 A.D.3d 920 (2d Dep't May 26, 2009) The plaintiff-insured, Atlantic Balloon & Novelty Corp., procured an insurance policy from the defendant-insurer, American Motorist Insurance Company, providing "business personal property" coverage. During the coverage period, the plaintiff-insured, after contracting with an auctioneer to conduct an auction of its inventory, claimed that the auctioneer (1) never turned over the proceeds from the auction, (2) stole some of Atlantic Balloons' merchandise, (3) sold the merchandise for less than the agreed-upon price, and (4) failed to ensure that bidders paid for items prior to leaving the premises. Atlantic Balloon thereafter made a claim to American Motorist for the losses it allegedly sustained; however, American Motorist denied the claim. As such, Atlantic Balloon brought suit against American Motorist seeking damages for breach of the insurance contract.

The Appellate Division, Second Department, held, *inter alia*, that American Motorist met its burden of establishing entitlement to judgment as matter of law by demonstrating that the policy included exclusions for "dishonest or criminal acts by you…or anyone to whom you entrust [your] property for any purpose", as well as for "false pretense", defined as "voluntarily parting with any property by you or anyone else to whom you have entrusted the property if induced to do so by any fraudulent scheme, trick, device or false pretense." According to the Second Department, the contract between Atlantic Balloon and the auctioneer established that Atlantic Balloon "entrusted" its merchandise to the auctioneer because, pursuant to the contract, Atlantic Balloon agreed that the auctioneer was to take the merchandise on "consignment" and auction it on Atlantic Balloon's behalf. Thus, the merchandise and auction proceeds stolen were not a covered loss under the policy.

Tradin Organics USA, Inc. v. Maryland Cas. Co., 2009 WL 1024633 (2d Cir. April 16, 2009)(applying New York law) The United States Court of Appeals, Second Circuit, in affirming the decision of the District Court, held that the business risk exclusions ("Your Product" or "Your Work") are intended to exclude coverage for damage to the insured's product, but not for damage caused by the insured's product to persons or other property. Therefore, it was held that breach warranty claims were contractual or commercial risks that the defendant-insurer did not intend to insure. Since the breach of warranty claim was based on damage to the insured's product – a risk specifically excluded by the "Your Product" provision – the defendant-insurer properly denied coverage of the claim.

CHOICE OF LAW

Travelers Cas. and Surety Co. v. Honeywell Int'l, Inc., 880 N.Y.S.2d 66 (1st Dep't June 4, 2009) Where it is necessary to determine the law governing a liability insurance policy covering risks in multiple states, the state of the

insured's domicile at the time of contracting should be regarded as proxy for the principle location of the insured risk, and that, for such purposes, a corporate insured's domicile is the state of its principle place of business, not the state of incorporation. According to the Appellate Division, First Department, there was no dispute that the principle place of business of the insured's predecessor, the purchaser of the policies at issue, was in New Jersey, and that New Jersey law should therefore apply to the coverage issues presented. Neither (i) the predecessor's use of a New York address on some of the policies, (ii) the use of New York brokers, (iii) the use of New York amendatory endorsements on some of the policies, or (iv) any of the other incidental connections to New York, raised a triable issue of fact as to whether the predecessor made a conscious choice of New York law at the time of contracting, or whether the application of New York law constituted the parties' reasonable expectation, where not one of the policies contained a choice-of-law provision and all parties knew that the risks were spread nationwide and that the predecessor's principle place of business was in New Jersey.

DUTY TO DEFEND

Village of Springville v. Reynolds, 61 A.D.3d 1353 (4th Dep't April 24, 2009) The plaintiff insured-village, brought action against its Commercial General Liability insurer, Argonaut Group, Inc., (and others) seeking a declaration that it was obligated to defend and indemnify it in an underlying action commenced by Walter F. Reynolds, seeking damage for loss of property and violation of various constitutional rights after the insured-village directed that a building Reynolds owned be demolished after it was destroyed by fire. The Appellate Division, Fourth Department, held that the insured-village failed to establish that the loss was caused by an occurrence under the Argonaut policy and, therefore, Argonaut's coverage was not triggered. According to the Fourth Department, the decision by the insured-village to demolish the building and the demolition itself were intentional. As stated by Fourth Department, "[a]lthough accidental results and unintended damages can follow from intentional acts, when the damages alleged in the underlying complaint are the intended result which flows directly and immediately from the insured's intentional act, rather than arising out of the chain of unintended though foreseeable events that occurred after the intentional act, there is no accident, and therefore no coverage." (internal citations omitted).

P.J.P. Mechanical Corp. v. Commerce and Indus. Ins. Co., 2009 WL 1687773 (1st Dep't June 18, 2009) The issue before the Appellate Division, First Department, was whether an affirmative defense asserted in an underlying action brought by the plaintiff-insured seeking recovery of an unpaid contract balance, triggered the defendant-insurer's duty to defend. The First Department began its analysis by noting that the defendant-insurer's policy, when read as a whole, clearly stated that the defendant-insurer had the duty to defend a suit, meaning a proceeding against the insured, not by the insured. The term "defend", by its clear import, did not, as per the First Department, envision affirmative litigation. Contrary to the plaintiff's arguments, an affirmative defense is substantively different from a counterclaim as it does not seek affirmative relief. In addition, according to the First Department, if the plaintiff-insured believed that the affirmative defense was truly a counterclaim, it should have immediately moved to strike the defense and force the defendant to re-plead the claim as a counterclaim, thus triggering the insurer's duty to defend.

EQUITABLE SUBROGATION

NYP Holdings, Inc. v. McClier Corp., 2009 WL 1663922 (1st Dep't June 16, 2009) In August 1998, plaintiff NYP Holdings, Inc. retained defendant McClier Corporation, a professional architectural firm, to provide certain design services related to the construction of a new printing plant. McClier thereafter produced a design and hired various subcontractors to perform the actual physical

construction. NYP subsequently became dissatisfied with the quality of the work done on the project and commenced suit against McClier, asserting causes of action for professional errors and omissions, malpractice, fraud, overbilling, delay damages and construction defects. McClier, in turn, instituted a third-party action against a number of the subcontractors, advancing claims predicated upon contractual and common-law indemnification, negligence, strict liability and breach of contract. Although the claims asserted by NYP against McClier aggregated over $100 million, McClier was able to settle its dispute with NYP for $23,900,000. The settlement did not, however, apportion the damages between design defects, for which McClier would be responsible, and construction defects, for which the third-party defendants would be responsible.

Lloyd's of London, which provided professional liability coverage to McClier, thereafter, as McClier's subrogee, sought indemnification for the sums it had paid toward settlement of the underlying suit from the third-party defendant subcontractors. The third-party defendants moved for summary judgment, arguing that Lloyd's was a volunteer, whose payment on behalf of NYP was outside its contractual responsibility and, thus, the settlement could not form the basis for a subrogation claim. In this regard, the third-party defendants urged that Lloyd's was not under any compulsion to pay for non-covered claims, and that if the sum paid toward settlement was for the covered professional negligence claims, then they were not liable to reimburse Lloyd's because they performed no professional services.

The Appellate Division, First Department, held that the threshold issue, however, was not whether Lloyd's was a volunteer, but, rather, whether its insured, McClier, had a cognizable claim against appellants. The First Department then went on to note that there had not been any factual determination as to which of the parties was responsible for the losses suffered by NYP, nor any apportionment of responsibility, and that in the absence of the settlement funded by Lloyd's, there would be no issue as to whether McClier could pursue its claims for indemnification, as well as contribution. The settlement did not, according to the First Department, alter any of these basic principles, and was made to forestall the possibility of a larger recovery after trial, which could have resulted in damages being assessed against any or all of the defendants. As such, the First Department determined that it would be inequitable, based upon the record before it, for the third-party defendants to escape responsibility without an adjudication of liability by a fact-finder, merely because they chose not to participate in the settlement of the underlying action. "Regardless of whether Lloyd's is the actual party in interest, permitting the [third-party defendants] to escape liability if they are responsible for some of the damages, would be the unjust enrichment that the principle of equitable subrogation seeks to avoid."

ESTOPPEL

Liberty Ins. Underwriters, Inc. v. Arch Ins. Co., 61 A.D.3d 482 (1st Dep't April 14, 2009) The Appellate Division, First Department, held that the doctrine of estoppel is not limited to coverage disputes between insurers and insureds and applies to coverage allocation disputes between insurers. According to the First Department, because the City of New York's tender was accepted by the insurer of a contractor without any reservation, the contractor's insurer's later claim to provide only excess insurance was prohibited by estoppel as the City's insurer lost control of the underlying defense and was otherwise prejudiced.

XL Ins. America, Inc. v. Lumbermens Mut. Cas. Co., 2009 WL 1752157 (1st Dep't June 23, 2009) Relying upon Liberty Ins. Underwriters, Inc. v. Arch Ins. Co, (above), the Appellate Division, First Department, again recognized that a co-insurer may be estopped from denying coverage in a coverage allocation dispute between insurers; however, prejudice must be established.

EXTRA-CONTRACTUAL DAMAGES

Woodworth v. Erie Ins. Co., 2009 WL 1652258 (W.D.N.Y. June 12, 2009) The plaintiffs purchased from the defendant-insurer, Erie Insurance Company, a homeowner's insurance policy and, on August 16, 2003, during the policy period, the plaintiffs' home was destroyed by a gas explosion. Plaintiffs thereafter brought action claiming that Erie breached the terms of the policy by failing to pay them for the full extent of their loss. After motion practice, the only cause of action remaining against Erie was for breach of contract based upon Erie's alleged failure to pay the plaintiffs the actual cash value of their destroyed home and "additional living expenses" as defined under the policy. However, the plaintiffs subsequently sought leave to amend their Complaint to request extra-contractual consequential damages as a result of Erie's alleged breach of the policy's implied covenant of good faith and fair dealing, based upon Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of New York, 10 N.Y.3d 187 (2008). The United States District Court for the Western District of New York recognized that in Bi-Economy, the New York Court of Appeals held "that an insured may recover consequential damages resulting from an insurer's breach of the policy's covenant of good faith and fair dealing provided such damages were within the reasonable contemplation of the parties at or before the time of contracting as the probable result of a breach." Relying upon the same, the plaintiffs sought to amend their Complaint to demand additional living expenses not covered by the policy; specifically, mileage to and from the summer cottage where they had been living since the gas explosion and the lost rental income from that cottage (the policy contained a provision expressly limiting reimbursement of living expenses to twelve months), as well as emotional distress damages and attorneys' fees.

With respect the Bi-Economy decision, the Western District noted that nothing in the decision itself suggested that it applied only to cases involving business interruption insurance or commercial insurance policies as argued by Erie. The Western District thereafter held, *inter alia*, that the plaintiffs were permitted to amend their Complaint to add a claim for extra-contractual living expenses since the plaintiffs had maintained throughout the litigation that they were entitled to reimbursement of their living expenses beyond the twelve month period included in the policy because Erie breached the policy by not paying the full amount of their loss, thus effectively preventing them from rebuilding.

However, the Western District denied the plaintiffs leave to amend the Complaint to assert a claim for emotional stress damages, finding that Erie had made a reasonable showing of prejudice in that Erie would require discovery regarding the same, substantially delaying the litigation, which was otherwise ready to proceed to summary judgment. In addition, although the Western District noted that the claim for attorneys' fees would not likely entail any additional discovery, it nonetheless denied leave to assert such a claim on the ground of futility. As per the Western District, nothing in Bi-Economy or any post-Bi-Economy authority suggested that the New York Court of Appeals intended through its Bi-Economy decision to alter in the insurance context the traditional American rule that each party should bear its own attorneys' fees. In addition, the Western District held that Erie had made a reasonable showing of prejudice concerning the plaintiffs' claim for emotional stress damages, in that Eire would require discovery regarding the same substantially delaying the litigation which was otherwise ready to proceed to summary judgment, and, therefore, did not allow the plaintiffs' to seek the same.

MISREPRESENTATION

Kiss Constr. NY, Inc. v. Rutgers Cas. Ins. Co., 61 A.D.3d 412 (1st Dep't April 2, 2009) In its application for Commercial General Liability insurance with defendant Rutgers Casualty Insurance Company, the plaintiff-insured listed the nature of its business as "Painting-100%-100% Interior." The Declarations page of the policy described the plaintiff-insured's business as a

painting contractor, and the Extension of Declarations included the further description "Paint Interior Buildings – No Tanks." The plaintiff-insured thereafter sought coverage under the policy for injuries that allegedly occurred during the construction of a building where the plaintiff-insured was acting as the general contractor for work involving excavation and paving. Rutgers disclaimed coverage based on alleged material misrepresentation in the application for insurance. In turn, the plaintiff-insured commenced an action seeking a declaration that Rutgers was obligated under the policy to provide coverage. As its fifth affirmative defense, Rutgers sought to void the policy *ab initio*, based on the alleged material misrepresentation in the application.

The Appellate Division, First Department, began its analysis by recognizing that for an insurer to be entitled to rescind a policy *ab initio*, it must show that the applicant made a material misrepresentation with an intent to defraud. However, a misrepresentation will not be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such a contract. In addition, while the materiality of a misrepresentation is ordinarily a jury question, it will become a matter of law for a court's determination when the evidence concerning materiality is clear and substantially uncontradicted. The First Department determined that the lower court should have granted Rutgers' Motion for Summary Judgment declaring the policy void *ab initio*. In this regard, Rutgers offered the affidavits of two of its Vice Presidents (one of whom was the Vice President of Commercial Underwriting), who each averred that the company did not write policies for such construction work, or for general contractors. This argument was further supported by the company's underwriting guidelines, by copies of e-mails declining coverage to similarly situated applicants, and by copies of disclaimer letters sent to similarly situated insureds making similar claims.

NOTICE

Guzman v. Nationwide Mut. Fire Ins. Co., 62 A.D.3d 946 (2d Dep't May 26, 2009) After securing judgment, plaintiff-creditor brought an action against the defendant-insurer seeking to recover on the judgment under Insurance Law §3420. The plaintiff-creditor submitted an affidavit of service by mail dated February 12, 2003, stating that service by mail of the judgment with notice of entry was made that day to the defendant-insurer. The judgment had been entered in the plaintiff-creditor's favor against the defendant-insurer's insured on February 10, 2003. According to the Appellate Division, Second Department, this raised a presumption that a proper mailing occurred, to which the defendant-insurer failed to raise a triable issue of fact in opposition. In addition, the Second Department determined that the defendant-insurer's 51 day delay before disclaiming coverage on April 4, 2003, on the ground of late notice of the underlying lawsuit was unreasonable as a matter of law.

Silverite Const. Co. v. One Beacon Ins. Co., 61 A.D.3d 415 (1st Dep't April 2, 2009) The Appellate Division, First Department, rejected the plaintiff-insured's excuse that it did not believe a worker would bring a claim for their 2 ½ month delay in providing notice to the defendant-insurer. The excuse was rejected given the evidence that the worker was removed from the worksite by ambulance, an accident report was prepared the same day, the worker missed a week of work, returned to work on limited duties and filed a notice of claim.

Continental Ins. Co. v. Atlantic Cas. Ins. Co., 2009 WL 1564144 (S.D.N.Y. June 4, 2009) Where an insured is the first to give notice of a claim to the insurer, then the injured party's rights are considered derivative of the insured. As such, where an insured's notice is untimely and the insurer disclaims coverage based upon the same, an injured party will be unable to recover under Insurance Law §3420 (which allows direct claims against insurers to recover unpaid judgments) on a judgment ultimately secured against the insured. Thus, it is critical, according to the United States District Court for the Southern District of New York, when assessing a claim brought against an insurer under

Insurance Law §3420, to determine which party first notified the insurer of the claim - the injured party or the insured. In that regard, if the injured party's notice is first and timely, but the insured's subsequent notice is not, a claim under §3420 will stand.

HBE Corp. v. Sirius America Ins. Co., 880 N.Y.S.2d 407 (4th Dep't June 5, 2009) The plaintiffs, HBE Corp. and Cornerstone Community Federal Credit Union, commenced a lawsuit alleging that the defendant-insurer violated Insurance Law 3420(d) by failing to provide timely written notice to the plaintiffs that it would neither defend nor indemnify its insured, the third-party defendant in an underlying action. According to the Appellate Division, Fourth Department, the record established that the underlying accident occurred in October 2002, the defendant-insurer received notice of the accident on February 25, 2004, and that the defendant-insurer sent a disclaimer to the insured on March 5, 2004 and to the plaintiffs' attorney on March 10, 2004. However, the plaintiffs claimed that the disclaimer letter sent to their attorney did not provide requisite notice with respect to the third-party action against the insured because the letter only stated that the defendant-insurer would not defend or indemnify the insured "in this matter", which referred only to the underlying main action. The Fourth Department rejected this argument, and noted that the letters sent by the defendant-insurer to both the insured and the plaintiffs' attorney stated that there was no coverage based on the failure to give the insurer notice "as soon as practicable."

PRIORITY OF COVERAGE

Eveready Ins. Co. v. Illinois Nat'l Ins. Co., 62 A.D.3d 404 (1st Dep't May 5, 2009) The Appellate Division, First Department, held that the clear and unambiguous "other insurance" clause of Illinois Union's auto policy limited its policy to "excess" coverage where a covered accident involved a vehicle not owned by its insured, Dominos Pizza. It was undisputed that the vehicle involved in the accident was owned by the Eveready's insured, a deliveryman for Dominos Pizza. As such, the First Department held that Illinois Union's policy was excess, only requiring it to contribute to the settlement after the exhaustion of Eveready's policy. According to the First Department, there was no merit to Eveready's argument that the "excess" provision of the "other insurance" clause of Illinois Union's policy was contradicted by the "proportionate payment" provision of the policy. In this regard, the First Department explained that the latter, by its terms, only applied to coverage that was "on the same basis," *i.e.* where the policy is primary and there are other primary policies, it will pay pro rata with the other primary policies, and where the policy is excess and there are excess policies, the policy will pay pro rata with the other excess polices.

Axelrod v. Magna Carta Companies, 880 N.Y.S.2d 69 (1st Dep't June 4, 2009) The plaintiff-insured's 20 month delay in notifying defendant-insurers of a new claim alleging advertising injury set forth against the insured via an Amended Complaint was held unreasonable as a matter of law. In this regard, the Appellate Division, First Department, stated that the plaintiff-insured was not relieved of its obligation to notify the defendant-insurers of the new claim simply because the defendant-insurers had disclaimed coverage based on the allegations in the original underlying Complaint.

RECOVERY OF ATTORNEYS' FEES

Oriska Ins. Co. v. American Textile Maintenance, 2009 WL 980090 (2d Cir. April 13, 2009) The United Stated Court of Appeals, Second Circuit, took the opportunity to reiterate its determination that under New York law it is well settled that an insured cannot recover his legal expenses in a controversy with a carrier over coverage, even though the carrier loses the controversy and is held responsible for the risk. Although the defendant-insureds argued that their application for reimbursement of fees fell under the exception to the rule

established by Mighty Midgets, Inc. v. Centennial Ins. Co., 47 N.Y.2d 12, 21 (1979), the Second Circuit explained that Mighty Midgets did no more than carve out a narrow exception that arises when a policyholder has been cast in a defensive posture by its insurer in a dispute over the insurer's duty to defend. Since the underlying litigation in this matter concerned a dispute over whether coverage existed, and not an insurer's duty to defend an insured, the holding of Mighty Midgets does not permit the insured to recover its fees.

SUBROGATION

Progressive Ins. Co. v. Lennon, 61 A.D.3d 951 (2d Dep't April 28, 2009) The defendants established their respective prima facie entitlement to summary judgment dismissing the action against them by demonstrating that the plaintiff-insurer commenced the subrogation action before such a cause of action accrued. In this regard, the Appellate Division, Second Department, recognized that an insurer's subrogation rights accrue upon payment of the loss and held that the plaintiff failed to raise a triable issue of fact as to whether it had paid the loss.

TIMELY DISCLAIMERS

Crocodile Bar, Inc. v. Dryden Mut. Ins. Co., 61 A.D.3d 1361 (4th Dep't April 24, 2009) Once an insurer has sufficient knowledge of facts entitling it to disclaimer, or knows that it will disclaim coverage, it must notify the policyholder in writing as soon as possible. In this matter, the defendant-insurer was aware on the day it received notice of the claim that the claim was excluded from the policy, and, according to the Appellate Division, Fourth Department, the defendant-insurer failed to establish that its 62 day delay in denying coverage was reasonably related to the completion of a necessary, thorough and diligent investigation.

New York City Housing Auth. v. Underwriters At Lloyd's London, 877 N.Y.S.2d 193 (2d Dep't April 14, 2009) The Appellate Division, Second Department, held that the plaintiff-insured made a prima facie showing of its entitlement to judgment as a matter of law by demonstrating that the defendant-insurer did not disclaim coverage on the ground of late notice until more than three months after the plaintiff-insured's notice, and 73 days after the plaintiff-insured turned over the litigation materials in connection with the underlying action to the defendant-insurer. The Second Department held that the defendant-insurer failed to raise a triable issue of fact in opposition by asserting that the delay was necessitated by its investigation of the claim, since the ground for the disclaimer was apparent, at the latest, when the defendant-insurer received the litigation materials. Moreover, the defendant-insurer did not establish the need for the investigation, nor did it provide detailed information demonstrating that the investigation was conducted diligently. As such, any purported failure on the part of the plaintiff-insured to provide the defendant-insurer with timely notice of the underlying claim did not excuse the defendant's unreasonably delay in disclaiming.

JT Magen v. Hartford Fire Ins. Co., 879 N.Y.S.2d 100 (1st Dep't May 14, 2009) The issue before the Appellate Division, First Department, was whether the prompt disclaimer requirement under the Insurance Law 3420(d) is triggered when an insurance carrier receives notice of claim from another insurer on behalf of a mutual insured asking that the insured be provided a defense and indemnity. In sum, the First Department held that the prompt disclaimer requirement is triggered, recognizing the distinction between an insurer's own claim for contribution and a tender letter by an insurer on behalf of its insured. In this regard, Insurance Law §3420(d) does not apply to claims between insurers, *i.e.* a request for a pro-rata contribution between coinsurers.

UMBRELLA COVERAGE

Castle Village Owners Corp. v. Greater New York Mut. Ins. Co., 878 N.Y.S.2d 311 (1st Dep't May 5, 2009) The Appellate Division, First Department, held, *inter alia*, that since the plaintiff-insured's Commercial Umbrella Liability policy provided that it applied only in excess of the total applicable limits of the policies on the Schedule of Underlying Insurance, the umbrella carrier's obligation was not triggered until it was notified by the underlying primary liability insurer that its policy had exhausted. In addition, the First Department held that although a reservation of rights letter by itself has no relevance to the question of timely notice of a disclaimer, since the umbrella carrier issued correspondence to the plaintiff-insured two months prior to the exhaustion of the primary policy advising that coverage was excluded for certain claims, it effectively conveyed its coverage position, putting the plaintiff-insured on notice that certain claims would not be covered under the umbrella policy.

LBC&C's INSURANCE INDUSTRY PRACTICE GROUP

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