LB&C QUARTERLY INSURANCE COVERAGE NEWSLETTER: NEW YORK

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CASES OF INTEREST BY TOPIC

ADDITIONAL INSURED COVERAGE

Federated Retail Holdings, Inc. v. Weatherly 39th Street, LLC, 77 A.D.3d 573 (1st Dep't October 28, 2010) According to the Appellate Division, First Department, the lower court erroneously determined that the section of a lease between a landlord and tenant, requiring the tenant to maintain insurance coverage for the benefit of itself and the landlord in the amount of $1 million for injury to any one individual, $3 million for any one accident, and $5 million in umbrella coverage, was not violated by the tenant's policies being subject to self-insured retentions. In construing the lease, the lower court improperly declined to consider the reasonable expectations of the parties and the purpose of the business contract. The First Department found that "[the lower] court's reading would leave the issue of insurance uncertain, as [the] tenant could simply choose to buy a policy with such a high self-insured retention (and concomitantly low premium) as to render insubstantial or even illusory the benefits of the insurance coverage for which [the] landlord bargained." Moreover, the First Department held that a subtenant's insurance did not cure the defect, as the landlord was not required to accept the subtenant's performance in lieu of the tenant's. In this regard, the subtenant could choose, at any time, to discontinue its insurance naming the landlord as an additional insured, and the landlord would have no recourse, as it was not in privity of contract with the subtenant.

Empire Builders & Developers, Inc. v. Delos Ins. Co., 78 A.D.3d 759 (2d Dep't November 9, 2010) An insurance policy issued by Scottsdale Insurance Company contained a Blanket Additional Insured Endorsement, which provided that the definition of an "insured" included "any person or organization whom you are required to add as an additional insured on this policy under a written contract, agreement or permit which must be executed prior the 'bodily injury', property damage'…." The Appellate Division, Second Department, held that Scottsdale made a *prime facie* showing that there was no additional insured coverage under the endorsement as a verbal understanding between Scottsdale's named insured and the purported additional insureds did not constitute an "agreement" within the meaning of the endorsement.

New York University v. American Bldg. Maintenance, 78 A.D.3d 615 (1st Dep't November 30, 2010) New York University and American Building Maintenance entered into a contract (i) requiring ABM to procure insurance naming NYU as an additional insured, (ii) indicating that notice of an occurrence provided by ABM to the insurer would be deemed notice by NYU, and (iii) providing that ABM "shall not commence any work…until it has obtained all of the insurance required…and such insurance is approved by [NYU's] Director of Insurance." ABM, thereafter, obtained a policy with Continental Insurance Company, including a $1 million self-insured retention which required that notice be provided "as soon as practicable" of a occurrence that "may result in a claim…for which the damages can reasonably be expected to exceed fifty percent…of the SIR." The lower Court held that Continental was not under an obligation to defend or indemnify NYU in an underlying action seeking damages for personal injuries sustained on NYU's premises. Although the Appellate Division, First Department, agreed with NYU that summary judgment in Continental's favor on the issue of coverage was precluded by an issue of fact as to whether the damages in the underlying action would exceed the $1 million SIR, the First Department nonetheless held that Continental did not receive timely notice and, therefore, had no obligation to indemnify NYU. The underlying accident occurred on March 6, 2003, and although NYU was aware of the accident by February 14, 2006, it did not provide Continental notice of the accident, and instead commenced action against Continental on August 14, 2008. In this regard, ABM initially informed NYU that its insurer was ACE USA, and NYU did not learn that ABM's insurer was actually Continental until May 27, 2008. However, according to the First Department, had NYU exercised its right under its contract with ABM to approve ABM's insurance, NYU would have been aware in 2000, when the contract was entered into, that ABM's insurer was Continental and not ACE. Since NYU "could have prevented the mishap", the First Department held that it did not give notice as soon as practicable.

10 Ellicott Sq. Court Corp. v. Mountain Valley Indem. Co., 2010 WL 5295420 (2d Cir. December 28, 2010) The owner and construction manager of a commercial building subcontracted the building's partial interior demolition to Ellicott Maintenance, Inc., and required that additional insured coverage be procured. As such, Ellicott purchased two policies – one primary and one umbrella policy – from Mountain Valley Indemnity Company, which, by its agent, issued a Certificate of Insurance evidencing the policies and the status of the owner and construction manager as additional insureds. The primary policy required that a written construction agreement be "executed" in order for additional insured coverage to be afforded under the policy. Before anyone on behalf of either Ellicott or the owner/construction manager signed the subcontract, a worker for Ellicott was injured. Mountain Valley denied additional insured coverage to the owner and construction manager in connection with a subsequently filed suit by the worker, arguing that because the subcontract was not signed nor fully performed prior to the worker's injury, it had not been "executed" as required by the primary policy. Although the United States Court of Appeals, Second Circuit, agreed that the subcontract had not been "executed" as required by the primary policy and that additional insured coverage was not available thereunder, such coverage was found under Mountain Valley's umbrella policy, since it provided coverage to "any person or organization with whom or with which you have agreed in writing prior to a loss, occurrence or offense to provide insurance…" and did not require "execution" of the agreement. Finally, recognizing that the intermediate appellate courts in New York are divided as to whether a Certificate of Insurance issued by an agent of the insurer may estop the insurer from denying coverage to a party identified as an additional insured on the certificate, the Second Circuit certified the following question to the New York Court of Appeals: "In a case brought against an insurer in which a plaintiff seeks a declaration that it is covered under an insurance policy issued by that insurer, does a certificate of insurance issued by an agent of the insurer that states that the policy is in force but also bears language that the certificate is not evidence of coverage, is for informational purposes only, or other similar disclaimers, estop the insurer from denying coverage under the policy?" We will be following for the Court of Appeal's decision.

ANTI-SUBROGATION

St. Paul Fire and Marine Ins. Co. v. FD Sprinkler Inc., 76 A.D.3d 931 (1st Dep't September 30, 2010) In this subrogation action, St. Paul Fire and Marine Insurance Company sought to recover amounts it paid on a claim filed by Chelsea 27th Street Apartments, its named insured, on a builder's risk insurance policy, for property damage caused by the unintended discharge of a sprinkler during construction. FD Sprinkler, the sprinkler subcontractor, and Woodworks, the drywall subcontractor, were alleged to have been responsible for the damage, and both were additional insureds under St. Paul's policy pursuant to a Special Provisions Endorsement that amended the Contractor's and Owner's Property Protection to include "All subcontractors as Additional Insureds, ATIMA [as their interests may appear]." Thus, the endorsement provided subcontractors with additional insured protection only to the extent of their property interest in the building under construction, to wit, the tools, labor and materials furnished or owned by the subcontractor. The St. Paul policy, however, did not provide the subcontractors with coverage for any damage they may have caused to property in which they had no interest. According to the Appellate Division, First Department, the subcontractors' obligation to replace work damaged by them spoke to their potential liability and did not create an insurable interest in the entire building. To the extent St. Paul sought recovery from Woodwork, the drywall contractor, such recovery was barred by the anti-subrogation rule. However, since St. Paul did not make any payments in connection with FD's sprinkler work, the anti-subrogation rule did not apply to St. Paul's claim against it.

APPLICABILITY OF EXCLUSIONS

Metalois v. Tower Ins. Co. of New York, 77 A.D.3d 471 (1st Dep't October 14, 2010) The plaintiff, Melina Metalois, hosted a party on February 12, 2005 for employees and friends at her Pluck U restaurant after closing hours. During the course of the party, Metalois witnessed a guest and former employee engaged in a verbal altercation with someone in the restaurant's kitchen, and a fight ensued. Shortly thereafter, the former Pluck U employee fatally stabbed the guest and injured another person outside the restaurant. With respect to the existence of coverage under Pluck U's Commercial General Liability policy, the Appellate Division, First Department, held that the lower court properly found that the defendant-insurer did not have a duty to defend and indemnify, based upon the "assault and battery" exclusion. According to the First Department, because the Complaint's negligence allegations could not survive except for the assault, those claims were deemed to have arisen from the assault and were, therefore, subject to the exclusion. Moreover, no merit was found to Pluck U's argument that the exclusion was inapplicable because the insured was not involved in the assault. With respect to Metalois' homeowners' policy, however, the First Department held that coverage was not precluded under the "business pursuits" exclusions, since it included an exception that coverage was not precluded for "activities which are ordinarily incident to non-business pursuits…" According to the First Department, this exception "focuses on the

objective nature of the activity itself rather than on the motivation of the policyholder." The First Department found that a social gathering is "ordinarily incident to a non-business pursuit"; therefore, even if Metalios' motivation was, in part, that of employee morale, the party itself fell under the exception to the exclusion.

Exeter Bldg. Corp. v. Scottsdale Ins. Co., 2010 WL 5141880 (2d Dep't December 17, 2010) The plaintiff-insured, Exeter Building Corporation, was the general contractor for two residential condominium developments. The defendant-insurer, Scottsdale Insurance Company, issued several Commercial General Liability policies to Exeter, excluding coverage for "that particular part of real property on which you…are performing operations, if the 'property damage' arises out of those operations; or…that particular part of any property that must be restored, repaired or replaced because 'your work' was incorrectly performed on it." The policies defined "your work", in pertinent part, as "work or operations performed by you or on your behalf," including "warranties or representations made at any time with respect to fitness, quality, durability, performance or use of 'your work.'" After commencement of an underlying action against Exeter alleging substantial defects in the design and construction of condominiums, Exeter brought this action seeking a declaration that Scottsdale was obligated to provide it with coverage. However, according to the Appellate Division, Second Department, Scottsdale was under no obligation to provide Exeter with a defense or indemnity, since the Complaint in the underlying action alleged that Exeter was responsible for various substantial interior and exterior construction defects, falling solely and exclusively within the work product exclusions of the policies. In sum, as per the Second Department, the damages sought in the underlying action did not arise from an occurrence resulting in property damage distinct from the work product of Exeter or its hired subcontractors.

BAD FAITH

Rapid Park Industries v. Great Northern Insurance Company, 2010 WL 4456856 (S.D.N.Y. October 15, 2010) The Southern District, although recognizing that the New York Court of Appeals has held that punitive damages are available in some circumstances as "an additional and exemplary remedy" for breach of contract when an insurer in bad faith declines coverage for a claim, held that the plaintiffs failed to make any showing that could support an award of punitive damages even if coverage were found to exist, which it was not. In order to be awarded punitive damages, a plaintiff must demonstrate that: (i) the defendant's conduct must be actionable as an independent tort; (ii) the tortious conduct must be of an egregious nature; (iii) the egregious conduct must be directed toward the claimant; and, (iv) the egregious behavior must be part of a pattern directed at the public generally.

Carden v. Allstate Ins. Co., 912 N.Y.S.2d 867 (N.Y. Sup. Westchester County December 10, 2010) In January 2007, the plaintiffs' home was substantially damaged by fire. At that time, the home was insured by Allstate Insurance Company under a Deluxe Homeowners policy. Due to the damage, the plaintiffs could no longer live in the dwelling and rented another residence, while also placing some of their rescued possessions in storage. In March 2007, after being notified of the fire and having an adjuster inspect the dwelling, Allstate offered to settle the claim for $265,000. The plaintiffs rejected the offer. Due to damage to the roof and consequent intrusion of rain water, mold was also a concern. Based upon the fire damage and mold concern, it was determined that the entire space should be gutted, and Allstate offered the plaintiffs $575,000 as a final settlement, which was also rejected. The plaintiffs then demanded that the amount of the loss be determined by appraisal pursuant to the policy. Plaintiffs retained a contractor which estimated the cost of repair to be $1,069,849; Allstate retained a separate contractor which estimated the cost to be $750,320; and, the Umpire, appointed pursuant to the policy, determined the cost of repair to be $832,982. Allstate agreed to pay the $832,982, and the dwelling was reconstructed. During the reconstruction, the plaintiffs' driveway and landscaping was damaged, for which Allstate refused to reimburse plaintiffs. Additionally, due to the delay in the settlement process and reconstruction, the plaintiffs were forced to remain out of the dwelling for 18 months. Under the policy, the plaintiffs were entitled to Additional Living Expenses for a maximum of 12 months, and Allstate refused to extend the Additional Living Expenses for the additional six months. As a result, the plaintiffs filed an action against Allstate seeking, *inter alia*, consequential damages based upon Allstate's bad faith delay in settling the claim. Based upon the fact that Allstate offered the plaintiffs $265,000 and then $575,000 on a claim ultimately determined to be, and paid, in the amount of $832,982, the Court held that the plaintiffs made out a *prime facie* claim for breach of the covenant of good faith, since the plaintiffs suffered damage due to the delay in the reconstruction of their dwelling as a result of Allstate's bad faith delay in settling the claim. As a result, the burden then shifted to Allstate to submit evidence that raised a question of fact, which Allstate failed to do. As such, the Court granted judgment on plaintiffs' causes of action seeking consequential damages against Allstate for damages equal to the sum of (i) the plaintiffs' Additional Living Expenses in excess of 12 months, (ii) the expense of the mold inspection, and (iii) expenses of the appraisal.

CONTRIBUTION

National Cas. Co. v. American Safety Cas. Ins. Co., 2010 WL 4968077 (S.D.N.Y. December 3, 2010) This matter arose from an underlying personal injury action wherein a employee of City Waste Services of New York, Inc. was injured while driving an automobile in the course and scope of his employment. At the time of the accident, City Waste was covered by a Commercial Auto Policy issued by National Casualty Company, and a Commercial General Liability policy issued by defendant, American Safety Insurance Company. National Casualty agreed to provide City Waste with a defense, pursuant to a reservation of rights, while American Safety denied coverage. National, thereafter, brought action against American Safety seeking a declaration as to their respective rights and obligations under the policies covering City Waste as well as for contribution. The Southern District held, *inter alia*, that National Casualty's claim for contribution against American Safety failed because they did not insure the same risk. In this regard, under New York law, an action for contribution is only available upon a showing that two or more insurers cover the same insured for the same risk. To the contrary, National Casualty's pleading against American Safety alleged that National Casualty had no obligation to indemnify City Waste and that American Safety did. It was, therefore, according to the Southern District, apparent from the face of the Complaint that the two insurers did not insure the same risk.

DIRECT ACTIONS

Nahshon Aaron Council v. Utica First Ins. Co., 77 A.D.3d 1433 (4th Dep't October 1, 2010) An injured nightclub patron brought a direct action against the nightclub's insurer, after securing a default judgment against the nightclub. According to the Appellate Division, Fourth Department, the insurer established its entitlement to judgment as a matter of law. In so holding, the Fourth Department recognized that the injured patron had testified during the hearing preceding the default judgment that he was injured when he was "tackled" by a bouncer at the nightclub during a discussion with the bar manager. Although the plaintiff alleged that he was injured as a result of the "negligence" of the bouncer, the Fourth Department found that the record demonstrated that it was not an unprovoked assault, and thus the event fell within the "Assault and Battery" exclusion of the nightclub's insurance policy. Contrary to the plaintiff's contention, the insurer was not estopped from asserting that its insured acted intentionally by virtue of the finding of negligence in the underlying action. In this regard, because the judgment was entered on default, the issue of negligence was not actually litigated and, therefore, had no collateral estoppel effect.

DISCLAIMERS

Rockland Exposition, Inc., v. Great American Assur. Co., 2010 WL 3932360 (S.D.N.Y. September 29, 2010) The Southern District confirmed that under New York law, an insurer only waives a late notice defense where it denies a claim, solely on the ground that it is not covered by the policy, without mentioning timeliness. An insurer cannot be said to have intended to waive a late notice defense that it explicitly raised in its claim denial, simply because it also denies the claim based upon other grounds.

Ostrowski v. American Safety Indem. Co., 2010 WL 3924679 (E.D.N.Y. September 30, 2010) The Eastern District held that an insurer's disclaimer of coverage issued to a purported additional insured in connection with an underlying personal injury action fifty-two days after receiving notice of the claim from the purported additional insured was timely under New York Insurance Law 3420, which requires insurers disclaiming liability to "give written notice as soon as is reasonably possible…" According to the Eastern District, the insurer was required to conduct an investigation in order to determine whether additional insured status did, in fact, exist, since the grounds for disclaiming were not immediately obvious from the notice sent by the additional insured. In this regard, the Eastern District noted that the extent of the insurer's investigation was well documented, consisting of an examination of issues by coverage counsel, and that the insurer's disclaimer was timely as it was sent eight days after the receipt of coverage counsel's opinion letter.

Khuns v. Bay State Ins. Co., 2010 WL 4540489 (4th Dep't November 12, 2010) The Appellate Division, Fourth Department, overturned the lower court's finding that the defendant-insurer's declination of coverage did not meet "the specific and clear requirements under the law." Since the action involved property damage, the Fourth Department noted that the claim was not controlled by the high degree of specificity required for a disclaimer of liability for death or bodily injury under Insurance Law 3420(d)(2). As such, the denial was found to "adequately set forth the policy provisions on which [the insurer] relied and, indeed, there was no indication that there was any confusion on [the insured's] part with respect to the policy provisions upon which defendant relied and thus that plaintiff was thereby prejudiced by any alleged lack of specificity."

233 East 17th Street, LLC v. L.G.B. Development, Inc., 78 A.D.3d 930 (2d Dep't November 16, 2010) The Appellate Division, Second Department, affirmed that where an insured fails to provide timely notice of an underlying claim, the late notice will not excuse the insurer's unreasonable delay in disclaiming coverage. The issue of whether a disclaimer is unreasonably delayed is generally a question of fact, requiring an assessment of all relevant circumstances; however, an insurer's explanation for its delay in disclaiming will be insufficient as a matter of law where the basis for denying coverage was or should have been readily apparent before the onset of delay.

York Restoration Corp. v. Solty's Const., Inc., 2010 WL 5094365 (2d Dep't December 14, 2010) The Appellate Division, Second Department, affirmed that a disclaimer under New York Insurance Law 3420(d) is unnecessary when a claim does not fall within the coverage terms of an insurance policy. Therefore, when a claim is denied because there is no coverage available in the first instance, there is no obligation to provide prompt notice of the disclaimer; requiring coverage of a claim for failure to provide a timely disclaimer would, in turn, create coverage where it never existed.

Magistro v. Buttered Bagel, Inc., 2010 WL 5095411 (2d Dep't December 14, 2010) Notwithstanding a delay in notice from an insured, an insurer must give written notice of a disclaimer of coverage as soon as reasonably possible after it first learns of the accident or of grounds for denial of coverage. Failure to do so precludes an effective disclaimer, even where the insured has failed in the first instance to provide timely notice of the claim. An explanation will be insufficient as a matter of law when the basis for denial of coverage was or should have been readily apparent before the onset of the delay, unless the delay is excused by the insurer's showing that its delay was reasonably related to its completion of a thorough and diligent investigation into issues affecting its decision whether to disclaim coverage. In this matter, the Appellate Division, Second Department, found that the insurer did not have a readily apparent basis for disclaiming coverage until it conducted an investigation into the underlying incident and the insured's awareness of the circumstances surrounding it. According to the Second Department, the insurer's denial of coverage, issued only three weeks after receiving the investigator's report and becoming aware that the insured was aware of the claimant's injury the day it occurred, during which time it consulted coverage counsel, was timely as a matter of law.

EMPLOYEE BENEFITS COVERAGE

Federal Ins. Co. v. Int'l Business Machines Corp., 911 N.Y.S.2d 148 (2d Dep't November 9, 2010) The plaintiff, Federal Insurance Company, issued an Executive Protection Excess Insurance Policy to defendant, IBM. IBM was the sponsor of defendant, IBM Personal Pension Plan, a defined benefit plan within the meaning of ERISA. The Federal policy provided coverage in excess of and in conformance with an underlying fiduciary liability policy issued by Zurich American Insurance Group. The Zurich policy's insuring agreement provided coverage for "all Loss for which the Insured becomes legally obligated to pay on account of any Claim first made against the Insured…for a Wrongful Act." The term "Wrongful Act" was defined, in part, as "any breach of the responsibilities, obligations or duties by an Insured which are imposed upon a fiduciary of a Benefit Program by [ERISA] or by the common or statutory laws of the United States…" A class action was filed against IBM and the Plan alleging that certain amendments in 1995 and 1996 violated various provisions of ERISA. IBM and the Plan ultimately reached a settlement of the class action and Federal then sought a declaration that neither IBM nor the Plan were entitled to indemnification for any amounts incurred by them in the class action, including attorneys' fees. According to the Appellate Division, Second Department, contrary to the contention of IBM and the Plan, a breach of fiduciary duty was required for a Wrongful Act to be committed under the Zurich policy. In this regard, the Second Department concluded that when IBM allegedly violated the age discrimination provisions of ERISA by making amendments to the Plan, it was acting in a settlor capacity, not a fiduciary one. The age discrimination provision of ERISA, which IBM allegedly violated by enacting the amendments, were not responsibilities, obligations or duties imposed upon a fiduciary of a Benefit Program by ERISA. Rather, they were obligations imposed on settlors of ERISA benefit plans. Thus, the class action did not allege that IBM or the Plan committed a Wrongful Act, as that term was defined in the Zurich policy, and Federal established its entitlement to judgment as a matter of law that coverage under its policy was not implicated.

SELF-INSURED RETENTIONS

New York State Thruway Authority v. KTA-Tator Engineering Services, P.C., 78 A.D.3d 1566 (4th Dep't November 12, 2010) Third-party defendant/second-third-party plaintiff, Liberty Insurance Company contended on appeal that the lower court erred in granting the cross-motion of second-third-party defendant, Continental Insurance Company, seeking a declaration that Liberty was the sole insurer of the cost of defense for the defendant third-party plaintiff, KTA-Tator Engineering Services, P.C., in the main action up to the $100,000 deductible/self-insured retention in the Continental

policy. The Appellate Division, Fourth Department, began its analysis by noting that although the Continental policy referred to a "deductible", the policy actually contained an SIR in the amount of $100,000. As explained by the Fourth Department, an SIR differs from a deductible in that an SIR is an amount that an insured retains and covers before insurance coverage beings to apply. Once an SIR is satisfied, the insurer is then liable to amounts exceeding the retention. In contrast, a deductible is an amount that an insurer subtracts from a policy amount, reducing the amount of insurance. In light of the finding that the policy included an SIR, the Fourth Department held that Liberty was obligated to provide sole primary coverage to KTA for its defense costs up to $100,000. Thereafter, the Fourth Department held that Liberty and Continental would share equally in KTA's defense costs in excess of that amount.

TRIGGER

Downey v. 10 Realty Co., LLC, 78 A.D.3d 575 (1st Dep't November 23, 2010) Greater New York Mutual Insurance Company was held to have no duty to defend or indemnify its insured in an underlying negligence action, since, according to the Complaint, Bill of Particulars and deposition testimony in the underlying tort action, plaintiff sued for injuries that allegedly occurred in October – or, at the earliest, August – of 2002, outside Greater New York's policy period, which ended on July 1, 2002. According to the Appellate Division, First Department, the plaintiff's alleged exposure to mold during the policy period did not trigger any duty to provide coverage thereafter, as New York follows the "injury-in-fact" test which "rests on when the injury, sickness, disease or disability actually began and…requires the insured to demonstrate actual damage or injury during the policy period."

MISCELLANEOUS

RLI Ins. Co. v. Smiedala, 77 A.D.3d 1293 (4th Dep't October 1, 2010) Although an excess insurer's duty to defend an insured under a Commercial Auto policy in an underlying personal injury action had not yet been triggered, since the primary coverage had not been exhausted, the insured was nonetheless entitled to recover attorneys' fees and costs for prevailing in the excess insurer's declaratory judgment action seeking an adjudication that it did not have a duty to defend or indemnify the insured. As stated by the Appellate Division, Fourth Department, attorneys' fees were recoverable since the excess insurer cast the insured in a defensive posture by the legal steps taken in an effort to free itself from its policy obligations.

Suffolk Federal Credit Union v. CUMIS Ins. Society, Inc., 270 F.R.D. 141 (E.D.N.Y. October 19, 2010) Suffolk Federal Credit Union commenced action against CUMIS Insurance Society, Inc. seeking declaratory relief and damages for breach of contract and alleging that CUMIS failed to pay amounts due under a fidelity bond it issued for certain losses sustained by Suffolk Federal as the result of wrongful acts of CU National Mortgage, LLC, an outside company with which Suffolk Federal conducted business. During discovery, Suffolk Federal served interrogatories upon CUMIS, which included the following: "Does CUMIS have any facultative or treaty reinsurance which could indemnify CUMIS… for any of the losses under the Bond?" While acknowledging that there is a split among the federal courts as to whether insurance information, and more specifically, reinsurance information is relevant discovery, the Eastern District relied upon the Advisory Committee's Notes to the 1970 Amendments to Rule 26 at "subdivision (b)(2) specifically stating that the amendment resolves the issue "in favor of disclosure". According to the Advisory Committee, "disclosure of insurance coverage will enable counsel for both sides to make the same realistic appraisal of the case, so that settlement and litigation strategy are based on knowledge and not speculation….Disclosure is required when the insurer 'may be liable' on part or all of the judgment."

LBC&C's INSURANCE INDUSTRY PRACTICE GROUP

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