New York Insurance Coverage Law Update

2008 Summary

New York Insurance Coverage Law Update
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New York Insurance Coverage Law Update 2008 Summary

TABLE OF CONTENTS

Page

Page

New York Insurance Coverage Law Update 2008 Summary

Additional and Named Insureds

Where Target Of Investigation Was Not A Named Insured, Costs In Responding To Investigation Are Not Covered Under Not-For-Profit Insurance Policy

Plaintiff and a number of other hospitals formed a joint venture called the Long Island Healthcare Network ("LIHN") to deliver healthcare on Long Island. Some time later, the New York State Attorney General served an investigative subpoena upon LIHN, seeking material relevant to "a confidential investigation into whether the activities of [LIHN] and the joint activities of hospitals within LIHN" violated certain provisions of federal and state antitrust laws. The US Department of Justice also served interrogatories upon LIHN. The plaintiff expended $2,300,877 answering the interrogatories and for legal fees, and sought coverage under a not-for-profit insurance policy for which it was a named insured. The court reasoned that because LIHN was the designated recipient of the subpoena and interrogatories and was the target of the investigation, and because LIHN was not a named insured under the policy, the plaintiff's costs and attorney's fees were not covered under the policy. The court noted that plaintiff incurred the costs and fees "solely by virtue of an independently imposed contractual obligation contained" in the joint venture agreement to pay them. [*Catholic Health Servs. of Long Island, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 46 A.D.3d 590 (2d Dep't 2007).]

Additional Insured Has Independent Duty To Provide Notice To Named Insured's Carrier

After the New York County Supreme Court ruled that the additional insured had an independent duty to provide notice to the named insured's carrier, the dispute reached the Appellate Division, First Department. The appellate court affirmed the Supreme Court's decision, reasoning that the named insured and the additional insured were adverse parties in the underlying action and, as a result, the additional insured had an independent obligation to provide timely written notice to the insurer. [*City of New York v. Welsbach Elec. Corp.*, 49 A.D.3d 322 (1st Dep't 2008).]

General Contractor Not Entitled To Coverage As Additional Insured Where Liability Did Not "Arise Out Of" Subcontractor's Operations

A general contractor constructing an apartment complex subcontracted with Pacific Steel, Inc., for construction of a staircase and handrailings. Pacific procured commercial general liability insurance through Farm Family Casualty Insurance Company that named the general contractor as an additional insured. After Pacific installed the stairs, but before it affixed the handrailings, an ironworker allegedly was injured when he slipped on fireproofing that had been applied to the stairs by another subcontractor. The ironworker sued the general contractor and the coverage dispute reached the New York Court of Appeals. The Court ruled that Farm Family was not required to defend or indemnify the general contractor.

In its decision, the Court pointed out that the additional insured endorsement stated that the general contractor was an additional insured only with respect to liability "arising out of [Pacific's] operations." The Court rejected the general contractor's contention that the ironworker slipping on the staircase established as a matter of law that his accident arose out of Pacific's work. Instead, the court explained that there must be "some causal relationship between the injury and the risk for which coverage is provided." The Court observed that an "entirely separate company was responsible for applying the fireproofing material." Given that the general contractor had conceded that it could not assert that the stairway had been negligently constructed, i.e., the staircase was merely the site of the accident, the Court found that it could not be argued that there was any connection between the ironworker's alleged accident and the risk for which coverage was intended. [*Worth Construction Co., Inc. v. Admiral Ins. Co.*, 10 N.Y.3d 441(2008).]

Plaintiff Was Neither Additional Insured Nor Third Party Beneficiary Under CGL Policy Obtained By Corporation

The plaintiff asserted that an insurer was obligated to defend the plaintiff under a commercial general liability policy the insurer had issued to a corporation on the grounds that the plaintiff was an additional insured under the policy's blanket additional insured endorsement and that he was an intended third party beneficiary under the policy. The trial court granted the plaintiff's motion for summary judgment, but the Appellate Division, Fourth Department, reversed. It observed that the blanket additional insured endorsement amended the provision defining "who is an insured" "to include as an insured any person or organization who you are required to name as an additional insured on this policy under a written contract or agreement." The Fourth Department pointed out that, pursuant to a property lease executed by the plaintiff and the corporation, the corporation was required to ocure CGL coverage for "the mutual benefit of" the plaintiff and the corporation. However, the appellate court explained, the lease did not require that the corporation name the plaintiff as an additional insured. The Fourth Department also ruled that the plaintiff was not an intended third party beneficiary under the policy. It stated that there was no suggestion of an intent to extend direct coverage to the plaintiff. The plaintiff was, at best, "merely an incidental beneficiary," the appellate court concluded. [*Kassis v. Ohio Cas. Ins. Co.*, 51 A.D.3d 1366 (4th Dep't 2008).]

Additional Insureds Obligated To Timely Notify Insurer Of Both "Occurrence" And "Suit"

Owners of property in Queens hired a company to perform renovation work. The renovation company obtained liability insurance for the project that named the owners as additional

insureds. The policy required notice "as soon as practicable" of both an "occurrence" and any "claim" or "suit" brought against any insured. Two workers allegedly were injured and brought suit against the owners and the renovation company. The owners made a demand that the insurer defend and indemnify them but the insurer disclaimed coverage because the owners had not furnished timely notice.

The Second Department held that the owners, as additional insureds, had an implied duty, independent of the renovation company's, to provide the insurer with the notices required under the policy, i.e., notice "as soon as practicable" of both the "occurrence" and of any "claim" or "suit" arising therefrom. It, however, concluded that there was a question of fact as to the "united in interest" exception, which provides that notice by one insured in the lawsuit is deemed notice by another where they are "united in interest" and there is "no adversity" between them. [*23-08-18 Jackson Realty Assoc. v. Nationwide Mut. Ins. Co.*, 53 A.D.3d 541 (2d Dept. 2008).]

Additional Insured's Failure To Timely Provide Its Own Notice Dooms Coverage

An insurance policy issued to Kimco Fine Interior Painting & Decorating contained a notice provision requiring any insured thereunder to provide notice "as soon as practicable" of an occurrence or an offense that may result in a claim, as well as of any suits or claims brought against the insured. The policy also contained an Additional Insured Endorsement that listed the owner of the property at which Kimco was working as an additional insured. A negligence suit against Kimco and the property owner was filed on April 2, 2007, alleging that an accident had occurred on October 27, 2006. The insurer received notice from the property owner on October 5, 2007, and disclaimed coverage based upon the property owner's late notice.

The court found that the insurer had no duty to defend or to indemnify the property owner in the underlying personal injury action, explaining that she had not notified the insurer of the accident until almost a year after it allegedly occurred and five months after she had been served with a summons and complaint. The court found "unavailing" the property owner's attempted reliance upon Kimco's presumably timely notice of the claim, noting that the property owner had asserted cross claims against Kimco, creating an adversarial relationship that precluded the property owner's reliance upon Kimco's notice to excuse her own late notice. The court also found that the property owner had failed to demonstrate that she had a reasonable belief in her non-liability, noting that she had been informed about the accident by Kimco either on the day it allegedly occurred or a day later, and that she was aware that the injured party had gone to a hospital emergency room after the accident. [*Gardner v. Phoenix Ins. Co.*, 21 Misc.3d 1135A (Sup. Ct. Kings County 2008).]

Conditions Precedent/ Late Notice

Two-Month Delay In Disclaiming Coverage Was Reasonable Where Insurer Needed To Investigate When Insureds Received Notice Of Accident

In this action, the plaintiff insurer sought a judgment declaring that it was not obligated to defend or to indemnify the defendants in an underlying bodily injury suit. The court, noting that §3420(d) of the New York Insurance Law precludes an insurer from relying upon a late notice defense if it fails to disclaim coverage "as soon as is reasonably possible" after it "first learns of the grounds for disclaimer of liability or denial of coverage," ruled that the delay of two months, occasioned by the insurer's need to investigate the claim to determine when its insureds had received notice of the accident, was reasonable under the circumstances. [*Hermitage Ins. Co. v. Arming, Inc.*, 46 A.D.3d 620 (2d Dep't 2007).]

Store's Failure To Notify Insurer Of Accident "As Soon As Practicable" Despite Employees' Knowledge Dooms Coverage Claim

A police officer allegedly was injured when he entered a store in the Bronx and fell through an open cellar door leading to the basement. Two employees were aware of the incident but did not tell the store owner. After the officer brought suit against the store, the store's insurer contended that it had no duty to defend or to indemnify the store because the store had not notified it "as soon as practicable" of an "occurrence . . . which may result in a claim." In response, the officer asserted that the store had first become aware of the officer's accident when the store owner received a letter of representation from the officer's counsel 18 months after the accident. The court rejected that argument, finding that the two employees' knowledge of the incident had to be imputed to the store owner, who in turn had a duty to notify the insurer of the officer's accident. It then held that the store had failed to satisfy the burden of establishing that the delay in giving notice to the insurer was reasonably founded upon a good faith belief of nonliability. Accordingly, the insurer was entitled to summary judgment declaring that it had no duty to defend or to indemnify the store in the officer's action. [*Tower Ins. Co. of N.Y. v. Saleh*, 18 Misc.3d 1119A (Sup. Ct. N.Y. County 2008).]

New York's Highest Court Finds That Bear Stearns Breached Policy Provision Obligating It To Obtain Insurers' Consent Before Settling Claims In Excess Of $5 Million, Barring Coverage

Insurers contended that Bear Stearns could not recover under a professional liability insurance policy and excess policies any part of an $80 million settlement it reached with various federal and state investigators because the policies provided that Bear Stearns would not settle any claim in excess of $5 million without first obtaining the consent of its insurers – and it had not obtained that consent. New York's highest court, the Court of Appeals, agreed with the insurers and concluded that Bear Stearns had breached its agreement not to settle any claim exceeding $5 million without the insurers' consent when it executed the April 2003 consent agreement with the U. S. Securities and Exchange Commission before notifying the insurers or obtaining their approval. The Court was not persuaded by Bear Stearns' argument that the settlement was subject to court approval. Accordingly, the Court concluded, Bear Stearns could not recover from the insurers any portion of the settlement payments it agreed to make. [*Vigilant Ins. Co. v. Bear Stearns Cos., Inc.*, 10 N.Y.3d 170 (2008).

Legislature Passes Bill Amending New York's Late Notice/No Prejudice Rule

The New York State Legislature has passed a bill proposed by New York Governor David Paterson to amend the Insurance Law: (i) to require that liability policies for injury to person or destruction of property contain a provision that failure to give prescribed notice will not invalidate a claim made by the insured, injured person or any other claimant unless the late notice prejudiced the insurer; (ii) to provide,

with respect to a personal injury or wrongful death claim, if an insurer disclaims liability or denies coverage based on a failure to provide timely notice, then the injured person or other claimant may maintain an action directly against the insurer on the question of late notice, unless the insured or the insurer, within 60 days of the disclaimer, initiates an action under the policy naming the injured person or other claimant as a party to the action; and (iii) to establish that (a) if notice is provided to an insurer within two years of the time required under the policy, then the burden to show prejudice – defined as including the material impairment of the insurer's ability to investigate or defend the claim – would fall on the insurer; (b) if notice is provided to the insurer more than two years after the time required under the policy, then the burden to show that the insurer is not prejudiced would fall on the insured, injured person or other claimant; and (c) if notice is provided to the insurer after the insured's liability is determined, or after the insured has settled the case, then there would be an irrebuttable presumption of prejudice. It is now up to the Governor to sign the bill before it can take effect.

Governor Signs Bill Amending New York's Late Notice/No Prejudice Rule

On July 23, New York Governor David Paterson signed the bill amending provisions of the New York Insurance Law relating to late notice and the no prejudice rule. For a discussion of the new law, see last month's "New York Insurance Coverage Law Update." The law, which takes effect 180 days from the date it was signed, i.e., January 17, 2009, applies to policies issued or delivered in New York on or after that date and requires that such policies contain the new provisions.

Late Notice By Additional Insured Dooms Claim Despite Timely Notice By Named Insured

Eight months after being sued for an accident, an out-of-possession landlord provided notice of the suit to the insurance carrier that had issued a commercial general liability insurance policy to the tenant naming the landlord as an additional insured. Because the landlord had offered no excuse for the delay, the Appellate Division, First Department, found that it constituted late notice as a matter of law and held that the insurer was not required to demonstrate prejudice by reason of the delay to disclaim coverage. The appellate court also ruled that the tenant could not be deemed to have provided timely notice on behalf of the landlord because the landlord and tenant had adverse interests "from the moment the complaint was served naming them both as defendants." [*1700 Broadway Co. v. Greater N.Y. Mut. Ins. Co.*, 54 A.D.3d 593 (1st Dep't 2008).]

Court of Appeals Rules That Notice Under Workers' Compensation Policy Is Not Notice Under CGL Policy, And Upholds Duty Of Each Insured To Provide Its Own Notice

In this case, the New York Court of Appeals ruled that, contrary to the insured's contention, notice provided under a workers' compensation policy in effect at the time of the alleged incident "did not constitute notice" under a commercial general liability policy "even though both policies were written by the same carrier." The Court explained that each policy imposed upon the insured a "separate, contractual duty to provide notice." Similarly, it added, an additional insured's notice to the carrier under a different policy did "not excuse the insured's obligation to provide timely notice under its policy." [*Sorbara Constr. Corp. v. AIU Ins. Co.*, 11 N.Y.3d 805 (2008).]

Third Department "Unpersuaded" In Liability Insurance Case By Limited Departure From "No Prejudice" Rule In SUM Cases

After a moving company employee allegedly was injured while working, the incident was reported to the company's workers' compensation carrier, the New York State Insurance Fund, by way of a C-2 claim form. The worker, who received workers' compensation benefits, thereafter brought a premises liability action against New York City. The City filed a third party action against the company (employer) seeking contribution and indemnification, and the company notified its general liability carrier of the action – but it did not notify the Fund. About a year later, the Fund learned of the third party action and disclaimed any duty to defend or to indemnify under the employer's liability coverage in the workers' compensation policy, arguing that the company had failed to provide prompt notice of the third party action.

The Third Department agreed with the Fund, observing that the workers' compensation policy required the company to report any injury "at once" and to "[p]romptly give [the Fund] all notices, demands and legal papers related to the injury, claim, proceeding or suit." The appellate court ruled that the Fund's receipt of notice of the accident "did not satisfy plaintiff's separate obligation" to provide prompt notice of the third party lawsuit. Moreover, the appellate court added, the Fund "was not required to demonstrate prejudice in order to successfully disclaim coverage." The Third Department stated that it was "unpersuaded" that recent departures from the general "no prejudice" rule in the context of supplemental uninsured and underinsured motorists coverage under automobile insurance policies should be extended to the facts of this case. [*Liberty Moving & Stor. Co., Inc. v. Westport Ins. Corp.*, 55 A.D.3d 1014 (3rd Dep't 2008).]

Late Notice Disclaimer Upheld Where Insured Did Not Know of Suit By Virtue Of Its Failure To Update Its Address With Secretary Of State

When Briggs Avenue L.L.C. was incorporated, it designated the Secretary of State as its agent to receive service of process. Briggs later moved but did not notify the Secretary of State of its address change. Thereafter, a personal injury action was filed against Briggs, with the plaintiff serving the summons and complaint on the Secretary of State. Because the Secretary of State did not have a correct address for Briggs, Briggs did not know that the lawsuit existed until the plaintiff served a default motion directly upon Briggs. Briggs then notified its liability insurer of the claim, but the insurer disclaimed coverage on the ground that Briggs had not complied with the policy condition requiring Briggs to give the insurer timely notice of the suit.

The New York Court of Appeals ruled that the insurer properly disclaimed coverage. It found that it was "unquestionably practicable" for Briggs to keep its address current with the Secretary of State to ensure that it would have received, and been able to provide, timely notice of the suit. The Court rejected Briggs's argument that its mistake had caused no prejudice to the insurer, observing that it had "long held, and recently reaffirmed, that an insurer that does not receive timely notice in accordance with a policy provision may disclaim coverage, whether it is prejudiced by the delay or not." The Court acknowledged that recent legislation "strikes a different balance, more favorable to the insured," but pointed out that because the legislation is limited to policies issued after January 17, 2009, the common law no-prejudice rule applied here. [*Briggs Ave.*

LLC v. Ins. Corp. of Hannover, 11 N.Y.3d 377 (2008).]

Coverage Grant

Insurer's Evidence That Alleged Injuries Were Not Causally Related To Accident Dooms Plaintiff's Summary Judgment Motion In Suit to Recover No-Fault Benefits

Plaintiff, a health care provider, brought suit to recover assigned first-party no-fault benefits and moved for summary judgment. The defendant insurer opposed the motion, asserting that the injuries allegedly sustained by the plaintiff's assignor were not causally related to the accident. The trial court denied the plaintiff's motion, and the Appellate Term, Second Department, affirmed. It ruled that the Accident Reconstruction Analysis report submitted by the defendant insurer and the sworn affidavit of the consultant who prepared the report were sufficient to raise a question of fact as to whether the alleged injuries arose out of an insured incident. [*Mani Med., P.C. v. NY Cent. Mut. Ins. Co.*, 19 Misc.3d 128A (2d Dep't 2008).]

First Department Affirms Lack Of Coverage Where "Operative Act" That Would Give Rise to Any Recovery Was An Assault

After Supreme Court, Queens County, granted the motion of Nationwide Mutual Fire Insurance Company for summary judgment declaring that it was not obligated to defend its insured in an underlying personal injury action, the insured appealed. The Appellate Division, Second Department, affirmed, finding that the assault alleged in the underlying action was "an intentional act," which did not constitute an "occurrence" within the meaning of the policy. The court also found that coverage was barred by the policy's exclusionary clause for intentional acts. The Second Department added that the inclusion in the underlying complaint of causes of action sounding in negligence and alleging carelessness did not alter the fact that "the operative act" giving rise to any recovery was the assault. Accordingly, it ruled that the insurer had no duty to provide a defense to the insured or to indemnify him in the underlying action to recover damages for the alleged assault. [*Desir v. Nationwide Mut. Fire Ins. Co.*, 50 A.D.3d 942 (2d Dep't 2008).]

No Coverage In Case Alleging Lead Paint Injuries Where Insurer Demonstrates That Infants' Alleged Injuries Were Sustained Before Policy Went Into Effect

After Supreme Court, New York County, granted the plaintiff insurer's motion for summary judgment and declared that it was not obligated to defend or to indemnify the property owner and management company in an underlying action for lead paint injuries, the dispute reached the Appellate Division, First Department. The appellate court affirmed, finding that the insurer had demonstrated that the infants' alleged lead injuries had been sustained before the subject policy went into effect. The court noted that the lead in the apartment had been abated before the policy period, and there was "no evidence that any lead ingestion could have occurred" after the abatement. The court concluded that a question of fact was not raised by one child's slightly elevated lead level during the policy period. [*Fire & Cas. Ins. Co. of Conn. v. Solomon*, 50 A.D.3d 340 (1st Dep't 2008).]

Insurer Not Obligated On Unsatisfied Default Judgment In Underlying Action Where There Was No Coverage

The plaintiff, a New York resident, allegedly was injured in an automobile accident in Maryland. The vehicle was insured under an insurance policy issued in Virginia to a Virginia resident who did not own the vehicle and who was not operating it at the time of the accident. In the underlying personal injury action, the plaintiff brought suit against the operator of the vehicle, allegedly a New York resident, and the New York corporation that owned the vehicle. After a judgment entered upon default against the operator and owner remained unsatisfied for more than 30 days, the plaintiff brought suit against the vehicle's insurer to recover the unsatisfied judgment. The Appellate Division, Second Department, found that the insurer was not obligated to satisfy the judgment. It pointed out that no judgment had been entered in the underlying personal injury action against the named insured. Moreover, it added, the underlying action was conclusive as to the identity of the vehicle's owner and the vehicle's operator, neither of whom were named insureds under the policy. The appellate court ruled that, although the policy provided coverage for "non-owned automobiles," the only individuals covered were the named insureds, relatives who resided in the same household as the named insureds, and "any other person or organization not owning or hiring the automobile, but only with respect to his or its liability because of acts or omissions of" a named insured or residing relative. The defendants against whom the judgment had been entered in the underlying action did not fit any of these categories, the Second Department concluded. [*Perkins v. Allstate Ins. Co.*, 51 A.D.3d 647 (2d Dep't 2008).]

Divided Fourth Department Rules That Incident Where Defendant Allegedly Punched Individual Was Not An "Occurrence"

According to the underlying personal injury complaint, the defendant in this declaratory judgment action assaulted another individual while the individual was attending a party at the defendant's home. The defendant testified at his deposition that he intended to hit the individual, that the individual had shoved him and was again advancing toward him, and that the defendant knew when he hit the individual that the individual "could be hurt from the punch."

A divided Appellate Division, Fourth Department, found that the defendant's insurer had no duty to defend or to indemnify the defendant, ruling that the alleged incident was not an "occurrence" within the meaning of the policy. The three justices in the majority explained that an incident was an occurrence if, "from the point of view of the insured, [the incident resulting in injury] was unexpected, unusual and unforeseen." Here, the majority concluded, the evidence did not support the conclusion that the result of the defendant's intentional act of punching the individual in the face "accidently or negligently" caused his alleged injuries, as provided in Automobile Ins. Co. of Hartford v. Cook, 7 N.Y.3d 131 (2006). The two justices in the minority also relied on Cook, concluding that because the complaint in the underlying action alleged negligent conduct by the defendant, and the defendant's description of the events and actions leading to the individual's injury supported the conclusion that the punch or its results were unexpected or unintended by the defendant, the insurer should have had a duty to defend the defendant. [*State Farm Fire & Cas. Co. v. Whiting*, 53 A.D.3d 1033 (4th Dept. 2008).]

Court Rejects Insurer's Contention That Alleged Middle School Fight Did Not Qualify As An "Occurrence"

A teacher's aide alleged that she had been injured when a fight broke out among eighth grade students and a boy threw a garbage can into the air that hit her. The aide sued the boy, whose parents sought coverage under their homeowner's policy. The insurer denied coverage on the basis that there was no "occurrence," which was defined in the policy as an accident. The court held that there was a duty to defend because the allegations in the complaint suggested the possibility of an "unintentional or unexpected event which potentially gives rise to a covered claim." [*Medrano v. State Farm Fire & Cas. Co.*, 54 A.D.3d 662 (2d Dep't 2008).]

Exclusions

Exclusion Bars Coverage Where Defendant Pleaded Guilty To Assault

The defendant in the underlying personal injury action shot an arrow from a compound bow at the claimant, striking him in the eye; the defendant thereafter pleaded guilty to assault in the first degree. After the claimant brought suit for damages, the defendant sought coverage under his parents' homeowners' policy. The insurer disclaimed coverage based upon the policy's exclusion for bodily injury "intended by, or which may reasonably be expected to result from the intentional or criminal acts or omissions [] of an insured person." The court agreed with the insurer, finding that it had submitted evidence establishing as a matter of law that the injury fell within the policy exclusion for injury resulting from the defendant's criminal act, and that the injury could reasonably have been expected to result from that act. [*Allstate Ins. Co. v. Swanson*, 46 A.D.3d 1453 (4th Dep't 2007).]

Independent Contractor Exclusion Bars Coverage In Boiler Installation Dispute

After the insured contracted to provide a new boiler in a commercial building, it purchased the boiler and arranged to have a boiler company install it. During the installation process, one of the installer's employees allegedly caused an explosion and fire while connecting a welder to an electrical source, with resultant injuries and damages. The insurer disclaimed coverage for all claims asserted against the insured, relying upon an exclusion in the policy for damages "arising out of operations performed for any insured by independent contractors." The Second Department found that the installer "was clearly an independent contractor." It noted that the installer had performed the work according to its own methods without being subject to the insured's control, except as to the product or result of its work. Because the insurer had demonstrated that it had properly relied upon the policy exclusion for independent contractors, and the insured had failed to raise a triable issue of fact, the Second Department ruled that summary judgment in favor of the insurer had been properly granted. [Metropolitan Heat & Power Co., Inc. v. AIG Claims Servs., Inc., 47 A.D.3d 621 (2d Dep't 2008).]

"Employee" Exclusion Deemed Applicable To Personal Injury Claim Asserted By Subcontractor's Employee

A plumber allegedly was injured when he stepped on wire mesh at a construction site. The plumber, who was an employee of the plumbing subcontractor at the site, brought suit against the owner of the property, the general contractor, and the electrical subcontractor. The general contractor sought coverage as an additional insured under the electrical subcontractor's commercial general liability policy. The court found that the insurer had no duty to defend or to indemnify the general contractor because, among other things, the "employee exclusion" barred coverage for "any" employees, contractors and employees of contractors. [*York Hunter Construction Services, Inc. v. Great American Custom Ins. Services, Inc.*, 2008 NY Slip Op. 30112(U) (Sup. Ct. N.Y. Co. Jan. 9, 2008) (\"Employee\" Exclusion Deemed Applicable To Personal Injury Claim Asserted By Subcontractor's Employee).]

Court Upholds Exclusion For "Loss Caused By Rupturing Or Bursting Of Water Pipes"

After the insured sustained property damage to its office in a New York City building when a water pipe from an upstairs office ruptured or burst, the insured sought coverage under its Business Owners Policy. The insurer disclaimed coverage based upon an exclusion for "loss caused by rupturing or bursting of water pipes." The insured argued that the exclusion was ambiguous because it did not exclude water damage caused by the flow of water from above the premises. The court rejected the insured's argument, finding that the exclusion was not ambiguous. It then found that because the insured's vice president had testified at her deposition that she went to the upstairs office and saw "a pipe under a sink that was a flexi pipe that came out or burst," the exclusion applied, and it granted the insurer's motion for summary judgment. [*Elefky Enterprises, Inc. v. Utica First Ins. Co.*, 2008 NY Slip Op. 30056(U) (Sup. Ct. N.Y. County 2008).]

Adverse Possession Claim Excepted From Coverage Under Title Insurance Policy

Homeowners argued that they were entitled to coverage under their title insurance policy with respect to an adverse possession claim asserted by their neighbors. The title insurer denied the homeowners' claim for defense and indemnification, arguing that the adverse possession of a portion of the homeowners' property was excluded from the policy coverage by an exception for "[r]ights of tenants or persons in possession." The court agreed with the title insurer. It explained that because it is not common practice for title insurance examiners to physically inspect the premises prior to the issuance of title insurance policies, most policies except the rights of persons in possession. Here, it concluded, even though there had been an inspection of the property, the inspection could "not have revealed the potential claim" for adverse possession because such an inspection "does not identify ownership, and no matter how precise the survey or survey inspection, it would not have disclosed the claim of ownership by adverse possession." [*Murphy v. Chicago Title Insurance Co.*, 2008 NY Slip Op. 30092(U) (Sup. Ct. Nassau County Jan. 8, 2008).]

No Coverage Under Homeowner's Policy For Alleged Sexual Assault By Minor Son

A minor alleged that she had been "physically detained and sexually assaulted" in her own home by the minor son of a husband and wife because of the couple's "careless and negligent" failure to properly supervise their son even though they allegedly knew he had a "predisposition to commit sexual acts." The couple sought insurance coverage under their homeowner's policy. The Suffolk County Supreme Court granted summary judgment in favor of the insurer, and the Appellate Division,

Second Department affirmed. The appellate court first pointed out that the policy specifically excluded "bodily injury . . . caused intentionally by or at the direction of any insured" and noted that the injuries allegedly sustained by the infant plaintiff were alleged to have resulted from the intentional sexual assault of the infant plaintiff by the couple's son, who was an "insured" as defined by the policy. The appellate court added that the policy specifically excluded coverage for child abuse or sexual abuse, with such exclusions deemed to apply regardless of whether claims were made directly, indirectly, or derivatively or sounding in negligence. Finally, the Second Department concluded, the insurer also had properly disclaimed coverage on the ground that the alleged incident was not an accident and, therefore, not a covered "occurrence." [*Kantrow v. Security Mut. Ins. Co.*, 49 A.D.3d 818 (2d Dep't 2008).]

Insurer Waived Exclusions That It Had Not Mentioned In Its Disclaimer Letter; Appellate Court Finds "No Valid Basis Upon Which To Deny Coverage"

After the plaintiff allegedly was injured when she fell after slipping on ice on a sidewalk in front of a commercial building, the building owner's insurer sent a disclaimer letter to the owner and the plaintiff's attorney denying coverage. The plaintiff obtained a default judgment against the owner and, when it remained unsatisfied for more than 30 days, brought suit against the insurer.

The Second Department found that the plaintiff was entitled to summary judgment against the insurer. It explained that a notice of disclaimer pursuant to §3420(d) of New York's Insurance Law "must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated," and that an insurer is precluded from relying upon exclusions not asserted in its notice of disclaimer. Here, it ruled, the insurer relied upon exclusions that it had not mentioned in its disclaimer letter, and "thus have been waived." [*Adames v. Nationwide Mut. Fire Ins. Co.*, 55 A.D.3d 513 (2d Dep't 2008).]

First Party Property

New York Court Of Appeals Permits Potential Recovery Of Consequential Damages Against First-Party Property Insurer

A fire occurred at a meat market that resulted in the loss of the insured's inventory and damage to the building and its contents. The insured submitted a claim to its insurer under a policy that provided business interruption coverage. Following a dispute over the insured's claim, the insured brought suit against the insurer for the insurer's alleged failure in bad faith to promptly pay the claim, among other things, seeking recovery of both the policy limits and consequential damages for "the complete demise of its business operation." New York's highest court, the Court of Appeals, first pointed out that there is an implied covenant of good faith and fair dealing in every insurance contract, and consequential damages are recoverable for breach of contract so long as such damages were "within the contemplation of the parties as the probable result of the breach at the time of or prior to contracting." It then held that the consequential damages the insured allegedly sustained in this case were foreseeable because the purpose served by business interruption coverage was to ensure that the insured had the financial support necessary to sustain its business operations in the event a disaster occurred. The dissent criticized the majority for side-stepping earlier precedent prohibiting punitive damages for breach of an insurance contract without "egregious tortuous conduct" and a "public" wrong. [*Bi-Economy Market v. Harleysville Ins. Co.*, 10 N.Y.3d 187 (2008).]

Homeowners Policy Properly Cancelled For Nonpayment

After obtaining a homeowners insurance policy on property he owned in Otsego County through the Leatherstocking Cooperative Insurance Company, the plaintiff began to fall behind in his monthly payments. He remitted a late payment that resulted in a change in the payment schedule and a higher monthly payment. When the plaintiff failed to make that higher payment, his policy was cancelled. Days later, the plaintiff's property was destroyed by fire. Leatherstocking disclaimed coverage on the basis that the policy had been cancelled for nonpayment, and the plaintiff brought suit.

The court found that the notice of cancellation was effective, noting that the change to the installment payment schedule had been fully disclosed on the billing statements the plaintiff had received and that the plaintiff had failed to remit the necessary amount to keep the payments current. The court also ruled that Leatherstocking had met its burden of proving that the final notice of cancellation had been properly mailed to the plaintiff by submitting proof of its standard operating procedure for mailing such notices, as well as by submitting proof of the actual mailing of notice to the plaintiff through the affidavit of an employee with personal knowledge. The plaintiff's testimony that he had never received the final notice was, without more, insufficient to rebut the presumption of receipt, the court ruled. [*Kaufmann v. Leatherstocking Coop. Ins. Co.*, 52 A.D.3d 1010 (3rd Dep't 2008).]

Homeowner's Policy Is Void Ab Initio Where Owner Misrepresented That She Would Live In Building And That No Business Would Be Conducted There

After a woman alleged that she had tripped and fallen on the sidewalk in front of a building in New York, the insurance company that had issued a homeowner's policy in favor of the property owner asserted that it had no duty to defend the lawsuit due to the owner's material misrepresentations that she would be living in the building and that no business would be conducted there. The insurer asserted that the woman lived elsewhere and presented evidence that "a pediatrician's office [was] being operated from the first and second floors of the premises."

The court found that the insurer had demonstrated that it would not have issued the policy had it known that the owner would not be residing there and that she would be running a business at the location. It also ruled that the owner had failed to raise an issue of fact regarding her alleged misrepresentations. The court then agreed with the insurer and ruled that the policy was void. [*Tower Ins. Co. of New York v. Rajaram*, 2008 NY Slip Op. 32344(U) (Sup. Ct. N.Y. County Aug. 19, 2008).]

Insured's Receipt Of CGL Policy Dooms Coverage Where Policy Did Not Insure Collapsed Building And Insured Had Taken "No Action" To Close Coverage Gap

After a building on the plaintiff's property collapsed during a snowstorm, the plaintiff brought suit against its commercial property insurance carrier and the agent that had obtained the coverage, arguing that they knew or should have known that the policy did not insure all of the buildings the plaintiff owned at the location in question.

The Fourth Department found that the plaintiff's actions against the insurer and agent were "barred by plaintiff's receipt" of the policy. The appellate court explained that the plaintiff was "charged with conclusive presumptive knowledge of the terms and limits" of the policy. It pointed out that the "express terms" of the policy provided that the insurer did not insure the collapsed building at the time of the loss – yet the plaintiff had taken "no action to close the gap in coverage." [*Gui's Lbr. & Home Ctr., Inc. v. Pennsylvania Lumbermens Mut. Ins. Co.*, 55 A.D.3d 1389 (4th Dep't 2008).]

Priority of Coverage

First Department Resolves Dispute Between Primary And Umbrella/Excess Policies

During the course of the construction of the Bronx Criminal Court Complex, a subcontractor's employee allegedly fell down an elevator shaft on which work had been performed by another subcontractor. The decedent's estate filed a wrongful death action, and a declaratory judgment action thereafter was brought to determine the priority of coverage between separate insurers for the construction manager and subcontractors.

The Appellate Division, First Department, held that the additional insured umbrella coverage to the owner and construction manager under one subcontractor's policy was excess to the owner and construction manager's own primary coverage, even though the construction contract required that the subcontractor's insurance be primary and noncontributory. The First Department reasoned that the extent of coverage, including a given policy's priority vis-à-vis other policies, was controlled "by the relevant policy terms, not by the terms of the underlying trade contract that required the named insured to purchase coverage." The appellate court also held that the owner and construction manager's additional insured umbrella coverage under one subcontractor's umbrella policy was excess to the additional insured coverage under another subcontractor's primary policy, even though the other subcontractor's primary policy contained an endorsement stating that the "commercial general liability coverage maintained by [other subcontractors] shall be primary and this policy shall be excess." The court construed the endorsement to apply to other coverage "on the same level," i.e., other primary insurance. [*Bovis Lend Lease LMB, Inc. v. Great American Ins. Co.*, 53 A.D.3d 140 (1st Dep't 2008).]

Applying Bovis, First Department Finds One Policy To Be Excess And That Primary CGL Policy Must First Be Exhausted

Carnegie Hall Corp. retained Tishman Construction Corp. to manage construction of a new music hall. Tishman obtained a commercial general liability ("CGL") insurance policy from National Union Fire Insurance Co. naming Carnegie as an additional insured; the policy limits were $1,000,000 per occurrence/$2,000,000 aggregate. Tishman retained Schiavone Construction Co. to work on the project. Schiavone obtained two insurance policies that named Tishman and Carnegie as additional insureds: a CGL policy issued by National Union with limits of $1,000,000 per occurrence/$2,000,000 aggregate, and a commercial umbrella policy issued by Great American Insurance Co. with limits of $25,000,000.

Tishman and Carnegie argued that their Great American additional insured coverage should be primary to Tishman's policy with National Union. Relying upon its recent decision in Bovis Lend Lease LMB, Inc. v. Great American Ins. Co. [see "New York Insurance Coverage Law Update," May 2008], the First Department ruled that Great American's policy was a true excess policy that provided the final tier of coverage. Among other things, the First Department noted that the policy language establishing it as a pure excess policy was substantially similar to the language in the policy in Bovis on which the First Department had relied to declare that policy purely excess. Moreover, the premium for the Great American policy was far less than the National Union premium even though the Great American policy had significantly higher limits. [*Tishman Constr. Corp. v. Great Am. Ins. Co.*, 53 A.D.3d 416 (1st Dep't 2008).]

Uninsured/ Underinsured Motorist

Court Permanently Stays Arbitration Of Uninsured Motorist Benefits Claim Where Insured Failed To File Required Statement Within 90 Days Of Alleged Accident

The insurer in this case filed a proceeding pursuant to CPLR Article 75 to permanently stay arbitration of a claim for uninsured motorist benefits. After Supreme Court, Kings County, denied the petition, the insurer appealed. The Appellate Division, Second Department reversed, finding that Supreme Court had erred in denying the petition because the respondents had failed to file a sworn statement with the insurer within 90 days of the alleged hit-and-run accident, in accordance with the requirement of the insurance policy's uninsured motorist endorsement. "The respondents thus failed to satisfy a condition precedent of coverage under the policy, and are not entitled to arbitrate their claim seeking coverage." Moreover, the Second Department concluded, the fact that the insurer apparently had received some notice of the accident by way of an application for no-fault benefits, "did not negate the breach of the policy requirement." [*In re Hanover Ins. Co. v. Etienne*, 46 A.D.3d 825 (2d Dep't 2007).]

Payments From Tortfeasor's Insurer Dooms Insureds' Claim For SUM Benefits

After a family of four insureds was involved in an automobile accident with another motor vehicle, the family received $50,000 from the tortfeasor's insurer, representing the limit for bodily injury liability coverage under the tortfeasor's policy. The insureds then made a demand for arbitration of their claims under the supplementary uninsured/underinsured motorist endorsement of their policy for $100,000, seeking $25,000 each. The Second Department ruled that the arbitration should be stayed. It noted that the insureds' policy was underwritten with SUM benefits equal to $25,000 per person and $50,000 per accident and that the policy limits for bodily injury liability were in those same amounts. Accordingly, because the tortfeasor's policy limits for bodily injury liability were identical to the insureds' policy limits for bodily injury liability, "the tortfeasor's vehicle was not underinsured." The appellate court also ruled that the insureds' insurer was entitled to offset the $50,000

received by the insureds from the tortfeasor's insurer against the SUM limits of its policy, thereby precluding any recovery of SUM benefits by the insureds from it. [In re *Clarendon Natl. Ins. Co. v. Nunez*, 48 A.D.3d 460 (2d Dep't 2008).]

Officer May Not Obtain Uninsured Motorist Benefits After Losing Control Of Her Car Where There Was No Contact With Other Car

A patrol officer responding to a call allegedly lost control of her vehicle on the expressway while attempting to avoid a collision with an unidentified vehicle that had entered the expressway in front of her, but the unidentified vehicle did not make contact with the officer's vehicle. After the insurer denied uninsured motorist benefits based upon the lack of physical contact with the unidentified vehicle, the officer filed arbitration on the issue. The insurer sought a permanent stay of the arbitration, which was granted by the Supreme Court, Erie County. On appeal, the officer argued that there should be coverage because two disinterested eyewitnesses confirmed that an unidentified vehicle forced her to take evasive action to avoid the collision, thereby causing her to sustain injuries. The Appellate Division, Fourth Department rejected that contention, finding that the insurance policy required "physical contact," which required "some physical contact with the unidentified vehicle." [In re *Erie Ins. Co. v. Calandra*, 49 A.D.3d 1237 (4th Dep't 2008).]

Truck Driver Was Not "Occupying" His Vehicle For Purposes Of SUM Coverage

A truck driver was struck by a hit-and-run driver while standing on the street after unloading equipment from a tractor-trailer that was insured by American Home Assurance Company. He filed a supplementary uninsured/underinsured motorist ("SUM") claim with American. American denied the claim, asserting that the truck driver was not covered by its policy because he was not "occupying" the vehicle at the time of the accident. The Appellate Division, Third Department agreed, reasoning that the truck driver's absence from the vehicle "was not intended to be brief" and, moreover, at the time of the accident, he was engaged in instructing another person about the operation of the delivered equipment. Under these circumstances, the appellate court ruled, it was "inescapable" that the truck driver was no longer "occupying" the truck. [*Faragon v. American Home Assur. Co.*, 52 A.D.3d 917 (3rd Dep't 2008).]

Court Finds No Uninsured Motorist Coverage Where Driver Intentionally Struck Someone With Car, But Holds That Other Coverage Is Available

After the driver of a car pleaded guilty to murder in the second degree, admitting that he intentionally had caused another person's death by striking him with an automobile, the automobile insurer argued that it was not obligated to provide coverage under the policy's uninsured motorist endorsement. The Second Department agreed, finding that, because no standard automobile liability policy would have provided coverage to the driver for the injuries he intentionally had inflicted, the insurer was not obligated to provide benefits under the uninsured motorist endorsement. The Second Department also found, however, that there was coverage under the policy's mandatory personal injury protection endorsement and its death, dismemberment, and loss of sight provisions because, from the victim's point of view, the incident that caused his injuries and death was certainly "unexpected, unusual and unforeseen," and was not the result of any "misconduct, provocation, or assault" on his part. [*State Farm Mut. Auto. Ins. Co. v. Langan*, 55 A.D.3d 281 (2d Dep't 2008).]

Miscellaneous

Medical Malpractice Insurance Policy Does Not Cover Claim Alleging Sexual Assault, Even Where It Allegedly Occurred During Thyroid Exam

After the insured doctor was accused of sexually assaulting a nurse employed by the nursing home where he was an attending physician, he referred the nurse's claim to his medical malpractice insurance carrier. The insurer disclaimed coverage, and the insured filed a declaratory judgment action against the carrier. Supreme Court, Ulster County, granted the insurer's motion for summary judgment dismissing the complaint and the plaintiff appealed. The appellate court affirmed, noting that the policy covered only those claims "brought against [plaintiff] because of Professional Services which [he] provided (or should have provided)." It reasoned that the nurse had not alleged such a claim because her complaint described only an alleged sexual assault perpetrated by the doctor as a co-worker while the nurse was performing her duties at her place of employment. In response to the doctor's argument that the nurse had also been his patient in that he had been palpating her thyroid when the alleged attack occurred, the appellate court concluded that the thyroid examination merely provided the occasion for the alleged assault and did not convert plaintiff's alleged acts into professional malpractice. [*Elashker v. Medical Liab. Mut. Ins. Co.*, 46 A.D.3d 966 (3rd Dep't 2007).]

Court Of Appeals Orders Trial Court To Determine Whether Consequential Damages Were Foreseeable Under "Builders Risk Coverage"

The insured, an owner of commercial rental property in Manhattan, had a commercial property insurance policy that included "Builders Risk Coverage" for damage to its property while undergoing renovation. After rain allegedly damaged the building during construction work, the insured filed a claim. The insurer denied the claim, stating that the loss was the result of repeated water infiltration over time and wear and tear rather than from a risk covered under the builders risk policy provision. The insured brought suit, seeking both direct and consequential damages. The Court of Appeals, referring to its decision in Bi-Economy, stated that an insured may be able to recover consequential damages where they were "'within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting.'" Here, the Court found, the lower courts had "failed to consider" whether the specific consequential damages sought by the insured were foreseeable damages as the result of the insurer's alleged bad faith breach of contract. Because the record was not fully developed on that issue, the Court ruled that the claim had to be considered by the trial court. [*Panasia Estates, Inc. v. Hudson Ins. Co.*, 10 N.Y.3d 200 (2008).]

Court Upholds Insurer's Decision To Rescind Policy Based On Allegedly Material Misrepresentations Made In Plaintiff's Insurance Application

The plaintiff sought to recover under its insurance policy with Utica First Insurance Company after its place of business was destroyed by a fire. Following an investigation, Utica notified the plaintiff that it was not entitled

to coverage for the loss and that it was rescinding the policy from its inception based upon allegedly material misrepresentations made in the plaintiff's insurance application with respect to the plaintiff's claims history. The plaintiff sued.

The court found that Utica had met its burden of establishing misrepresentations as a matter of law such that Utica would not have issued the policy had it known the facts. The court added that Utica did not have to demonstrate that the misrepresentations were willful to rescind the contract; rather, it stated, a material misrepresentation, even if innocent or unintentional, was "sufficient to warrant a rescission of the policy." Finally, the court rejected the plaintiff's contention that Utica was estopped from disclaiming coverage because of an eight-month delay in notifying the plaintiff that it was rescinding the policy. The court concluded that even if Utica's notice of disclaimer was untimely, it was not estopped from rescinding the policy as void ab initio inasmuch as the plaintiff had failed to demonstrate any prejudice based upon Utica's alleged delay in disclaiming coverage. [*Precision Auto Accessories, Inc. v. Utica First Ins. Co.*, 52 A.D.3d 1198 (4th Dep't 2008).]

Court Allows Claim For Consequential Damages Under Environmental Pollution Liability Policy To Proceed

The plaintiff obtained an insurance policy to cover environmental pollution liabilities in connection with its remediation of a contaminated precious metals manufacturing facility. The insurance carrier paid $2 million in claims under the "cost cap" section of the policy, but denied coverage under a different portion of the policy covering third-party claims for clean-up costs. The plaintiff sought recovery for breach of the duty of good faith and fair dealing based upon the insurer's alleged failure to even investigate the claim before denying coverage, and the insurer moved to dismiss.

The Supreme Court, New York County, found that the plaintiff had sufficiently alleged a basis for seeking consequential damages beyond the policy limits for the alleged breach of the duty of good faith. Referring to the New York Court of Appeals' decisions in Bi-Economy Mkt. and Panasia [see New York Insurance Coverage Law Update, March 2008], the court found that the plaintiff had "sufficiently pled, at this early state in the litigation, that consequential damages were within the contemplation of the parties as a probable result of the breach at the time of, or prior to, contracting." The court stated that the purpose of the environmental pollution liability policy was to ensure that the policyholder "had the financial support to conduct and finish the remediation," and that an insurer in such circumstances could contemplate damages to the plaintiff's business if the insurer breached its obligations to timely investigate in good faith and pay covered claims. It then concluded that the plaintiff had "sufficiently alleged a claim for consequential damages." [*Handy & Harman v. American Int'l Group, Inc.*, 2008 NY Slip Op. 32366(U) (Sup. Ct. N.Y. County Aug. 25, 2008).]

Insurer's Request For Protective Order Limiting Discovery Is Granted

In an action for a judgment declaring that the defendant insurer was obligated to defend and indemnify the plaintiff in an underlying personal injury suit, the insurer appealed from an order that denied its motion for a protective order limiting discovery in the coverage action. The Appellate Division, Second Department, ruled that a protective order should have been issued with regard to demands seeking documents as to past and current litigation involving the interpretation of certain terms in policies issued by the insurer because they were "overly broad and would be unduly burdensome to comply with." The court concluded that the documents also "would be of questionable relevance to the present case or would likely be privileged or confidential." [*Greenman-Pedersen, Inc. v. Zurich Am. Ins. Co.*, 54 A.D.3d 386 (2d Dep't 2008).]

Court Finds More Significant Contacts Were With Connecticut Than New York, And That Connecticut's Law Governs

After a personal injury lawsuit involving a woman who was injured after exiting an elevator in a building in Hamden, Connecticut, was settled for $2.5 million, Liberty Surplus Insurance Company brought an action in a New York court against two other insurers. Liberty contended that the insurers had wrongly refused to defend Home Properties Apple Hill and Home Properties, Inc., in the personal injury lawsuit. The two insurers moved to dismiss, arguing that New York law applied to Liberty's complaint.

The court found that Connecticut was the principal location of the insured risk because the elevator company's operations at the Connecticut building were insured under each policy; the personal injury action was litigated in Connecticut; and the risks for which the additional insureds sought coverage arose from the elevator company's work for them at the Connecticut building. Moreover, Liberty asserted that Apple Hill's principal place of business was in Hamden. Finding that the more significant contacts here were with Connecticut, and rejecting the argument that New York's interest in regulating the conduct of its resident insurers warranted the application of New York law, the court ruled that Connecticut law governed Liberty's claims. [*Liberty Surplus Ins. Corp. v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 20 Misc.3d 1128A (Sup. Ct. N.Y. County 2008).]

Prompt Disclaimer Requirement Of Insurance Law § 3420(d) Does Not Apply to Title Insurance Dispute, Second Department Rules

After his claim under a title insurance policy was dismissed, the claimant appealed, asserting that the title insurer had failed to promptly disclaim coverage. The claimant premised his argument on case law discussing the prompt disclaimer requirement of Insurance Law § 3420(d). The Second Department found that the claimant's position was "without merit," explaining that the requirements of Insurance Law § 3420(d) were "expressly limited to claims for bodily injury or death arising out of accidents" and had "no application to other claims such as the title dispute in this case." [*Doyle v. Siddo*, 54 A.D.3d 988 (2d Dep't 2008).]

"Staged Accident Defense" Permitted To Go To Trial Even Where Insurer Had Not Presented A "Strong Case" Of A Staged Accident

A medical service provider moved for summary judgment after showing that it had properly submitted bills to a No Fault insurer and that the insurer had failed to pay or deny the claim within 30 days. The court denied the motion, stating that although it did not believe that the insurer had presented a "strong case of a staged accident," it had presented "enough inconsistencies" to rise above the base level of "unsubstantiated hypothesis and suppositions" so as to permit this defense to go to trial. The evidence included statements of the assignors that, although unsworn and unsigned, were certified by a transcriber and the signed and sworn affidavit of a representative of the insurer's Special Investigations Unit that memorialized inconsistencies in the various assignors' statements, including the color and make of the car that was supposedly involved in the accident, different reasons why they were

all together with the same driver, who was seated in the front of the car at the time of the accident and whether the car was stopped at the time of the accident. [*Manhattan Med. Imaging, P.C. v. State Farm Mut. Auto. Ins. Co.*, 20 Misc.3d 1144 (N.Y. Civ. Ct. Richmond County 2008).]

"Negligent Genetic Counseling" Claim Against Physician's Employee Is Not Covered Under Physician's Medical Malpractice Policy

After the plaintiff, an employee of a physician, was sued for "negligent genetic counseling services," she sought coverage under the physician's medical malpractice policy. The policy covered the physician himself and "Vicarious Liability Claims" made against the physician, but stated that it did not provide coverage for the acts of "certain people" for whose conduct the physician was responsible. The exclusions section of the policy identified "certain people" as "Employed Physicians," physician's assistants, specialist's assistants, nurses providing anesthesia services, nurse practitioners, and midwives employed by the physician.

The trial court found that the policy was ambiguous as to whether it covered employees of the physician other than the ones listed in the exclusions section. The appellate court reversed that decision, however, and ruled in favor of the insurer. The appellate court found that the policy's vicarious liability coverage was not ambiguous, and it concluded that coverage for the physician for "[s]ervices which were provided . . . by other people for whose conduct [he was] legally responsible" did not create coverage for those "other people." [*Cohen v. Medical Malpractice Ins. Pool of N.Y. State*, 56 A.D.3d 296 (1st Dep't 2008).]