# New York Insurance Coverage Law Update

# 2016 Compilation

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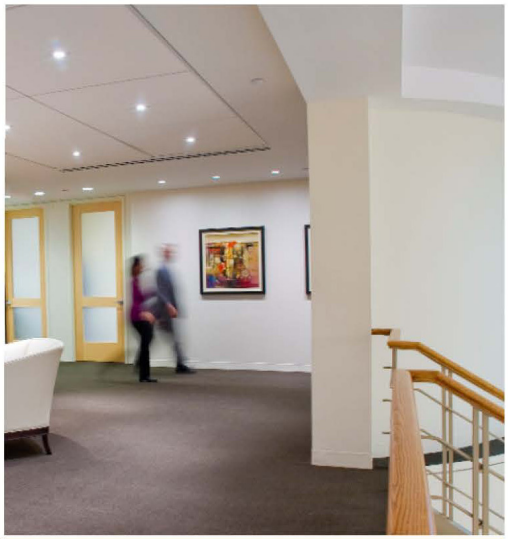

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## ADDITIONAL AND NAMED INSUREDS/CO-INSURANCE

### Landlords' Coverage As Additional Insureds Deemed Primary To Landlords' Own Coverage

Landlords were named insureds under a policy issued by Tower Insurance Company of New York and additional insureds under a policy issued by another insurer to the ground-floor tenant. The tenant's policy provided additional insured coverage to the landlords for "liability arising out of the ownership, maintenance or use of that part of the premises leased" to the tenant. After the landlords were sued over an alleged defect in the sidewalk outside the demised premises, Tower contended that the additional insured coverage was primary. The court agreed, stating that the landlords were covered as additional insureds for "accidents occurring outside the demised premises." The court concluded that the "Other Insurance" clause in Tower's policy stated that it was excess over another policy providing primary coverage to its named insured as an additional insured, and that the other insurer provided such coverage. [*Tower Ins. Co. of N.Y. v. Leading Ins. Group Ins. Co., Ltd.*, 134 A.D.3d 510 (1st Dep't 2015).]

### Only Those With Written Contracts Directly With Named Insureds Were Additional Insureds, First Department Rules

The Dormitory Authority of the State of New York ("DASNY") retained a joint venture ("JV") to provide construction management services for a project in Manhattan. DASNY also entered into a contract with a prime contractor requiring the prime contractor to obtain additional insured coverage for JV. After JV was sued, it sought coverage as an additional insured under a commercial general liability insurance policy issued to the prime contractor that provided additional insured coverage to any "organization with whom you [the prime contractor] have agreed to add as an additional insured by written contract." The Appellate Division, First Department, held that JV did not qualify as an additional insured because the policy required the named insured to have executed a contract with the party seeking coverage as an additional insured. The court concluded that the prime contractor's agreement with DASNY was "insufficient" to afford the JV coverage as an additional insured under the policy. [*Gilbane Bldg. Co./TDX Constr. Corp. v. St. Paul Fire & Marine Ins. Co.*, 143 A.D.3d 146 (1st Dep't 2016).]

### Absence Of Written Contract With Construction Manager Doomed Claim For Additional Insured Status Under Its Insurance Policy

Companies were sued by workers who claimed that they had been injured by toxic material and contaminated air during clean-up and demolition activities at buildings following the 9/11 terrorist attacks in Manhattan. The companies sought coverage as additional insureds from the insurer for the general construction manager overseeing the work. The insurer disclaimed coverage because there was no written contract "executed prior to the occurrence" requiring such additional insured coverage. The court agreed with the insurer, finding that the companies did not have a fully executed agreement with the construction manager. [*Taunus Corp. v. Zurich American Ins. Co.*, 2016 N.Y. Slip Op. 31747(U) (Sup.Ct. N.Y. Cty. Sept. 19, 2016).]

### Hotel Was Additional Insured Even In Absence Of Allegations That Named Insured Had Been Negligent Or At Fault, First Department Says

An employee of Transel Elevator, Inc. allegedly was injured when he lost his footing on a hotel stairway, and he sued the hotel. The hotel's insurer maintained that the hotel was entitled to a defense under a policy issued to Transel, which provided additional insured coverage to the hotel for losses caused by Transel's "acts or omissions" or "operations." The trial court agreed, Transel's insurer appealed, and the Appellate Division, First Department, affirmed. The First Department reasoned that the alleged injuries to Transel's employee resulted from his "acts or omissions" while performing his work, even though he fell on a stairway, not in the elevator that was being repaired. The court noted that the additional insured provision at issue did not depend upon a showing that Transel's conduct had been "negligent or otherwise at fault." [*Aspen Specialty Ins. Co. v. Ironshore Indem. Inc.*, 144 A.D.3d 606 (1st Dep't 2016).]

## CONDITIONS PRECEDENT/LATE NOTICE

### Insurer Did Not Prove Prejudice By Late Notice, Appellate Court Concludes

A passenger in a vehicle was injured when the vehicle was hit from behind. The passenger sought supplemental un-insured/underinsured motorist ("SUM") coverage under her mother's automobile insurance policy. The insurer disclaimed coverage on the ground that the passenger failed to provide timely notice, and the passenger sued. The court held that the insurer failed to demonstrate that it was prejudiced by the untimely notice. The insurer argued that it was prejudiced because it did not have an opportunity to inspect the damage to the vehicles. However, the court opined that the "vehicles would have been repaired in the time between the accident" and when the passenger was "required to give notice" and, therefore, the insurer failed to establish it would have had the opportunity to inspect if provided with timely notice. The court also rejected the insurer's argument that it suffered prejudice because it was unable to conduct an EUO or IME before the passenger underwent surgery, reasoning that the insurer "fail[ed] to establish that the postsurgery examinations" and medical records "will not yield the information sought." [*Slocum v. Progressive Northwestern Ins. Co.*, 137 A.D.3d 1634 (4th Dep't 2016).]

### Insurers Did Not Have To Show Prejudice To Deny First Party Claim After Insureds Provided Late Notice

Nikolai and Harutyun Minasian asserted that their apartment was burglarized and jewelry was stolen. They filed a claim with their insurers 86 days after the alleged loss. The insurers denied coverage based upon the Minasians' breach of the timely notice requirements in their policies, and the Minasians sued. The court granted the insurers' motions for summary judgment. The court found that the 86-day delay was untimely as a matter of law and that the Minasians had no valid reason for the delay. The court rejected the Minasians' argument that the insurers could not rely upon the delay to deny coverage because they had not been prejudiced, concluding that there was no authority in New York for the proposition that the lack of prejudice was a mitigating factor that could itself create or support an excuse for late notice. [*Minasian v. IDS Property Cas. Ins. Co.*, 2015 WL 1782040 (S.D.N.Y. Dec. 9, 2015).]

### No Coverage Under Title Insurance Policy Where Insured Settled Claim Without Insurer's Consent

The insured settled a dispute without obtaining his title insurer's consent and then sought coverage under the policy. The title insurer denied the claim, and the insured sued. The trial court dismissed the complaint and the insured appealed. The appellate court affirmed, reasoning that the insured had breached a policy provision obligating him to obtain the consent of the insurer before settling any claim. [*Bartolomeo v. Fidelity Natl. Tit. Ins. Co. of N.Y.*, 134 A.D.3d 1063 (2d Dep't 2015).]

### Failure To Provide Timely Notice Of Lawsuit Dooms Coverage – Even In Absence Of Prejudice To Insurer

A general contractor provided timely notice to its liability insurer of an alleged accident involving a subcontractor's employee but did not notify the insurer of the lawsuit that was subsequently filed. The contractor's policy was issued before a showing of prejudice was required by New York statute. Even though the insured provided timely notice of the accident, the court ruled that the insurer had no obligation to provide coverage based upon the insured's failure to give timely notice of the lawsuit, without requiring a showing of prejudice. The court distinguished earlier cases involving S.U.M. coverage because a liability insurer is "unlikely to obtain pertinent information through other means." [*Kraemer Bldg. Corp. v. Scottsdale Ins. Co.*, 136 A.D.3d 1205 (3d Dep't 2016).]

### Insurers Could Not Require Bear Stearns To Obtain Their Consent To Settle Because Court Found They Had Effectively Disclaimed Coverage

After Bear Stearns settled Securities and Exchange Commission and New York Stock Exchange regulatory proceedings predicated on allegations that it had facilitated deceptive market timing and late trading activities, it sought indemnification from its insurers. The insurers argued that Bear Stearns was not entitled to indemnification because it had not obtained their consent to settle. The court found that the insurers had effectively disclaimed coverage prior to Bear Stearns' settlement with the SEC. As a result, the court ruled that Bear Stearns was excused from the obligation to obtain its insurers' consent prior to settling and was entitled to enter into a reasonable settlement. [*J.P. Morgan Sec. Inc. v. Vigilant Ins. Co.*, 53 Misc.3d 694 (Sup. Ct. N.Y. Cty. July 7, 2016).]

### Second Department Affirms Judgment Against Insurer Based Upon Inadequate Disclaimer

The plaintiff fell on snow and ice outside her condominium and notified the snow removal company, Florite Maintenance Corp., which notified its insurer. The plaintiff subsequently sued Florite, which did not answer and did not notify the insurer of the suit. Before seeking a default judgment, the plaintiff notified the insurer of the action. In a letter addressed to Florite and copied to the plaintiff's counsel, the insurer notified Florite that it was disclaiming coverage due to Florite's failure to provide timely notice of the lawsuit. The plaintiff was awarded a $3 million default judgment against Florite, and then brought a direct action against the insurer seeking coverage for the unsatisfied judgment. The Appellate Division, Second Department, held that the insurer's disclaimer of coverage was invalid as to plaintiff because it addressed only Florite's failure to provide timely notice of the underlying lawsuit, and not whether the plaintiff's notice to the insurer of her lawsuit had been untimely. Therefore, the Second Department ruled that the insurer was precluded from disclaiming coverage to plaintiff. [*Pollack v. Scottsdale Ins. Co.*, 143 A.D.3d 794 (2d Dep't 2016).]

## COVERAGE GRANT

### Appellate Court Rules That Insureds' Alleged Negligent Handling Of Electronic Data Was Not A Claim For "Property Damage

A computer network used by the operators of fast food restaurants to store customer credit card information was hacked. A bank sued the operators, alleging that they had failed to exercise reasonable care in safeguarding the cardholders' information. The bank's claims were based on losses due to theft and misuse of electronic data and/or electronic vandalism at the restaurants. The court held that the operators' insurer had no duty to defend or to indemnify them under their liability policy because the claims were not for "property damage" and were excluded from coverage. The court noted that the policy defined "property damage" as "physical injury to tangible property" or "loss of use of tangible property that is not physically injured," but the policy stated that "electronic data is not tangible property" and excluded "[d]amages arising out of the loss of … electronic data." [*Rvst Holdings, LLC v. Main St. Am. Assur. Co.*, 136 A.D.3d 1196 (3d Dep't 2016).]

### N.Y. Court Of Appeals Finds That "All Sums" Allocation And "Vertical" Exhaustion Apply In Asbestos Coverage Case Based On Policies' Language

Viking Pumps, Inc. faced significant potential liability in connection with asbestos claims. As its primary and umbrella coverage neared exhaustion, litigation arose regarding whether Viking was entitled to coverage under excess policies issued to Viking by various insurers from 1972 to 1985 and, if so, how indemnity should be allocated across the triggered policy periods. New York's highest court, the Court of Appeals, interpreting the various policies' language, determined that an "all sums" or "joint and several" allocation applied where the excess insurance policies either followed form to a non-cumulation provision or contained a non-cumulation and prior insurance provision (so-called "Condition C"). The Court stated that such an approach permits the insured to collect "its total liability… under any policy in effect during the periods that the damage occurred up to the policy limits." The Court opined that the non-cumulation clauses at issue could not be reconciled with the pro rata allocation approach used by the Court in *Consolidated Edison Co. of N.Y. v. Allstate Ins. Co*., 98 N.Y.2d 208 (2002). Under a pro rata approach, "each insurance policy is allocated a 'pro rata' share of the total loss representing the portion of the loss that occurred during the policy period." The Court concluded that vertical exhaustion was "conceptually consistent with an all sums allocation," permitting the insured to "seek coverage through the layers of insurance available for a specific year." [*Matter of Viking Pump, Inc*., 27 N.Y.3d 244 (2016).]

### No Coverage Where Actions Against Insured Were Based On Its Sales Of Counterfeit Products, Not Its Advertising Activities, Second Circuit Says

After a company sold luxury goods bearing counterfeit Fendi trademarks, the seller was sued and found liable for trademark infringement. The seller's insurer sought a declaration that it did not have to indemnify the company. The U.S. District Court for the Southern District of New York held that the policies did not cover the claims because they were not the result of an "advertising injury." The U.S. Court of Appeals for the Second Circuit affirmed, explaining that the insured did not engage in "any advertising of the counterfeit goods" and that Fendi had not alleged that it had suffered injury because of any "advertising activities" on the insured's part. Rather, the Second Circuit pointed out, Fendi complained that it suffered injury because of the sale of counterfeit goods, and it had been awarded damages based not on the insured's advertising activities, but on its sale of counterfeit products. The Second Circuit concluded that the insured's use of the Fendi mark did not constitute advertising within the insurance policies' definition of "advertising." [*U.S. Fidelity and Guaranty Co. v. Fendi Adele S.R.L*., 823 F.3d 146 (2d Cir. 2016).]

### No Coverage Where Underlying Complaint Alleged That Insured Had Failed To Complete Its Contractual Duties

610 West Realty LLC, the sponsor of a condominium project, sued A-1 Testing Laboratories, a subcontractor, alleging that A-1 had failed to detect that another contractor's work was defective. A-1's insurer asserted that the underlying action was not covered by A-1's policy. The court agreed, stating that there was "no doubt" that 610 West's allegations fell within the "no occurrence, no coverage" rule for commercial general liability policies under New York law. The court found that the allegations related exclusively to A-1's alleged failure to complete its contractual duties and, therefore, did not stem from an occurrence and did not create a reasonable possibility of coverage. It concluded that New York law also was "clear" that recitation of a cause of action labeled "negligence" in an underlying complaint did "not suffice to create coverage for faulty work product." [*Maxum Indemnity Co. v. A One Testing Laboratories, Inc.,* 150 F.Supp.3d 378 (S.D.N.Y. 2015).]

### Insurer Need Not Indemnify Insured For Property Damage Attributable To Periods When Liability Insurance Was Unavailable

Keyspan Gas East Corporation brought a declaratory judgment action seeking indemnification for the costs of environmental clean-up at two gas plants. The Appellate Division, First Department, deciding an issue of first impression in New York State appellate courts, held that the insurer is not obligated to indemnify Keyspan for property damage attributable to time periods when pollution liability insurance was unavailable in the marketplace and Keyspan could not have obtained such insurance even if it had wanted to do so. The First Department reasoned that none of the insurers' policies required the insurer to cover property damage outside of the policy period. The appellate court rejected Keyspan's argument that such a risk should be transferred from policyholders to insurers, concluding that, in the absence of a contract requiring such action, spreading risk "should not by itself serve as a legal basis for providing free insurance to an insured." [*Keyspan Gas E. Corp. v. Munich Reins. Am., Inc.*, 143 A.D.3d 86 (1st Dep't 2016).]

### No Coverage Despite Untimely Disclaimer Where There Was Lack Of Coverage In The First Instance

A subcontractor's employee alleged that he was injured while demolishing a chimney and sued a contractor, which filed a third-party action against the subcontractor. The subcontractor tendered its defense to its insurer. The insurer disclaimed more than two months later on the ground that demolition work was not within any of the four classifications of work covered by the policy. The subcontractor sued the insurer, and the court found that the insurer's disclaimer was not subject to the timeliness requirement of Insurance Law §3420(d) because the insurer did not owe the subcontractor coverage due to "a lack of coverage in the first instance." Because the alleged loss "did not arise from activities within the classifications set forth on the declarations page," the policy did not cover

the subcontractor's alleged liability "under any circumstances," and the court upheld the disclaimer. [*Black Bull Contr., LLC v. Indian Harbor Ins. Co*., 135 A.D.3d 401 (1st Dep't 2016).]

### Prisoners' Class Action Constituted Multiple Occurences, Court Of Appeals Rules

A proposed class action lawsuit was filed against a county in upstate New York after it implemented a policy of strip-searching every prisoner admitted into its jail. The county's insurer agreed to provide a defense, subject to policy limits and the deductible for personal injury damages. The parties agreed to settle for $1,000 for each plaintiff – slightly more than 800 in total. The county contended that it owed its insurer only one deductible because there had been only one occurrence. New York's highest court, the Court of Appeals, disagreed. The Court found that the policies were clear that they covered "personal injuries to an individual person as a result of a harmful condition." Because the harm each plaintiff had experienced was as an individual, each of the strip searches constituted a "single occurrence," the Court concluded. [*Selective Ins. Co. of Am. v. County of Rensselaer*, 26 N.Y.3d 649 (2016).]

### Appellate Court Finds No Coverage For Insured's Own Work Product

Eurotech Construction Corp. was sued and then sued its insurer for a defense and indemnity for the underlying action. The appellate court held that Eurotech was not covered because the claims asserted against Eurotech in the underlying action arose from damage to its own work product – the installation of allegedly defective fire stops and its alleged failure to install wooden sub-flooring – and that there were no allegations in any of the underlying pleadings that Eurotech had caused damage aside from or beyond its own work. The court explained that damage to the insured's own work or product did not constitute "property damage" caused by an "occurrence" within the meaning of Eurotech's policy. [*Eurotech Construction Corp. v. QBE Ins. Corp*., 137 A.D.3d 605 (1st Dep't 2016).]

## DUTY TO DEFEND/INDEMNIFY

### Insurers Not Liable For Insured's Defense Costs Where Policies Did Not Cover Claims Against Insured, Second Circuit Holds

A pipeline control valve failed at an oil transport and storage facility owned and operated by Petroterminal de Panama, S.A.. Petroterminal was sued and sought coverage for its defense costs under a policy that provided coverage for sums "which the insured shall become liable as damages," including defense costs "paid as a consequence of any occurrence covered hereunder." The Second Circuit ruled that the policies did not impose a "duty to defend" on the insurers. Instead, the court held that such language only imposes a duty to pay defense costs where the insurer has a duty to indemnify, not where there are claims "only potentially falling within the policy's coverage." Because the claims were not covered, the insurers were not obligated to pay for Petroterminal's defense, the Second Circuit concluded. [*Petroterminal de Panama, S.A. v. Houston Cas. Co*., 2016 U.S. App. Lexis 16629 (2d Cir. Sept. 8, 2016).]

## EXCLUSIONS

### Contractor or Subcontractor Limitation Precluded Coverage Even If Worker Was Independent Contractor, First Department Holds

A worker, claiming that he had been injured while working, sued the property owners. The property owners' insurer denied that it had a duty to defend or to indemnify them, and the Appellate Division, First Department, agreed. The court reasoned that the worker had been hired either by the property owners or the general contractor and that coverage, therefore, was excluded by the policy's "contractor or subcontractor limitation", which precluded coverage for bodily injury to a "contractor or subcontractor of the insured." That the worker might be an independent contractor did not preclude him from being considered a contractor or subcontractor for purposes of the exclusion, the court concluded. [*Tudor Ins. Co. v. Sundaresen*, 143 A.D.3d 642 (1st Dep't 2016).]

### Assault And Battery Exclusion Precluded Coverage For Claim That Intoxicated Patron Assaulted Another Customer

A patron sued a restaurant, alleging that she had been injured as a result of an altercation with another patron who was intoxicated. The injured patron alleged the restaurant knowingly served an intoxicated person, violated the Dram Shop Act, and negligently supervised its staff. The restaurant's insurer disclaimed coverage, relying on the assault and battery exclusion endorsement in the restaurant's policy. The court agreed with the insurer that coverage was precluded by the exclusion, reasoning that all of the claims asserted in the personal injury action arose out of the assault and/or battery and, therefore, fell within the exclusion. [*Amato v. National Specialty Ins. Co*., 134 A.D.3d 966 (2d Dep't 2015).]

### Insurer Must Provide Defense To Hazing Lawsuit Where Allegations Did Not Fit "Solely And Entirely" Within Policy's Exclusioner

A village in upstate New York sought a declaratory judgment that its insurer was obligated to provide a defense to three volunteer firefighters sued for allegedly forcing sexual acts as part of a hazing ritual. The court granted summary judgment to the village, reasoning that the underlying lawsuit's allegations did not fit "solely and entirely" within the policy's sexual abuse exclusion. The court found that some of the allegations could be "reasonably read" to fall within the policy's definition of "sexual harassment," which was carved out of the sexual abuse exclusion. [*Village of Piermont v. American Alternative Ins. Corp*., 151 F.Supp.3d 438 (S.D.N.Y. 2015).]

### Exclusions Preclude Coverage For Counterclaims Against Lawyer Stemming From Business Venture

A lawyer, who was the president of a company that sought to build and promote an international degree program in China, sued a colleague he worked with on the project. The lawyer alleged that the colleague made false representations that injured the lawyer. The colleague filed counterclaims against the lawyer, who then sued his professional liability insurer, seeking a declaration that the insurer was obligated to defend the counterclaims. The court granted the insurer's motion for summary judgment, finding that the lawyer's actions in his capacity as an officer, partner, and/or manager of the business venture triggered the policy's "capacity" exclusion. It also ruled that the 49 percent equity interest the lawyer and his wife held in the venture triggered the policy's "equity interests" exclusion, rejecting the lawyer's attempt to "feign an issue of fact" by "contradicting prior admissions" in the underlying action. [*Law Offices of Zacahary R. Greenhill, P.C. v. Liberty Ins. Underwriters, Inc*., No. 2016 N.Y. Slip Op. 30078(U) (Sup. Ct. N.Y. Cty. Jan. 7, 2016).]

### Second Department Rejects Application of "Insured Versus Insured" Exclusion

Boro Park Land Co., LLC, leased property to the operator of a nursing home, which obtained an insurance policy that listed Boro Park as an additional insured, as required by the lease. An employee of the nursing home who alleged that she was injured in its parking garage sued Boro Park for negligently maintaining the property. After Boro Park's insurer denied coverage to Boro Park based on the policy's "Insured Versus Insured" exclusion, Boro Park sued. The trial court ruled that the insurer had to defend and indemnify Boro Park, and the Appellate Division, Second Department, affirmed. The appellate court reasoned that the "Insured Versus Insured" exclusion at issue was ambiguous under the circumstances as it was not clear from the exclusion's language whether or not the nursing home's employee was an "insured," and interpreted the exclusion against the insurer. [*Boro Park Land Co., LLC v. Princeton Excess Surplus Lines Ins. Co.*, 140 A.D3d 909 (2d Dep't 2016).]

### "Sewage" Is Pollutant Under Pollution Exclusion, New York Federal Court Rules

Families residing near Love Canal sued Roy's Plumbing, Inc., alleging that its negligence had led to the discharge of hazardous chemicals onto their property and into their homes. Roy's sought coverage from its insurer, arguing that its policy's total pollution exclusion did not apply because at least some of the injuries alleged in the underlying lawsuits were the result of sewage, not hazardous waste. The court ruled that the exclusion applied, reasoning that the "polluting" character of the "contaminated sediment" and "myriad" of "hazardous chemicals" gave rise to the underlying litigation. [*Cincinnati Ins. Co. v. Roy's Plumbing, Inc*., 2016 WL 3212458 (W.D.N.Y. June 10, 2016).

### Class Action Claims Against NASDAQ Stemming From Facebook's IPO Fell Within Policy's "Professional Services" Exclusion, Southern District Decides

Retail investors in Facebook filed a class action lawsuit against NASDAQ in the aftermath of Facebook's troubled initial public offering ("IPO") on the NASDAQ stock exchange. One of NASDAQ's insurers contended that another insurer, ACE American Insurance Company, had to provide indemnity coverage to NASDAQ under its D&O policy in connection with the litigation. ACE argued that the class action fell within the "professional services" exclusion of its policy. The court first ruled that retail investors in a company, such as Facebook, listed on a stock exchange, such as NASDAQ, were "unambiguously" customers or clients of the exchange for purposes of the exclusion. The court then determined that the class action complaint alleged that NASDAQ had failed to adequately render professional services on behalf of its customers. Accordingly, it concluded that the "professional services" exclusion applied to preclude indemnity. The court, however, found that ACE had a duty to defend pending the court's determination of no coverage. [*Beazley Ins. Co., Inc. v. Ace American Ins. Co*., 2016 WL 3842315) (S.D.N.Y. July 12, 2016).]

## AUTO/UNINSURED/UNDERINSURED MOTORIST

### Court Finds That No-Fault Insurer's Lack-Of-Coverage Defense Was Not Subject To Preclusion

A health care provider timely submitted claim forms to recover assigned no-fault benefits from the Motor Vehicle Accident Indemnification Corporation (MVAIC). MVAIC sent verification requests to the wrong address and, after the provider sued, the trial court ruled that MVAIC was precluded from arguing that the provider had not filed a "notice of intention to make claim" form, as required to trigger coverage. The appellate court reversed, ruling that MVAIC's defense of lack of coverage was not subject to preclusion because MVAIC did not have a duty to notify the claimant that the notice had not been timely submitted. [*Apollo Chiropractic Care, P.C. v. MVAIC*, 50 Misc.3d 142(A) (App.Term 2d Dep't Feb. 23, 2016).]

### No-Fault Law Does Not Authorize Payment For OBS Facility Fees, New York's Top Court Rules

A medical doctor billed no-fault insurance carriers for his professional services through Metropolitan Medical and Surgical P.C. and separately billed them for facility fees associated with his office-based surgery ("OBS") services through Avanguard Medical Group, PLLC, a limited liability corporation he owned. According to Avanguard, the OBS facility fees were a charge for the use of the physical location and equipment and also included payment for technicians and medical assistants who helped with the surgical procedures. The insurers paid the doctor's professional fees, but declined reimbursement for the facility fees which exceeded $1.3 million. The insurers sought a declaratory judgment that they were not legally obligated under New York Insurance Law § 5102 to reimburse Avanguard for the OBS facility fees. New York's highest court, the Court of Appeals, agreed with the insurers. The Court ruled that these fees were not expressly permitted by the no-fault law or

its payment schedules and that permitting Avanguard and other OBS centers to collect facility fees would undermine the purpose of the no-fault law "to contain costs by subjecting service charges to statutory ceilings and regulatory-fixed rates." [*Government Employees Ins. Co. v. Avanguard Medical Group, PLLC*, 27 N.Y.3d 22 (2016).]

### Health Insurer That Paid Insured's Medical Bills May Not Demand Reimbursement From Insured's No-Fault Carrier, N.Y. Court Of Appeals Rules

After Luz Herrera was injured in a car accident, her health insurer, Aetna Health Plan, paid bills submitted by her medical providers. Aetna subsequently sought reimbursement from Herrera's no-fault automobile insurer, Hanover Insurance Company, alleging that the bills should have been paid by Hanover. New York's highest court, the Court of Appeals, ruled that Aetna was not entitled to reimbursement. It reasoned that New York's no-fault law and regulations contemplated reimbursement to a health care provider, not to a health insurer. The Court concluded that Aetna could not recover because it was not a "provider of health care services." [*Aetna Health Plans v. Hanover Ins. Co.*, 27 N.Y.3d 577 (2016).]

### Insurer Must Provide "Specific Objective Justification" For EUO Request Upon Provider's Timely Inquiry

Avalon Radiology P.C. submitted no-fault claims to Ameriprise Insurance Company, and the insurer noticed an examination under oath ("EUO") for Avalon. Avalon responded with a letter asking for the good faith, objective reason for Ameriprise's request for an EUO pertaining to Avalon's incorporation and licensure, as well as the basis for suspecting it had engaged in fraudulent behavior. Ameriprise stated that it was not required to provide the justification for its request. Avalon failed to appear at the EUO, its claims were denied, and it sued Ameriprise. The court granted summary judgment to Avalon, reasoning that Ameriprise failed to comply with the no-fault regulations requiring that it provide "the specific objective justification for the EUO request." [*Avalon Radiology, PC. v. Ameriprise Ins. Co.*, 52 Misc.3d 836 (Dist. Ct. Suffolk Cty. June 8, 2016).]

### Second Department Revisits Its Prior Ruling Regarding Calculation Of SUM Benefits

After her husband was killed in a car accident, Maria Sherlock received the $50,000 policy limits from an insurance policy covering the driver of the other car as well as $425,000 from a village's insurance company. Sherlock also sought supple-mental uninsured/underinsured motorist ("SUM") benefits under her auto policy, which had a per person liability limit of $250,000. The insurer denied her claim, asserting that the SUM coverage had been entirely offset by the payments she already had received. The trial court, relying upon a 2012 decision by the Appellate Division, Second Department, ruled in favor of the insurer. Sherlock appealed, contending that Condition 11 ("Non-Duplication") in her auto policy only applied to a duplicate recovery for the same injury. The Second Department agreed with her, concluding that, to the extent its 2012 decision required the amount of SUM coverage to be reduced without regard to the actual value of bodily injury damages that had been suffered, it should no longer be followed. [*Matter of Government Empls. Ins. Co. v. Sherlock*, 140 A.D.3d 872 (2d Dep't 2016).]

### Insurer May Seek EUO Before Receiving Provider's Claim Form, First Department Rules

Balgobin Manoo was allegedly injured in an automobile accident, received treatment from Active Care Medical Supply Corporation, and executed an assignment of benefits in favor of Active Care. Manoo's no-fault insurer requested an examination under oath ("EUO") to confirm the facts and circumstances of Manoo's loss and his treatment. Manoo did not appear for the EUO, and the insurer sought a declaration that it was not obligated to pay Active Care's claim. The trial court denied the insurer's summary judgment motion, reasoning that it had not submitted proof that it received Active Care's NF-3 claim form. The Appellate Division, First Department, reversed, holding that the insurer was entitled to request an EUO before receiving Active Care's NF-3 claim form and, therefore, it could properly deny Active Care's claim based on Manoo's failure to appear. [*Mapfre Ins. Co. of N.Y. v. Manoo*, 140 A.D.3d 468 (1st Dep't 2016).]

### Insurer Demonstrated That It Had Not Insured Vehicle Involved In Accident

A health care provider sued an automobile insurance company, seeking to recover assigned first-party no-fault benefits. The insurer moved for summary judgment, arguing that it had not provided coverage for the vehicle that allegedly was involved in the accident. In support of its motion, the insurer submitted affidavits by its claim litigation representative and products specialist establishing that the vehicle driven by the health care provider's assignor at the time of the accident had not been covered by any insurance policy it had issued. The trial court granted the insurer's motion, and the appellate court affirmed. It concluded that the insurer had demonstrated that the alleged injuries had not arisen out of an insured incident and that the health care provider had not raised a triable issue of fact in opposition. [*Compas Med., P.C. v. Travelers Ins. Co.*, 52 Misc.3d 144(A) (App. Term 2d Dep't Aug. 18, 2016).]

### Trial Court Should Not Have Given Insured Second Chance To Appear At EUO, Appeals Court Declares

After a health care provider sued to recover assigned first-party no-fault benefits, the trial court granted the insurer's motion for summary judgment conditionally dismissing the complaint if the plaintiff's assignor failed to appear for an examination under oath ("EUO") to be "re-notice[d]" by the insurer. The Appellate Division, Second Department, reversed, ruling that upon finding that the insurer had timely and properly denied the plaintiff's claims on the ground that its assignor had failed to appear for duly scheduled EUOs, the trial court should not have given the plaintiff's assignor an

opportunity to cure, but should have granted the insurer's motion for summary judgment "unconditionally." [*Integrative Pain Medicine, P.C. v. Allstate Ins. Co.*, 153 Misc.3d 141(A) (App. Term 2d Dep't Oct. 13, 2016).]

## FIRST PARTY PROPERTY

### No Coverage For Repair Of Code Violations Discovered During Inspection Necessitated By Covered Event, Court Rules

Certain apartments on the upper floors of a cooperative apartment building in Brooklyn were damaged in a flood. While performing repairs, the building owner discovered that concrete slabs under the floors had deteriorated, although not as a result of the flooding. The deteriorated concrete slabs violated New York City's building code and the building owner sought coverage for the cost of repairing them under the "Blanket Ordinance or Law Coverage Endorsement" of the building's property insurance policy. The Appellate Division, First Department, ruled that the endorsement was not triggered under the circumstances "where it is fortuitously discovered in the course of performing remediation of covered property, that structural repairs or modifications are needed to bring the building into compliance with applicable codes." If the rule were otherwise, the appellate court concluded, the insurance company would be liable for the necessary replacement of "shoddy original construction" any time the problem happened to be uncovered in the course of remediating covered property. [*St. George Tower v. Ins. Co. of Greater N.Y.*, 139 A.D.3d 200 (1st Dep't 2016).]

### Policy's One-Year Limitation Period Barred Coverage Suit, Appellate Court Rules

The insured property owner sued its insurer in New York in June 2013, alleging that its property had been damaged over a period of time ending in December 2010. The trial court dismissed the action as time-barred, and the insured appealed. The Appellate Division, Second Department, affirmed, ruling that the lawsuit had been filed after the expiration of the one-year limitation period in the policy. The appellate court rejected the insured's contention that the insurer should be prohibited from asserting the policy's limitation period as a defense because it had engaged in a course of conduct that had lulled the insured into inactivity based on a belief that its claim ultimately would be paid. The appellate court explained that negotiations between an insured and its insurer either before or after expiration of a limitation period contained in a policy was not sufficient to prove waiver or estoppel. [*Botach Mgt. Group v. Gurash*, 138 A.D.3d 771 (2d Dep't 2016).]

### Insured's New York Suit Was Time-Barred, Despite Prior Texas Action

On June 25, 2012, Chandler Management Corporation sued its insurer, First Specialty Insurance Corporation, in a Texas state court, asserting that the insurer had failed to cover storm damage to its property in Texas. The court dismissed the action, finding that Chandler had not complied with the New York forum selection clause in the First Specialty policy. On August 5, 2015, Chandler sued First Specialty in a New York court. The insurer moved to dismiss, asserting that the New York action was time-barred under the 12-month suit limitation provision in the policy. The court granted the motion, finding that Chandler had failed to bring its New York suit within 12 months after the alleged occurrence. It also ruled that even if the Texas action had been timely, Chandler's choice of Texas as a forum violated the New York forum selection clause in the First Specialty policy. [*Chandler Management Corp. v. First Specialty Ins.*, 2016 N.Y. Slip Op. 30823(U) (Sup. Ct. Kings Cty. May 4, 2016).]

### Insurers' Failure To Identify Specific Ground For Disclaiming Did Not Result In Coverage

After heavy rains caused water damage to a commercial property in Nyack and a retaining wall collapsed, the insurers disclaimed coverage and the property owner sued. The trial court, relying upon policy exclusions concerning flood and surface water, ruled in favor of the insurers. The owner appealed, arguing that the insurers did not identify the exclusions in their letter disclaiming coverage, so they could not rely upon them in the coverage action. The Second Department affirmed. The court first ruled that N.Y. Insurance Law § 3420(d) did not apply because the owner's insurance claim did not arise out of an accident involving bodily injury or death. It then decided that the insurers' failure to specifically identify the flood and surface water exclusions in the disclaimer letter did not result in a waiver because "the failure to disclaim based on an exclusion will not give rise to coverage that does not exist." Finally, the insurers were not estopped from relying upon policy exclusions not detailed in their disclaimer letter because the owner failed to show that it had been prejudiced. [*Provencal, LLC v. Tower Ins. Co. of N.Y.*, 138 A.D.3d 732 (2d Dep't 2014).]

### Whether Insured Had Intended Misstatements In Proof Of Loss To Defraud Insurer Was Issue For Trial

A fire damaged a Brooklyn home and the insured submitted a claim to his insurer. The insurer denied the claim and the insured sued. The insurer moved for summary judgment, contending that the insured had violated the concealment or fraud condition of the policy by making certain material misrepresentations in his proof of loss statements. The trial court denied the motion and the insurer appealed. The Appellate Division, Second Department, affirmed. The court reasoned that, although the insured may have given inaccurate information in his proof of loss statements, a triable issue of fact existed as to whether he had intended to defraud the insurer and whether the alleged misrepresentations had been sufficiently material to warrant denial of coverage. [*Walker v. Tighe*, 142 A.D.3d 549 (2d Dep't 2016).]

### Sagging Roof Was Not A Collapse, Court Confirms

The owner of a building in the Bronx sought coverage under its property policy for a damaged roof, claiming it "collapsed," a covered cause of loss under the policy. The court granted the insurer's motion for summary judgment, finding that "no part of the premises fell to the ground" and that there was only "sagging and cracked roof members." [*HB Holdings & Realty Management LLC v. Tower Ins. Co. of N.Y.*, 2016 N.Y. Slip Op. 31857(U) (Sup. Ct. Westchester Cty. Sept. 30, 2016).]

### Policy's Two-Year Suit Limitation Provision Applied To Business Income Coverage, Fourth Department Rules

The insured sought to recover lost rents under an insurance policy providing coverage for, among other things, special business income ("SBI") losses due to the interruption of the insured's business operations arising from a covered direct physical loss of or damage to its property. The trial court denied the insurer's motion for summary judgment, but the Appellate Division, Fourth Department, reversed. The Fourth Department found that the "only fair construction" of the policy was that the two-year suit limitation provision contained in the policy's "Property Choice Coverage Part" was a condition that "unambiguously" applied to the entire coverage part, including the SBI coverage form under which the insured sought to recover. The appellate court concluded that the SBI coverage was not "separate and distinct coverage" falling outside the coverage part to which the two-year limitation period applied. [*Albert Frassetto Enters. v. Hartford Fire Ins. Co.*, 144 A.D.3d 1556 (4th Dep't 2016).]

## WAIVER/ESTOPPEL/3420(d)

### Insurer That Issued Untimely Disclaimer Was Obligated To Pay Default Judgment Against Its Insured

The plaintiff sued the insured, who failed to answer, and the plaintiff obtained a default judgment against the insured. Approximately one year after receiving the default judgment with notice of entry, and nearly three years after learning of the plaintiff's claim, the insurer assigned counsel to represent the insured in a hearing to determine the validity of service of the summons and complaint. After the trial court decided that the insured had been properly served, the insurer disclaimed coverage on the basis of the insured's alleged failure to cooperate. The plaintiff sued the insurer to recover the amount of the unsatisfied judgment and moved for summary judgment. Finding that the insurer failed to adequately explain its delay in issuing its disclaimer, the court ruled that the plaintiff was entitled to summary judgment. The court opined that an insurer must issue a timely disclaimer pursuant to New York Insurance Law §3420(d) even where the insured's own notice to the insurer was untimely. [*Batista v. Global Liberty Ins. Co. of N.Y.*, 135 A.D.3d 797 (2d Dep't 2016).]

### Court Rejects Late Disclaimer Based On Policy Exclusion

New York City was an additional insured under a CGL policy that excluded abuse or molestation, but contained an endorsement restoring such coverage if reported within 60 days of the policy's expiration. More than 60 days after the policy expired, the City notified the insurer of such a claim under the policy. More than six months after it received the City's notice, the insurer disclaimed based upon the exclusion for abuse and molestation. The court ruled that the disclaimer was ineffective, reasoning that the claim was "eliminated from coverage by the exclusion but not added back in by the endorsement, and thus required a [timely] disclaimer." The court also rejected the insurer's argument that the policy's premises limitation endorsement provided a basis to decline coverage, concluding that the City's alleged acts of negligence had been "incidental to" the "use" of the premises designated in the limitation. [*City of New York v. Granite State Ins. Co.*, 136 A.D.3d 523 (1st Dep't 2016).]

## BAD FAITH/EXTRA-CONTRACTUAL

### Private Dispute Over Policy Coverage Did Not Support Insured's GBL § 349 Claim Against Insurer, Fourth Department Rules

A building owner sued its insurance company for deceptive acts and practices under New York General Business Law § 349, alleging that the insurer had retained a non-engineer to conduct an investigation into its claim for damage to its building and had misrepresented the investigator's credentials in disclaiming coverage. The trial court denied the insurer's motion for summary judgment, but the Appellate Division, Fourth Department, reversed. The court ruled that the insurer's allegedly deceptive conduct stemmed from a private contract dispute over policy coverage, and was not "consumer-oriented" such that it impacted consumers at large, as required to assert a valid § 349 claim. [*JD&K Assoc., LLC v. Selective Ins. Group, Inc.*, 143 A.D.3d 1232 (4th Dep't 2016).]

## MISCELLANEOUS

### No Coverage For Crane Damaged By Superstorm Sandy, New York Appellate Court Rules

A 750-foot tall tower crane affixed to a 74-story mixed-use hotel and residential building under construction in Manhattan was dislodged and partially destroyed by Superstorm Sandy. The project's owner and construction manager sued the insurers that had issued a $700 million builder's risk policy. The court held that there was no coverage. It reasoned that the property covered under the policy included "Temporary Works," defined to include structures that were "incidental" to the project." The court found that the crane was "integral" to, and not "incidental" to, the project and, therefore, did not fall within the definition. The court concluded that even if the crane fell within the definition of "Temporary Works," the contractor's tools, machinery, plant, and equipment exclusion would apply to preclude coverage. [*Lend Lease (US) Constr. LMB Inc. v. Zurich Am. Ins. Co.*, 136 A.D.3d 52 (1st Dep't 2015).]

### No Coverage For Contractor Where No Policy Had Been Issued, Notwithstanding Certificate Of Insurance

An employee of Teji Construction, Inc., a subcontractor, sued Vikram Construction, Inc., alleging that he was injured while working. Vikram sought coverage from Atlantic Casualty Insurance Company. Vikram relied on a "certificate of liability insurance" given to Vikram by Teji which said that Teji had liability insurance with Atlantic and that Vikram was an additional insured. After Atlantic denied that a policy was in effect, Vikram sued. The Appellate Division, Second Department, ruled that Atlantic was not obligated to defend or to indemnify Vikram because it had demonstrated that no policy had ever been issued to Teji. The court added that even if the certificate of insurance had raised a triable issue of fact as to whether Atlantic issued a policy to Teji, the effective date on the face of the certificate post-dated the incident upon which the underlying action was based, and Vikram was not entitled to coverage where it was not named as an additional insured as of the date of the accident. [*Vikram Construction, Inc. v. Everest Nat'l Ins. Co*., 139 A.D.3d 720 (2d Dep't 2016).]

### State Attorney General's Letter Was A "Demand" That Precluded Coverage For Subsequent Federal Prosecution

Edward Weaver, the former chief executive officer of Multivend, LLC, sued Axis Surplus Insurance Company for breach of contract, challenging its refusal to provide coverage to him under Multivend's directors and officers liability insurance policy for his criminal prosecution by the United States Department of Justice. The federal district court ruled that the policy excluded coverage for defense of the action because it related to a claim first made prior to the policy's "Pending and Prior Claims Date." Weaver appealed, arguing that the district court erred in finding that a letter that Multivend received from the Securities Division of the Maryland Attorney General's Office was a "demand" within the meaning of the policy. The Court of Appeals for the Second Circuit affirmed, finding that, under New York law, the letter was not just a "mere request for information" but, rather, was a "demand" because it set forth the Securities Division's request for documents under a claim of right and put Multivend on notice of legal consequences for failure to comply. [*Weaver v. Axis Surplus Ins. Co*., 639 Fed. Appx. 764 (2d Cir. 2016).]

### Court Strikes Down Amendment to Workers Compensation Law

In 2013, New York's legislature amended the workers compensation law to remove liability from the state's "reopened case fund" for the payment of workers compensation benefits to certain employees whose cases were closed and later reopened and to impose that liability, instead, on workers compensation insurers. The insurers challenged the law, and the Appellate Division, First Department, struck it down as unconstitutional because the law impermissibly imposed on the insurers "significant additional" retroactive liability. [*American Economy Ins. Co. v. State of New York*, 139 A.D.3d 138 (1st Dep't 2016).]

### Court Reforms Umbrella Policy After Finding That Insurer Failed to Comply With Insurance Law § 3425

For years, the insured maintained his primary automobile insurance policy and umbrella policy with the same insurance company. After he switched his primary auto policy to another insurer, his umbrella insurance company increased the underlying primary limits that the insured needed to maintain. The insured did not raise his limits and, when he was involved in an accident, his umbrella insurer told him that there was a gap in his coverage due to his failure to increase his limits. The insured sued, and the court reformed the umbrella policy to be excess of the insured's original, lower primary limits. The court reasoned that New York Insurance Law § 3425 requires an insurer to notify a policyholder, at least 45 days before the end of the coverage period, of its intention to condition renewal "upon change of limits or elimination of any coverages," and to provide a specific reason for so conditioning renewal. The court held that the umbrella insurer failed to comply with this notice requirement because it did not tell its insured that the required underlying primary limits were being increased. [*Gotkin v. Allstate Ins. Co*., 142 A.D.3d 17 (2d Dep't 2016).]

### Insured Could Not Recover Its Attorneys Fees From Insurer, Fourth Department Decides

A construction company sued its insurer, alleging that it had breached its coverage obligations under a commercial auto insurance policy. The trial court awarded the construction company the attorneys fees it had incurred in prosecuting the action, and the insurer appealed. The Appellate Division, Fourth Department, reversed, citing the "well established" rule that an insured may not recover expenses it incurred in bringing an affirmative action against an insurer to determine its rights under a policy. The court rejected the insured's argument that the attorneys fees were consequential damages resulting from the breach of the insurance policy. [*Zelasko Constr., Inc. v. Merchants Mut. Ins. Co*., 142 A.D.3d 1328 (4th Dep't 2016).]

### Underlying Plaintiff Did Not Have Standing To Appeal Insurer's Default Judgment Against Insured In Coverage Action

Cynthia Smith sued a property owner for injuries she allegedly suffered in a slip and fall on its property. The owner's insurer disclaimed coverage on the basis of untimely notice and filed a declaratory judgment action. The insurer moved for a default judgment against the owner and Smith. The owner did not oppose the motion and Smith did not oppose the insurer's request for a default judgment against the owner. Instead, Smith argued that the action against her should be dismissed as abandoned. The trial court granted the insurer's motion for a default judgment against the owner and dismissed its action against Smith, and she appealed.

The Appellate Division, First Department, observed that Smith could have opposed the insurer's position on coverage, but that she had elected to seek dismissal on procedural grounds. Having been granted the relief Smith sought on her own behalf, the court concluded that she was not an "aggrieved party" and did not have standing to appeal from the order granting the default judgment against the owner. It then dismissed her appeal. [*Hermitage Ins. Co. v. 186-190 Lenox Rd., LLC*, 142 A.D.3d 422 (1st Dep't 2016).]

### District Court Finds In Favor Of Insurers Where Company Failed To Provide Policies Or Evidence Of Their Terms

Troy Belting & Supply Company was sued in lawsuits alleging bodily injury caused by exposure to asbestos from products it allegedly manufactured. After settlements, Troy Belting asserted claims in the United States District Court for the Northern District of New York against insurers it contended had issued insurance policies to Troy Belting. These insurers moved for summary judgment, maintaining that no evidence supported Troy Belting's claim that the insurers provided insurance covering asbestos claims between 1949 and 1974. Moreover, they added, even if Troy Belting had provided some evidence of coverage, it had not provided any information about the terms of the policies, the policy limits, or whether the policies had provided coverage for injuries caused by asbestos exposure. The district court ruled in favor of the insurers, deciding they had no duty to provide coverage to Troy Belting. The court pointed out that no copies of any insurance policies issued by the insurers existed and explained that, even if Troy Belting had produced evidence that created a question of fact as to the existence of a policy, it had not produced sufficient evidence by which a jury could find the terms and conditions of the policy by a preponderance of the evidence. Speculation as to the terms and conditions was "insufficient" to defeat summary judgment, the district court concluded. [*Pacific Employers Ins. Co. v. Troy Belting & Supply Co.*, 2016 U.S. Dist. Lexis 134224 (N.D.N.Y. Sept. 28, 2016).]

### Insureds' Misrepresentation That Property Would Be Their Primary Residence Was Sufficient For Insurer To Rescind Policy, Second Department Decides

Owners of a residential property in Brooklyn procured a homeowners insurance policy, representing that they would occupy the property as their primary residence. After a fire at the property, their insurer discovered that the owners did not occupy the premises as their primary residence and the insurer rescinded the policy. The owners sued, the trial court ruled in favor of the insurer, and the Appellate Division, Second Department, affirmed. The Second Department noted that the owners admitted that, at the time the application was completed, they did not intend to occupy the premises. It then ruled that the representation that the property was an owner-occupied primary residence – even if innocent or unintentional – was a material misrepresentation of a then-existing fact that was sufficient for rescission under New York Insurance Law § 3105. [*Joseph v. Interboro Ins. Co.*, 144 A.D.3d 1105 (2d Dep't 2016).]

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