New York Insurance Coverage Law Update

2017 Compilation

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New York Insurance Coverage Law Update 2017 Compilation

TABLE OF CONTENTS

New York Insurance Coverage Law Update 2017 Compilation

Page

New York Insurance Coverage Law Update 2017 Compilation

ADDITIONAL AND NAMED INSUREDS/PRIORITY

"Contractual Privity" Not Required For Project Consultant To Be "Additional Insured," New York Trial Court Rules

Rockefeller Group Development Corporation, as an agent for 1221 Avenue Holdings LLC, contracted with A. Best Contracting Co., Inc. ("Abestco") to have Abestco perform construction work at 1221 Avenue of the Americas in Manhattan. The contract allegedly required that Abestco name Gordon H. Smith Corporation ("GHS"), the project consultant, as an additional insured on Abestco's general liability policy. An employee of Abestco alleged that he was injured while working at the construction site, and he sued GHS. GHS's insurer sought a declaration that GHS was an additional insured under Abestco's policy, which provided additional insured coverage to any entity Abestco was "required under a written contract with [Abestco] to name as an additional insured." Abestco's insurer moved to dismiss because the contract was not between Abestco and GHS, but the court denied the motion, reasoning that the policy did not restrict additional insured coverage to an entity "in contractual privity with Abestco." [*Valley Forge Ins. Co. v. Arch Specialty Ins. Co.*, 2016 N.Y. Misc. Lexis 4357 (Sup. Ct. N.Y. Cty. Nov. 22, 2016).]

Unsigned Purchase Order Was Written Contract For Purposes Of Additional Insured Endorsement, First Department Decides

A contractor's employee sued the property owner, alleging that he had been injured while working at the property. The contractor's insurer contended that the owner was not an additional insured under a policy providing additional insured coverage where required by "written contract" because the purchase order between the contractor and the owner under which the contractor operated was unsigned. The Appellate Division, First Department, ruled that the owner was an additional insured, reasoning that the unsigned purchase order met the "written contract" requirement. [*Zurich Am. Ins. Co. v. Endurance Am. Specialty Ins. Co.*, 145 A.D.3d 502 (1st Dep't 2016).]

No Additional Insured Coverage For School District That Leased Cafeteria To Insured Where Accident Allegedly Occurred On Exterior Staircase

The Chappaqua Central School District leased the cafeteria in a middle school building to the Chappaqua Children's Workshop, Inc. ("CCW") to use for an after-school program. A CCW employee allegedly was injured when she tripped and fell while descending an exterior staircase that led from the school to the parking lot. The employee sued the District, and the District sought coverage as an additional insured under CCW's policy. The Appellate Division, Second Department, held that CCW's insurer was not obligated to defend or to indemnify the District because the District-lessor was only covered for "liability arising out of the ownership, maintenance or use of that part of the premises leased or rented to [CCW]," the cafeteria. The court opined that there was "no causal relationship between the injury and risk and for which coverage is provided." [*Chappaqua Cent. Sch. Dist. v. Phila. Indem. Ins. Co.*, 148 A.D.3d 980 (2d Dep't 2017).]

Second Circuit Rules That One Policy Providing Additional Insured Coverage Was Excess To Another

A federal district court in New York ruled that an insurance policy issued by Admiral provided primary coverage to certain additional insureds and that the additional insured coverage provided by Liberty was excess. Admiral appealed to the United States Court of Appeals for the Second Circuit, which affirmed. The Second Circuit noted that Liberty's "Other Insurance" provision provided that its additional insured coverage was excess except as to the additional insureds' "own . . . policies" – which, the Second Circuit said, were those policies on which they were named insureds. Therefore, the Second Circuit concluded, Liberty's additional insured coverage was excess to the primary additional insured coverage provided by Admiral's policy. [*Liberty Ins. Corp. v. Admiral Ins. Co.*, 688 Fed. Appx. 91 (2d Cir. 2017).]

New York Court Of Appeals Limits Scope Of Additional Insured Coverage

An excavator contracted with the New York City Transit Authority ("NYCTA") to perform tunnel excavation work on a subway construction project. Its excavation machine touched a live, buried electrical cable, resulting in an explosion and injury to the claimant. The claimant sued the City, which impleaded NYCTA and MTA New York City Transit. The excavator's insurer denied additional insured coverage to NYCTA and MTA, contending that the excavator coming in contact with the cable had not been the proximate cause of the claimant's injury and that NYCTA had been solely responsible for the accident because it had failed to identify, mark or deenergize the cable. The New York Court of Appeals agreed with the insurer and ruled that NYCTA and MTA were not entitled to additional insured coverage under the excavator's policy, which limited additional insured coverage to "liability" for bodily injury "caused, in whole or in part," by the "acts or omissions" of the named insured. The Court reasoned that the additional insured coverage applied to injury "proximately caused by the named insured." The Court expressly rejected an "arising out of" or "but for" causation interpretation of the policy language and found that the lower court had "erroneously interpreted this policy language as extending coverage broadly to any injury causally linked to the named insured, and wrongly concluded that an additional insured may collect for an injury caused solely by its own negligence, even where the named insured bears no legal fault for the underlying harm." [*Burlington Ins. Co. v. N.Y.C. Transit Auth.*, 29 N.Y.3d 313 (2017).]

No Additional Insured Coverage Where Alleged Accident Occurred Off Leased Space

An employee of Linea 3 allegedly was injured in the parking lot while walking from his car to space Linea leased in a building owned by Atlantic Ave. Sixteen AD, Inc. The employee sued Atlantic, which sought additional insured coverage under Linea's policy. The Appellate Division, Second Department, held that Atlantic was not covered as an additional insured, reasoning that the additional insured coverage was for "liability arising out of the ownership, maintenance or use of that part of the premises" leased to Linea. The court added that Linea leased only a portion of the building from Atlantic, not the parking lot where the accident allegedly occurred, and that Linea had no duty to maintain the parking lot. As such, the court concluded, there was no causal relationship between the alleged injury and the risk for which additional insured coverage had been provided to Atlantic. [*Atl. Ave. Sixteen AD, Inc. v. Valley Forge Ins. Co*., 150 A.D.3d 1182 (2d Dep't 2017).]

Agreement To Name Party As Additional Insured Was Not Agreement To Assume Liability In Tort For That Party, Fourth Department Says

Several employees of J.M. Pereira & Sons, Inc., were allegedly injured or killed while working with waterproofing products produced by RPC, Inc. The injured employee and the estates of the two deceased employees sued RPC, which in turn commenced a third-party action against J.M. J.M.'s insurer disclaimed coverage to J.M. based upon an exclusion for bodily injury to J.M. employees. The insurer maintained that the exception to the exclusion for liability assumed by J.M. "under an insured contract" did not apply because there was no contractual indemnity agreement between RPC and J.M where J.M. assumed the tort liability of RPC. The Appellate Division, Fourth Department, agreed with the insurer. Although J.M. and RPC had submitted evidence that there was a contract between them requiring J.M. to name RPC as an additional insured on J.M.'s insurance policies, the court found that an agreement to name a party as an additional insured was "not an agreement to assume liability in tort for that party." [*Erie Ins. Exch. v. J.M. Pereira & Sons, Inc.*, 151 A.D.3d 1879 (4th Dep't 2017).]

CONDITIONS PRECEDENT/LATE NOTICE

Court Holds Insurer Did Not Establish Insured's Failure To Cooperate

An insurer's disclaimer based on the insured's lack of cooperation was challenged in court. The Appellate Division, Second Department, found that the insurer made diligent efforts that were reasonably calculated to obtain its insured's cooperation. However, the court ruled that the disclaimer could not be enforced because the insurer had not demonstrated that its insured's conduct constituted "willful and avowed obstruction." [*Matter of Gov't Empls. Ins. Co. v. Fletcher*, 147 A.D.3d 940 (2d Dep't 2017).]

Endorsement Precluded Coverage For Construction Worker's Suit Against Property Owner, Federal Court Decides

A contractor's employee sued the owner of property where he was allegedly injured. The property owner's insurer sought a declaration that it had no duty to defend or to indemnify the property owner. The court ruled in favor of the insurer. The court explained that the policy's "independent contractors or subcontractors conditions" endorsement provided that the insurer was not liable for coverage unless the contractor carried insurance that covered the property owner as an additional insured. The court found that the contractor had no such insurance, and that the mere fact that the property owner had been listed as an additional insured on the contractor's certificate of insurance was insufficient to confer additional insured status on the property owner. The court also ruled that the insurer's disclaimer, which it issued 29 days after it learned of the grounds for disclaiming, was timely. "Disclaimers issued within one month are timely as a matter of law," the court concluded. [*Am. Safety Cas. Ins. Co. v. 385 Onderdonk Ave., LLC*, 249 F.Supp.3d 629 (E.D.N.Y. 2017).]

Insurer Failed To Demonstrate Insured's Noncooperation, Second Department Rules

The claimant sued ML Specialty Construction, Inc., alleging that her property had been damaged by construction work performed by ML on a neighbor's property. ML's insurer retained counsel to defend ML. The insurer disclaimed coverage on the ground that ML stopped cooperating after five years, and ML's counsel withdrew from the case. ML defaulted, the claimant obtained a judgment against ML, and the claimant then filed a direct action against ML's insurer seeking coverage for her judgment against ML. The trial court denied the insurer's motion for summary judgment, and the Appellate Division, Second Department, affirmed. The Second Department ruled that the insurer had not met its "heavy burden" of demonstrating ML's noncooperation with admissible evidence. The appellate court opined that most of insurer's proof regarding ML's alleged affirmative refusal to cooperate was inadmissible hearsay, and that the investigator's affidavit as to its inability to obtain ML's cooperation was conclusory. [*DeLuca v. RLI Ins. Co.*, 153 A.D.3d 662 (2d Dep't 2017).]

COVERAGE GRANT

Claims-Made Policy Afforded Insured 60 Days After End Of Term To Notify Insurer

An employee of New York Institute of Technology ("NYIT") sued NYIT for defamation on February 26, 2009, and NYIT received notice of the action on August 6, 2009. NYIT's claims-made-and-reported insurance policy ended on September 1, 2009. NYIT notified its insurer of the employee's action on

September 15, 2009. The insurer disclaimed coverage on the ground that NYIT failed to report the claim during the policy period, NYIT sued, and the insurer moved to dismiss. The court denied the insurer's motion. It ruled that NYIT's notice was timely because the policy should have afforded NYIT an additional 60 days at the end of the policy term to notify the insurer of the employee's suit under New York law, notwithstanding that NYIT first received notice of the suit during the policy period and not during its extended reporting period. [*N.Y. Inst. of Tech. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 2017 N.Y. Misc. Lexis 646 (Sup. Ct. N.Y. Cty. Feb. 23, 2017).]

Alleged Abuse In Foster Home Over Many Years Constituted Multiple Occurrences

Ten individuals who had been placed as foster children in a woman's home sued the Roman Catholic Diocese of Brooklyn, alleging that they had been abused there over many years. Insurers contended that there were multiple occurrences triggering separate self-insured retentions, and the court agreed. Applying New York's "unfortunate event test" in the absence of controlling policy language, the court ruled that the alleged incidents of abuse suffered by each of the underlying claimants constituted multiple occurrences. The court concluded that there was at least one "occurrence" per claimant per policy period because the injuries allegedly suffered by each claimant were unique to that claimant in a given policy year and caused by separate incidents. [*Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Roman Catholic Diocese of Brooklyn*, 2017 N.Y. Misc. Lexis 687 (Sup. Ct. N.Y. Cty. Feb. 27, 2017).]

Insurer Had No Duty To Defend County In Civil Rights Suit, Second Department Decides

After Dewey Bozella's second murder conviction was overturned based on newly discovered evidence that allegedly should have been disclosed to his defense counsel by the district attorney's office, he sued the county for allegedly violating his civil rights. The county's insurer disclaimed coverage, and the county asked a court to declare that the insurer was obligated to defend and indemnify it in connection with Bozella's suit. The trial court ruled in favor of the insurer, and the Appellate Division, Second Department, affirmed. The Second Department explained that Bozella alleged that the evidence had been withheld from 1977 through 2008. The court concluded that there was no coverage under the public officials liability coverage part of the policy because the alleged wrongful acts had occurred "in part" prior to the policy's retroactive date of October 1, 1999. It also found no coverage under the policy's law enforcement liability coverage part, as the wrongful acts allegedly had been committed prior to the policy's effective date of October 1, 2009. [*County of Dutchess v. Argonaut Ins. Co.*, 150 A.D.3d 672 (2d Dep't 2017).]

"Vertical Exhaustion" Of Primary Policies Triggered Excess, But Excess Policies' Prior Insurance Provision Limited Insured's Recovery, Second Circuit Holds

Olin Corporation, a chemical manufacturer, contended that an excess insurer that had issued three consecutive annual policies had to indemnify it for environmental contamination that had taken place over a number of years at several manufacturing sites. The excess insurer argued that, under "horizontal exhaustion," Olin's primary policies had not been exhausted and, therefore, its excess policies had not been triggered. The United States Court of Appeals for the Second Circuit disagreed, reasoning that the New York Court of Appeals' decision in *In re Viking Pump, Inc.*, 52 N.E.3d 1144 (N.Y. 2016), dictated "vertical exhaustion" because the excess insurer's policies called for an "all sums" allocation. As such, the excess insurer's policies were triggered. The Second Circuit also ruled, however, that the excess insurer's policies' prior insurance provision applied to any other excess policy issued within the same layer, and not just a prior policy it had issued, thereby reducing the limits of its policies by those of any prior policies covering the same loss. As a result, the Second Circuit concluded, Olin could not recover multiple times for a single loss by pursuing multiple insurers within the same layer of coverage. [*Olin Corp. v. OneBeacon Am. Ins. Co.*, 864 F.3d 130 (2d Cir. 2017).]

Loss From Spoofed Email Was Covered As Computer Fraud, District Court Decides

An employee in the accounts payable department of Medidata Solutions, Inc., received a phone call from a person who identified himself as a Medidata attorney and advised her to process a wire transfer to him. After the employee received an email that she believed to be from Medidata's president authorizing the wire transfer, she logged onto the online system of Medidata's bank and wired $4,770,226 to the bank account to which she had been instructed to send the money. Medidata later learned that it had been defrauded, and that the company's president had not sent the email approving the transfer. Medidata sought coverage under the computer fraud section of its insurance policy. Its insurer denied the claim on the basis that there had been no "computer fraud", defined as "fraudulent entry of [d]ata into Medidata's computer system." Medidata sued and moved for summary judgment. The United States District Court for the Southern District of New York granted Medidata's motion. The district court reasoned that the fraud on Medidata had been achieved by entry into Medidata's email system with a spoofed email armed with a computer code that masked the thief's true identity. The thief's computer code also changed data from Medidata's president's true email address to achieve the email spoof. The district court also found that the Medidata employee had initiated the transfer as a direct result of the thief sending a spoofed email posing as Medidata's president. Accordingly, the district court concluded, Medidata had demonstrated that its losses had been a direct result of

"computer fraud." [*Medidata Sol., Inc. v. Fed. Ins. Co.*, 2017 U.S. Dist. Lexis 122210 (S.D.N.Y. July 21, 2017).]

Appellate Division Rules That Policy Covered Loss Caused By A Defect That Began Before Policy's Effective Date

The insured made a claim under its insurance policy for losses that resulted when a power-generating turbine was taken out of operation due to excessive vibrations. The vibrations were found to have been caused by a crack in the turbine's rotor. The insurer denied the claim on the ground that the crack had begun to form before the policy's inception. A trial court ruled in favor of the insured, and the Appellate Division, First Department, affirmed. The appellate court decided that because there was no provision in the policy that excluded physical loss or damage originating prior to the commencement of the policy period, the policy covered the loss. [*Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. TransCanada Energy USA, Inc.*, 61 N.Y.S.3d 4 (1st Dep't 2017).]

No Coverage For Home Not "Residence Premises"

After the trustees of a trust that owned a residence in Brooklyn were sued, the insurer that issued a homeowners insurance policy for the property disclaimed coverage. The New York trial court agreed that there was no coverage under the policy for several reasons, including that (1) the trustees did not live at the property at the time of the alleged loss, as required by the policy's definition of "residence premises"; (2) the property was a three-family dwelling and thus was not a covered "residence premises"; and (3) the trust was not an insured on the policy. The court also refused to reform the policy to include the trust as an insured because the insurer did not insure premises owned by trusts and, therefore, could not have intended to do so. [*CastlePoint Ins. Co. v. Atkins*, 2017 N.Y. Misc. Lexis 3675 (Sup. Ct. N.Y. Cty. Sep. 25, 2017.]

DUTY TO DEFEND/INDEMNIFY

Court Rejects Insurers' Defenses To Coverage For Bear Stearns' Settlement With SEC

Bear Stearns agreed to pay $250 million to resolve claims by the Securities and Exchange Commission that it had facilitated its customers' late trading and market timing practices in its performance of clearing services on their behalf. Of that amount, part was labeled "disgorgement" and another part was deemed a penalty. Bear Stearns asked the court to order its insurers to indemnify it for the disgorgement payment. The court ruled that the disgorgement payment was a covered "loss" because it represented the gains of Bear Stearns' customers and not profits for Bear Stearns. The court also rejected the insurers' contentions that public policy, and the wrongful act and "personal profit" exclusions, barred indemnification and that the settlement was unreasonable. [*J.P. Morgan Sec. Inc. v. Vigilant Ins. Co.*, 57 Misc.3d 171 (Sup. Ct. N.Y. Cty. 2017).]

EXCLUSIONS

No Coverage For Insured Who "Created" Loss By Wiring Funds To Settlement Agent Who Allegedly Misappropriated Them, Second Department Declares

The insured sought coverage under a title insurance policy for losses it allegedly suffered when a settlement agent misappropriated funds he had been directed to use to pay off a prior mortgage. The title insurer denied the claim based upon a policy exclusion for any loss "created, suffered, assumed or agreed to by the Insured Claimant." The Appellate Division, Second Department, upheld the denial. The court held that the insured created the loss because it had wired funds to its settlement agent, whose acts in allegedly misappropriating the funds were imputed to the insured. [*Plaza Home Mtge., Inc. v. Fidelity Nat'l Title Ins. Co.*, 145 A.D.3d 1048 (2d Dep't 2016).]

New York's Top Court Rules That Contractor's Tools Exclusion Did Not Render Coverage "Illusory"

A construction manager contended that the contractor's tools exclusion in a builder's risk insurance policy should not be enforced because it rendered illusory coverage granted under the policy's temporary works provision. New York's highest court, the Court of Appeals, ruled that the exclusion did not render coverage illusory because it did not defeat *all* of the policy's coverage for temporary works and did not create a result that "would have the exclusion swallow the policy." [*Lend Lease (US) Constr. LMB Inc. v. Zurich Am. Ins. Co.*, 28 N.Y.3d 675 (2017).]

"Auto" Exclusion Precluded Coverage For Employee's Injuries

An employee of Truck-Rite Distributions Systems Corp. alleged that he was injured while unloading a shipping trailer leased to Truck-Rite when a lift gate failed and he fell. The court ruled that there was no coverage for the claim under a truckers policy issued to Truck-Rite because of the exclusion for bodily injury "arising out of" the use, including the loading and unloading, of autos operated by or rented or loaned to Truck-Rite. The court ruled that the fact that the employee's injury allegedly had been caused by the defective nature of the trailer lift did "not remove the injury from the policy exclusion." [*Country-Wide Ins. Co. v. Excelsior Ins. Co.*, 147 A.D.3d 407 (1st Dep't 2017).]

Exclusion For Any "Employment-Related Wrongful Act" Barred Coverage For FLSA And Labor Law Claims

Plaintiffs alleged that Vannguard Urban Improvement Association, Inc. and the chair of Vannguard's board of directors violated the federal Fair Labor Standards Act or New York Labor Law in a variety of ways. The board chair sought a defense under Vannguard's directors and officers liability policy. Vannguard's insurer denied the claim based on the policy's exclusion

for "any employment-related Wrongful Act." The court ruled that the exclusion "unambiguously" encompassed claims regarding violations of wage laws and retaliation for complaints about violations of wage laws. The court concluded that it was "clear" that the policy did not insure against the "employment-related" claims raised by the plaintiffs in the underlying action. [*Hansard v. Fed. Ins. Co.*, 147 A.D.3d 731 (2d Dep't 2017).]

Exclusion Trumped General Provisions, Third Department Finds

A bar was sued by a patron allegedly injured by the bar's employee. The bar's insurer disclaimed coverage based on the policy's assault and battery exclusion. The exclusion stated that it was "subject to the terms contained in the General Liability Coverage," and provided that "[n]otwithstanding anything contained herein to the contrary," the policy excluded "claims arising out of any assault, battery, fight, altercation, misconduct or other similar incident." The bar sued its insurer, and the trial court granted summary judgment in favor of the insurer. The Appellate Division, Third Department, affirmed. The bar argued that the exclusion was ambiguous because the general terms of the general liability coverage provided coverage for reasonable force but the exclusion did not. The Appellate Division disagreed, ruling that the terms of the general liability coverage applied "except as altered by the words" of the exclusion - which precluded coverage. [*Graytwig Inc. v. Dryden Mut. Ins. Co.*, 149 A.D.3d 1424 (3d Dep't 2017).]

Assault And Battery Exclusion Precluded Coverage For Negligence Claims Based On Alleged Assault, Federal District Court Rules

Eduardo Rojas' estate sued the owner, lessees, and operators of a New York City nightclub, alleging that Rojas had been killed by club patrons while waiting to enter the club and that the defendants had negligently failed to provide proper security. The club's insurer sought a declaration that it had no duty to defend or to indemnify any of the defendants based upon the policy's assault and battery exclusion for bodily injury arising out of any assault or battery. The United States District Court for the Eastern District of New York granted summary judgment in favor of the insurer. The court explained that the exclusion applied because the underlying negligence claim would not exist "but for" the alleged assault perpetrated against Rojas. [*Northfield Ins. Co. v. Queen's Palace, Inc.*, 252 F.Supp.3d 161 (E.D.N.Y. 2017).]

Sewage Is Pollutant For Purposes Of Pollution Exclusion, Second Circuit Rules

After Roy's Plumbing, Inc., was sued in connection with alleged chemical contamination at Love Canal near Niagara Falls, New York, it contended that it was entitled to defense and indemnification from its insurer. The United States District Court for the Western District of New York ruled that the insurer had no such duty, and the Second Circuit affirmed. The court decided that sewage was a contaminant for purposes of the "broad definition" of "pollutant" in the policy's pollution exclusion. The court rejected Roy's Plumbing's argument that the pollution exclusion was overbroad and, therefore, ambiguous. [*Cincinnati Ins. Co. v. Roy's Plumbing, Inc.*, 692 Fed. Appx. 37 (2d Cir. 2017).]

Despite Hazardous Materials Exclusion, Fourth Department Finds Duty To Defend Complaint Alleging Foul Odors

The operators of a recycling facility were sued for allegedly allowing hazardous materials and substances to contaminate the surrounding neighborhood. The operators also allegedly "caused a malodorous condition." The operators' insurer contended that its policy's hazardous materials exclusion precluded coverage for the claims asserted against the operators. The Appellate Division, Fourth Department, found a duty to defend based on a "reasonable possibility of coverage." The court reasoned that the alleged foul odors were "not always caused by the discharge of hazardous materials." [*Hillcrest Coatings, Inc. v. Colony Ins. Co.*, 151 A.D.3d 1643 (4th Dep't 2017).]

Employer's Liability Exclusion Did Not Bar Coverage, Second Circuit Says

An employee of Universal Photonics, Inc. ("UPI"), sued Hastings Development, LLC, a subsidiary of UPI, alleging that he had been injured while operating Hastings' machine in Hastings' building. Hastings tendered the action to its commercial general liability insurer, which disclaimed based upon the policy's employer's liability exclusion for bodily injury to "an employee of the Named Insured." Hastings was one of the named insureds on the policy. The court held the exclusion did not apply under the circumstances because a reasonable reading of the exclusion was that it applies where the bodily injury is to an employee of the Named Insured seeking coverage, and the bodily injury was not to Hastings' employee. [*Hastings Dev., LLC v. Evanston Ins. Co.*, 701 Fed. Appx. 40 (2d Cir. 2017).]

Federal Court Deems Employment-Related Practices Exclusion Ambiguous Under Circumstances, Denying Insurer's Summary Judgment Motion

The former chief executive officer of American Apparel, Inc. sued Standard General L.P., a New York-based investment firm, for, among other things, defamation, false light, "unfair business acts," and "false advertising." Standard General's insurer denied coverage, and Standard General sued. The United States District Court for the Southern District of New York held that the lawsuit did not involve covered "advertising injury." However, the court found that the action triggered the coverage for "personal injury" and that the employment-related practices exclusion did not preclude a duty to defend. The court found that the exclusion did not clearly apply under the circumstances where there was no employment relationship between the insured and the allegedly injured party. [*Standard Gen. L.P.*

v. Travelers Indem. Co. of Conn., 261 F.Supp.3d 502 (S.D.N.Y. 2017).]

"Insured v. Insured" Exclusion Precluded Coverage For Former Board Member's Suit, Second Circuit Decides

A corporation's former board member sued the company's board and obtained judgment. The board members assigned their rights under a directors and officers insurance policy to the former board member. He then sued the insurer, which maintained that coverage for his suit against the board was precluded by the policy's insured-versus-insured exclusion. The United States District Court for the Eastern District of New York agreed with the insurer, and the United States Court of Appeals for the Second Circuit affirmed. The Second Circuit rejected the former board member's contention that the exclusion applied only to claims brought by directors in their capacity as directors and ruled that, on its face, the exclusion applied to all claims (except employment-related claims) regardless of whether the director brought the claims in an individual or fiduciary capacity. [*Intelligent Digital Syst., LLC v. Beazley Ins. Co.*, 2017 U.S. App. Lexis 18273 (2d Cir. Sep. 19, 2017).]

Pending/Prior Claims Exclusion Precluded Coverage For SEC's Investigation, Federal Court Decides

On December 15, 2009, the Securities and Exchange Commission began investigating a private investment firm. The SEC requested documents in 2010 and more documents in May and June 2011, and then issued a subpoena dated July 1, 2011 pursuant to a formal order of investigation. The SEC issued another subpoena on February 27, 2012 and, on March 30, 2015, the SEC instituted an administrative and cease-and-desist proceeding against the firm. The company sought a defense from its insurer under its directors and officers liability policy that was bound in August 2, 2011, and its insurer denied the claim on the ground that the policy's "pending and prior claims" exclusion precluded coverage. The United States District Court for the Southern District of New York upheld the denial, finding that the July 1, 2011 subpoena, the SEC's formal order of investigation, and the SEC's underlying investigation of the firm, analyzed "separately or collectively," constituted a claim that was pending before the inception of the insurance policy and, therefore, was excluded from coverage. [*Patriarch Partners, LLC v. AXIS Ins. Co.*, 2017 U.S. Dist. Lexis 155367 (S.D.N.Y. Sep. 22, 2017).]

"Carrier for Hire" Exception To "Dishonest Acts" Exclusion Applied, Second Circuit Rules

The insured contracted with a shipping company to move its products to its Manhattan retail store, but the products were stolen while at the shipping company's warehouse. The insurer denied coverage for the insured's claim, asserting that the "dishonest acts" exclusion applied. In response, the insured argued that the "carrier for hire" exception to the dishonest acts exclusion applied, and the United States District Court for the Southern District of New York agreed. The United States Court of Appeals for the Second Circuit affirmed. The Second Circuit noted that the shipping company was registered as a carrier for hire and concluded that the theft of the insured's products from the shipping company's warehouse did "not alter the fact" that it had been in the shipping company's custody for purposes of the exception. [*Warehouse Wines and Spirits v. Travelers Prop. Cas. Co. of Am.*, 2017 U.S. App. Lexis 18239 (2d Cir. 2017).]

"Action Over Exclusion" Precluded Coverage For Subcontractor's Suit Against Prime Contractor, Federal Court Decides

A subcontractor's employee sued the prime contractor on a construction project for injuries he allegedly sustained when he fell from a ladder at the site. The prime contractor sought defense and indemnification from the subcontractor's insurer as an alleged additional insured. The insurer disclaimed coverage under its policy's "Action Over Exclusion," which precluded coverage for claims arising out of bodily injury to an employee of the named insured while arising out of employment by the named insured. The United States District Court for the Southern District of New York held that the exclusion applied to preclude coverage. The district court also decided that the insurer's disclaimer to the prime contractor was timely. The court explained that an insurer did not have to disclaim for purposes of New York Insurance Law section 3420(d) as to a particular insured until that insured had given notice of its claim. The district court concluded that the prime contractor's tender to the subcontractor was not sufficient to put the insurer on notice of the prime contractor's claim for coverage as an additional insured, and that the insurer timely disclaimed after it first received notice directly from the prime contractor. [*Century Sur. Co. v. EM Windsor Constr. Inc.*, 2017 U.S. Dist. Lexis 196190 (S.D.N.Y. Nov. 29, 2017).]

AUTO/UNINSURED/UNDERINSURED MOTORIST

No SUM Benefits For Person Injured Walking To Parked Car, Second Department Decides

The plaintiff alleged that he was walking across the street to his parked car; he remotely unlocked it; and he was "half a step" away when he was struck by a vehicle driving by. He sought supplementary uninsured/underinsured benefits. The insurer denied his claim, reasoning that he was a pedestrian and was not occupying the insured vehicle at the time of the accident. The Appellate Division, Second Department, affirmed summary judgment to the insurer, reasoning that the accident occurred as the plaintiff was walking back across the street and had not yet reached the insured vehicle. His "mere intent to enter" the insured vehicle was deemed insufficient to show that he had been an "occupant" at the time of the accident, the Second Department concluded. [*J. Lawrence Constr. Corp. v. Republic Franklin Ins. Co.*, 145 A.D.3d 761 (2d Dep't 2016).]

Auto Insurer Could Not Retroactively Rescind Auto Policy Under Georgia Or New York Law, Second Department Says

A health care provider sued an automobile insurer, seeking to recover assigned first-party no-fault benefits. The insurer contended that it had retroactively rescinded the policy under Georgia law after discovering that the assignor had lived in Brooklyn and had garaged the vehicle there, not in Georgia. The Appellate Division, Second Department, rejected the insurer's arguments, ruling that both Georgia and New York prohibited the retroactive rescission of an automobile insurance policy issued to a natural person for a private passenger vehicle. [*JCC Med., P.C. v. Infinity Grp.*, 2016 N.Y. Misc. Lexis 4714 (2d Dep't 2016).]

No-Fault Insurer Timely Requested EUO Of Provider After Conducting Assignor's EUO, Court Rules

On December 19, 2013, after receiving a health care provider's bills requesting payment of assigned no-fault benefits, the insurer conducted a timely examination under oath ("EUO") of the assignor. On January 9, 2014, believing that the assignor's testimony raised questions regarding the accuracy of the provider's claims, the insurer requested that the provider appear for an EUO. The provider failed to appear, and the insurer sent a second letter requesting that it appear for an EUO on February 18, 2014. The provider again failed to appear, and the insurer denied its claims on February 20, 2014. The provider sued, arguing that the insurer had not timely mailed its request for an EUO of the provider within 15 days of its receipt of the provider's claims. The court ruled that the insurer's EUO request of the provider had been timely. It explained that the 15 days within which a no-fault insurer must request an EUO of the provider started anew after it completed the assignor's EUO and discovered the need for an EUO of the provider. The court concluded that the decision to conduct the EUO of the provider was based on "new information" and, therefore, was a "new verification request." [*Sure Way NY, Inc. v. Travelers Ins. Co.*, 56 Misc.3d 289 (Civ. Ct. Kings Cty. 2016).]

MVAIC Had No Obligation To Pay Health Care Provider Without Proof That Its Assignor Was A New York Resident

A health care provider sued the Motor Vehicle Accident Indemnification Corporation ("MVAIC") to recover assigned first party no-fault benefits. MVAIC argued that it was not liable to the provider because it had not received proof that the provider's assignor was a New York resident at the time of the accident, and also had not received proof that the provider's assignor had exhausted his remedies against any other available insurance coverage. The court dismissed the health care provider's complaint, explaining that proof that the claimant was a resident of New York is a condition precedent to no-fault benefits from MVAIC and the health care provider did not demonstrate the unavailability of other insurance coverage. [*Advanced Chiropractic of N.Y., P.C. v MVAIC*, 2017 N.Y. Misc. Lexis 2842 (App. Term 2d Dep't July 21, 2017).]

Sharply Divided New York Court Of Appeals Rules Upon Policy's "Hired Auto" Coverage And New York Insurance Law Section 3420's "Issued or Delivered" Requirement

Claudia Carlson was killed when her car was hit by a truck owned by MVP Delivery and Logistics, Inc., and driven by its employee who was on a personal errand. MVP and DHL Worldwide Express, Inc., were parties to a cartage agreement under which MVP used its fleet of trucks and employees as an independent contractor to perform DHL's package delivery services in Western New York, but there was evidence that DHL may have exercised control over MVP's trucks/deliveries. Carlson's husband obtained a judgment against MVP and its driver and sought coverage directly from DHL's auto insurers under DHL's auto policies. The policies included "hired auto" coverage covering DHL and others (as "insureds") using covered vehicles "hired" by DHL with DHL's "permission." The Appellate Division, Fourth Department, granted the insurers' motion to dismiss on the grounds that the MVP truck was not a "hired" vehicle and DHL could not grant "permission" to use it. However, the Court of Appeals reversed, finding, among other things, that "the degree of control exercised by DHL over MVP's trucks is pivotal to the determination of whether they are hired autos," and this "fact-specific" issue and others must be resolved by the trier of fact, not on a motion to dismiss.

The Court of Appeals also ruled that section 3420(a) & (b) of the New York Insurance Law permitted a direct action against DHL's insurer that issued a policy to DHL's predecessor at its headquarters in Washington that was later assumed by DHL in Florida. The Court held that section 3420, which applies to policies "issued or delivered" in New York, applies to a policy covering an insured and risks located in New York, even if the policy was not sent to the insured in New York. The Court concluded that this standard was met because DHL "has a substantial business presence and creates risks in New York." The Court said it is "even clearer" that "DHL purchased liability insurance covering vehicle-related risks arising from vehicles delivering its packages in New York, because its insurance agreements say so." (The dissent opined that the policy was not "issued or delivered" in New York as that phrase is ordinarily understood, and posited that the majority's ruling would "wreak havoc" because of the frequency with which that phrase is used in the New York Insurance Law, including when identifying policies potentially triggered by Section 3420(d)'s timely disclaimer requirement. The dissent also opined that the MVP vehicle was not a "hired auto" used with DHL's "permission" under "settled principles of insurance law", including because MVP was an independent contractor.) [*Carlson v. Am. Int'l Grp., Inc.*, 2017 N.Y. Lexis 3280 (N.Y. Nov. 20, 2017).]

FIRST PARTY PROPERTY

Insureds' 86-Day Delay In Notifying Insurers Of Alleged Burglary Doomed Their Claim, Second Circuit Says

The insureds sued their insurer, alleging that it had breached their policies by failing to pay for losses resulting from an alleged burglary of their property. The United States District Court for the Southern District of New York granted summary judgment in favor of the insurer, finding that the insureds had not provided timely notice of their alleged loss as required by their policies. The insureds appealed and the United States Court of Appeals for the Second Circuit affirmed. The court explained that the policies required that the insureds provide notice of loss to their insurers "as soon as reasonably possible," "immediate[ly]," and "as soon as practicable." The Second Circuit noted that the alleged burglary occurred on January 1, 2014 and that the insureds had learned of it that day, but that they did not notify their insurers until March 28, 2014. The Second Circuit held that the 86-day delay was "unreasonable as a matter of law," and that the insureds' alleged lack of sophistication did not excuse the delay. [*Minasian v. IDS Prop. Cas. Ins. Co.*, 676 Fed. Appx. 29 (2d Cir. 2017).]

Federal District Court Dismisses Homeowner's Lawsuit Against Insurer Filed Outside Limitations Period

A homeowner submitted a claim to her insurance carrier for damage to a retaining wall on her property. The insurer disclaimed coverage, explaining that its policy did not cover damage from earth movement and that all the damage to the insured's property had resulted from earth movement. Almost 10 years later, the homeowner sued the insurer, which moved to dismiss. The United States District Court for the Eastern District of New York granted the insurer's motion. The court explained that the lawsuit was outside both the two year limitation period set forth in the policy and the six year limitation for contract claims under New York law. The court rejected the homeowner's contention that the limitation periods should be tolled or that the insurer should be estopped from relying upon them. The homeowner's claims, the court concluded, were "barred." [*Maniello v. State Farm Fire and Cas. Co.*, 2017 U.S. Dist. Lexis 16450 (E.D.N.Y. Feb. 6, 2017).]

Court Finds Fact Question As To Whether Insureds Resided At Insured Home Destroyed By Fire, Precluding Summary Judgment

While a married couple stayed at the wife's mother's residence to care for her, their two sons, a cousin, and a friend stayed at the couple's home. After their home was destroyed by a fire, the couple's insurer disclaimed, contending that it was not a covered dwelling because the couple had not resided in their home for over two years. The couple sued and the parties moved for summary judgment. The court denied the motions, finding a question of fact as to whether the couple had continued to "reside" at the insured home while they were caring for the wife's mother. [*Harrison v. Allstate Indem. Co.*, 55 N.Y.S.3d 692 (Sup. Ct. Steuben Cty. 2017).]

Second Department Rules That Further Litigation Is Necessary As To Whether Insurer Properly Canceled Policy

After an insurance company sent a notice canceling a commercial insurance policy on a residential rental building to the agent listed in the policy, there was a fire on the top floor of the building. The building owner sued the insurer, asserting that the policy had not been effectively canceled. The building owner argued that the insurer failed to comply with the requirement in New York Insurance Law Section 3426 that the cancellation notice be sent to its "authorized agent or broker." The building owner contended its broker (not the agent on the policy) should have received the notice. The trial court denied the owner's motion for summary judgment, and the Appellate Division, Second Department, affirmed, reasoning that the insurer raised triable issues of fact as to whether the agent listed in the policy was the building owner's "authorized agent or broker." [*GC Clinton, LLC v. Leading Ins. Grp. Ins. Co., Ltd. (U.S. Branch)*, 153 A.D.3d 603 (2d Dep't 2017).]

Federal Court Upholds Insurer's Decision To Void Policy For Material Misrepresentation In Application

An application submitted by the insured's broker for insurance on an apartment building in the Bronx indicated that the building was not vacant and was not undergoing any major renovations. The policy was issued and the building was subsequently vandalized. The owner sought coverage from its insurer, which determined that the building had been vacant and undergoing major renovations at the time of the insurance application. The insurer denied the claim because of the apparent material misrepresentation. The owner sued and the insurer moved for summary judgment. The United States District Court for the Southern District of New York granted the insurer's motion to declare the policy void *ab initio*. The district court ruled that the misrepresentation was material because had the insurer known the property was vacant, it would not have issued the policy pursuant to its underwriting guidelines. The court also rejected the insured's argument that any misrepresentation should be attributed to its broker because the insured retained the broker to fill out the application so "the onus for any mistakes or omissions should fall on the shoulders" of the insured, not its agent. [*866 E. 164th St., LLC v. Union Mut. Fire Ins. Co.*, 2017 U.S. Dist. Lexis 164679 (S.D.N.Y. Oct. 3, 2017).]

WAIVER/ESTOPPEL/3420(d)

Subcontractor's Insurer Could Not Disclaim Coverage Where It Failed To Send Disclaimer Directly To General Contractor

A partially demolished five-story building collapsed, causing debris to fall onto the street, resulting in personal injury actions against the owner of the building and the

general contractor. Just after the collapse, the general contractor's insurer provided notice to the insurer for the demolition subcontractor, demanding that the subcontractor's insurer defend and indemnify the owner and the general contractor. The subcontractor's insurer sent a letter to the general contractor's insurer disclaiming to the general contractor based upon a policy exclusion for "work over 1 story in height." The insurer did not disclaim as to the owner and did not send notice of disclaimer directly to the owner or the general contractor. The Appellate Division, Second Department, ruled that the owner was not entitled to coverage because it did not qualify as an insured, and that New York Insurance Law's timely disclaimer requirement did not apply because the denial was "based on a lack of coverage, rather than on a policy exclusion." However, the court held that the disclaimer as to the general contractor based on the exclusion was defective because it was not sent directly to the general contractor. The court reasoned that although the general contractor's insurer had been acting on its behalf when it sent notice to the subcontractor's insurer, this did not make the insurer the general contractor's agent for all purposes or for the specific purpose of receiving a notice of disclaimer. [*Harco Constr., LLC v. First Mercury Ins. Co.*, 148 A.D.3d 870 (2d Dep't 2017).]

Insurer Timely Disclaimed, Federal Court Concludes

A subcontractor's employee was injured at a job site and sued the general contractor who sought additional insured coverage from the subcontractor's insurer. Thirty-one days later, the insurer disclaimed based on an exclusion in its policy. The United States District Court for the Southern District of New York ruled that the disclaimer was timely under New York Insurance Law Section 3420. The district court reasoned that the insurer had to be given "reasonable time to adequately investigate" the claim to determine whether it wanted to disclaim coverage. The district court referred to a recent case where it held that fifty-five days was reasonable as a matter of law and concluded that "[t]here is no exact number of days that can be said to be reasonable or unreasonable" because the determination is "fact-specific" and "ultimately focuses on whether the investigation was 'used as a dilatory tactic' or was made promptly and in good faith." [*Netherlands Ins. Co. v. United Specialty Ins. Co.*, 2017 U.S. Dist. Lexis 140403 (S.D.N.Y. Aug. 30, 2017).]

Second Circuit Holds Section 3420(d)(2) Does Not Apply To Claims Between Insurers

After the owner and operator of a shopping center were sued for injuries the plaintiff allegedly suffered while walking through a construction site, the general contractor's insurer defended them as additional insureds. The general contractor's insurer then sued a subcontractor's insurer, contending that it had a duty to defend the shopping center's owner as an additional insured. The subcontractor's insurer disclaimed coverage based upon a construction exclusion. The general contractor's insurer contended that the disclaimer was untimely under New York Insurance Law section 3420(d)(2) because it was not issued as soon as was "reasonably possible." The United States District Court for the Southern District of New York rejected that argument, and the general contractor's insurer appealed to the United States Court of Appeals for the Second Circuit. The Second Circuit affirmed, stressing that New York courts have "uniformly" held that section 3420(d)(2) "does not apply to claims between insurers." The general contractor's insurer argued that it was invoking section 3420(d)(2) on behalf of its insureds, but the Second Circuit was not persuaded. The court concluded that the insurer could not invoke the protection of section 3420(d)(2) against a co-insurer even though its insureds may be protected by the statute. [*Zurich Am. Ins. Co. v. Liberty Mut. Ins. Co.*, 2017 U.S. App. Lexis 19618 (2d Cir. Oct. 5, 2017).]

BAD FAITH/EXTRA-CONTRACTUAL

Federal Court Dismisses Bad Faith And Statutory Claims Against Insurer

A building owned by Violet Realty, Inc. was damaged by fire, and Violet sought coverage from its insurance company. The insurer paid $2.2 million for direct losses from the fire. Dissatisfied, Violet sued the insurer for breach of contract and for failure to act in good faith, unfair claim settlement practices in violation of New York Insurance Law Section 2601, and deceptive business practices in violation of New York General Business Law Section 349. The insurer moved for judgment on the pleadings with respect to all but the breach of contract cause of action, and the United States District Court for the Western District of New York granted its motion. The district court dismissed Violet's claim for breach of the covenant of good faith and fair dealing as duplicative of its breach of contract claim. The court found that the insured did not "plausibly claim" that the insurer's delay in payment "created losses which would not otherwise be remedied by a full payment" of the insured's breach of contract claim. The court also dismissed Violet's claim under Section 2601, reasoning that there is "no private right of action" under that law. Finally, the court dismissed Violet's Section 349 claim, concluding that the law did not apply to a dispute "concerning a private insurance contract." [*Violet Realty, Inc. v. Affiliated FM Ins. Co.*, 2017 U.S. Dist. Lexis 138409 (W.D.N.Y. Aug. 28, 2017).]

Court Rejects Surgeon's Bad Faith Claims Against Insurers

After a jury awarded $8.6 million to a couple who sued an orthopedic surgeon for malpractice, the surgeon asserted that his primary and excess insurers had acted in bad faith by failing or refusing to settle the action within the limits of his available insurance during jury deliberations. The

court granted the primary insurer's motion for summary judgment because there had never been an actual opportunity to settle the case within the primary limits at a time when all serious doubts as to the surgeon's liability were removed, and the insurer's conduct did not result in a failure to settle for the insurers' combined limits. The court also granted summary judgment to the excess insurer, finding that the excess insurer's conduct did not cause a lost settlement opportunity. [*Healthcare Prof. Ins. Co. v. Parentis*, 2017 N.Y. Misc. Lexis 3583 (Sup. Ct. Albany Cty. Sep. 21, 2017).]

MISCELLANEOUS

Statutory Damages Paid To Settle FCRA Action Were Compensatory, Not A Penalty, First Department Holds

Insureds settled a putative class action that alleged that their business practices had violated provisions of the Fair Credit Reporting Act ("FCRA"). Their insurer argued that the statutory damages that the insureds had paid to settle the action constituted a penalty, rather than compensatory damages, and were excluded from their insurance policy. The Appellate Division, First Department, rejected that argument, finding it was "clear" that Congress intended the statutory damages provided for by the FCRA to be compensatory, not a penalty. [*Navigators Ins. Co. v. Sterling Infosystems, Inc.*, 145 A.D.3d 630 (1st Dep't 2016).]

Insurer Demonstrated Mailing Of Grace Period Notice, Second Circuit Concludes

An insurer's contention that a life insurance policy had lapsed due to nonpayment of premiums was challenged on the ground that the insurer had not mailed the "Grace Period Notice" required by New York law. The United States District Court for the Eastern District of New York ruled in favor of the insurer, and the United States Court of Appeals for the Second Circuit affirmed. The Second Circuit explained that the insurer had offered evidence regarding its office procedures as proof that the notice had been mailed, including declarations of its director of information technology and director of records management, as well as deposition testimony of the general manager of its mail processor. The Second Circuit found that this was sufficient to create a presumption of receipt of the notice and, in the absence of evidence to rebut this presumption, the insurer had satisfied its mailing obligations. [*Stein v. Am. Gen. Life Ins. Co.*, 665 Fed. Appx. 73 (2d Cir. 2016).]

Rescission Of Policy Did Not Strip Arbitrator Of Jurisdiction

Hereford Insurance Company, as subrogee, filed arbitrations against Infinity Indemnity Insurance Company arising out of payments Hereford made in connection with a collision between vehicles they insured. Infinity argued that it rescinded its policy after the accident so it did not provide coverage on the date of the accident. The arbitrator rejected that argument and made awards in favor of Hereford. Infinity asked the Appellate Division, Second Department, to vacate the awards, contending that the arbitrator had no jurisdiction to decide the issue because its policy had been rescinded. The court rejected Infinity's contention, noting that the jurisdictional defense was not raised by an application for a stay and, therefore, was waived. [*Matter of Infinity Indem. Ins. Co. v. Hereford Ins. Co.*, 149 A.D.3d 1075 (2d Dep't 2017).]

Court Severs Insurance Coverage Action From Main Liability Action

After a worker sued for injuries he allegedly sustained at a construction project, one of the defendants filed a third-party insurance coverage action seeking a declaration that an insurer had a duty to defend and to indemnify it in the main liability action. The trial court granted the insurer's motion to sever the third-party coverage action from the main liability action, holding that it would be "prejudicial" to the insurer to have the issue of insurance coverage litigated with the underlying liability claims. [*Hlinko v. Gold Star Builders, Inc.*, No. 607749-16 (Sup. Ct. Suffolk Cty. May 12, 2017).]

Second Department Rules That Policy Properly Canceled And Not "Divisible"

Antonio Garcia was injured by a vehicle owned by Jeanne Rakowski and obtained a judgment against her. He sought to recover the unsatisfied portion of the judgment from a personal umbrella policy that had been issued to Rakowski, but the insurer contended that the policy had been canceled before the accident for nonpayment of premium. Garcia argued that the $1 million of coverage for which Rakowski had paid a premium was in effect at the time of the accident, and that only the additional $1 million of coverage she had sought, but had not paid for, had been canceled. The Appellate Division, Second Department, disagreed, reasoning that Rakowski's payment of only a portion of her premium for her policy resulted in the insurer's valid cancellation of the policy after the prorated period covered by her partial premium payment had expired. The court concluded that because there was no ambiguity in what Rakowski had contracted for – $2,000,000 in coverage before the policy term began – there likewise was no ambiguity in the insurer's notice of cancellation, which "could only have pertained to Rakowski's coverage of $2,000,000, which was the only coverage the policy provided for the policy period." [*Garcia v. Gov't Empls. Ins. Co.*, 151 A.D.3d 1020 (2d Dep't 2017).]

Owner Who Did Not Reside At Two-Family Home Was Not Covered For Personal Injury Lawsuit

A personal injury lawsuit was filed against the owner of a two-family home who tendered the lawsuit to his homeowners insurer. The insurer learned that the insured owner had not lived at the property for several years before the alleged incident and that tenants lived there. The insurer disclaimed because its policy only covered bodily injury arising out of an insured location, defined as the "residence premises" where "you reside". The insured acknowledged that he did not

live at the home at the time of the alleged incident but claimed that the insurer knew that he had moved because he had sent letters to the insurer from another address. The trial court granted summary judgment to the insurer, reasoning that the insured mailing letters to the insurer from another address did "not create an issue of fact." [*Tower Ins. Co. of N.Y. v. Burrell*, 2017 N.Y. Misc. Lexis 4065 (Sup. Ct. N.Y. Cty. Oct. 18, 2017).]

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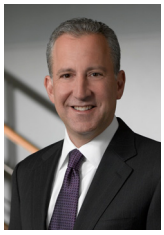

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