New York Insurance Coverage Law Update

2018 Compilation

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ADDITIONAL AND NAMED INSUREDS/PRIORITY

General Contractor Obtains Additional Insured Coverage Under Policy Issued To Subcontractor That Was "Proximate Cause" Of Damage

A fire occurred on the Throgs Neck Bridge while the roadway deck was being replaced. The general contractor sought additional insured coverage under an insurance policy issued to its subcontractor and maintained that the fire damage was "caused, in whole or in part" by the subcontractor's "acts or omissions". The subcontractor's insurer asserted that the general contractor was not entitled to coverage as an additional insured because the fire had been caused by the general contractor's employees who were doing torch work on the bridge and ignited the fire. The court held that the general contractor was covered as an additional insured because the subcontractor was the "proximate cause" of the loss based upon a report by the New York City Fire Marshal. The report concluded that the general contractor might have prevented the initial fire by installing fire treated wood, but the severity of the fire and resulting damage was caused by the explosion of gas that was improperly stored by the subcontractor, not the small fire started by the general contractor. [*E.E. Cruz & Co., Inc. v. Axis Surplus Ins. Co.*, 2017 N.Y. Misc. LEXIS 5137 (Sup. Ct. N.Y. Co. Dec. 20, 2017).]

No Additional Insured Coverage For Suit By Subcontractor's Employee In Absence Of Contract For His Work

A subcontractor's employee alleged that he was hurt while installing exterior finishing known as EIFS at a construction project in Long Island City. He sued the property owner, the original construction manager, and the guarantor replacement manager. They sought additional insured coverage under the subcontractor's insurance policy which provided additional insured coverage "as required by contract" for "liability arising out of" the subcontractor's work for the additional insured. The subcontractor's insurer moved for summary judgment, contending that the work leading to the employee's accident was outside of the parties' contract and, therefore, not covered. The court granted the insurer's motion, reasoning that there was no contract executed prior to the loss pertaining to the subcontractor's EIFS work. [*Pavarini McGovern, LLC v. Geiger Constr. Co., Inc.*, 58 Misc. 3d 1203(a) (Sup. Ct. N.Y. Co. 2017).]

First Department Holds Signed Bid Proposal Enough To Find Additional Insured Coverage For Property Owner

A lawsuit alleging an injury at a construction site was filed against the property owner, which sought additional insured coverage under a contractor's insurance policy. The policy provided additional insured coverage to any "entity required by written contract ... to be named as an insured." The Appellate Division, First Department, ruled that a "Bid Proposal Document" for the project was such a written contract, even though the parties had intended to execute a more formal agreement. The proposal, the court pointed out, named the parties and the "total agreed price," contained the dated signatures of the parties, incorporated by reference "the approved plan for the entire project," and required the contractor to obtain a policy naming the owner as an additional insured. Accordingly, the court ruled, the insurer had to defend and indemnify the owner. [*Netherlands Ins. Co. v. Endurance Am. Specialty Ins. Co.*, 157 A.D.3d 468 (1st Dep't 2018).]

First Department Finds Duty to Defend Additional Insured But Indemnity Premature Because Not Determined That Named Insured Proximately Caused Injury

New York City entered into a construction contract with a joint venture that entered into a subcontract with L&L Painting. Robert Vargas sued all three for alleged bodily injury at the job site, alleging that they operated, maintained, managed and controlled the site and that they were negligent. The City sought a defense and indemnity for Vargas' action as an additional insured under L&L's policy. L&L's insurer maintained that the City was not covered as an additional insured because Vargas' bodily injury was not "caused by" L&L or those acting on its behalf as required by the policy. The Appellate Division, First Depart-ment, held that L&L's insurer had a duty to defend because Vargas' complaint alleged at least the possibility that Vargas' injury was caused by L&L. However, the court found that it was "premature to declare" that the insurer had a duty to indemnify the City because it "has not yet been determined if L&L was the proximate cause" of Vargas' injury, citing the Court of Appeals' recent decision in *Burlington Ins. Co. v. NYC Tr. Auth.*, 29 N.Y.3d 313 (2017).

Finally, the court held that the insurer's late disclaimer did not preclude the insurer from maintaining that the City was not covered as an additional insured, but that the late disclaimer precluded its reliance upon a lead exclusion in the policy. The court noted that the insurer was correct that "when a putative insured first makes a claim for coverage in a complaint, the insurer may disclaim via its answer," but ruled that the City "did not waive" its argument that the disclaimer was untimely by agreeing to extend the insurer's time to answer. [*Vargas v. City of N.Y.*, 158 A.D.3d 523 (1st Dep't 2018).]

First Department Rejects Additional Insured Coverage Where Named Insured's Acts Or Omissions Were Not Proximate Cause Of Injury

A security guard employed by Protection Plus Security Corporation sued the Manhattan School of Music, alleging that he slipped and fell on a recently mopped floor while working at the school. The school sought coverage as an additional insured under the insurance policy issued to Protection. The Appellate Division, First Department, ruled that the insurer did not have to defend or to indemnify the school, citing *Burlington Insurance Company v. N.Y.C. Transit Authority*, 29 N.Y.3d 313 (2017). The court explained that the school was an additional insured "only with

respect to liability for 'bodily injury'. . . caused, in whole or in part, by" acts or omissions of the named insured – Protection – in the performance of Protection's operations for the school. Because Protection's acts or omissions "were not a proximate cause of the security guard's injury," coverage was not available to the school under its policy, the First Department concluded. [*Hanover Ins. Co. v. Philadelphia Indem. Ins. Co.*, 159 A.D.3d 587 (1st Dep't 2018).]

New York Court Of Appeals Rules That Additional Insured Coverage Required Written Contract Between Named Insured And Purported Additional Insured

The Dormitory Authority of the State of New York ("DASNY") entered into separate contracts with a construction manager ("CM") and a general contractor ("GC") for a construction project. DASNY's contract with the GC required the GC to obtain additional insured coverage for the CM. After the CM was sued for an accident at the project, it sought additional insured coverage under the GC's insurance policy. The New York Court of Appeals ruled that the CM was not covered as an additional insured under the GC's policy, which limited additional insured coverage to "any person or organization with whom you [the GC] have agreed to add as an additional insured by written contract." The Court found this language "facially clear," and that it did not provide additional insured coverage unless the CM was an organization "with whom" the GC had a written contract. Because the CM had no written contract with the GC requiring additional insured coverage for the CM, it was not entitled to additional insured coverage under the GC's policy, the Court concluded. [*Gilbane Bldg. Co./TDX Constr. Corp. v. St. Paul Fire and Marine Ins. Co.*, 31 N.Y.3d 131 (2018).]

Court Denies Additional Insured Coverage Because No Written Contract Requiring Such Coverage

Two parties sought additional insured coverage under their contractor's insurance policy, which covered persons or organ-izations who were required under a written contract to be named as additional insureds. The Supreme Court, New York County, ruled that they were not entitled to coverage, finding no written contract that required that they be added as additional insureds. The court noted that the word "insurance" was mentioned in a contract, but that the contract did not state what the insurance was for, who the insurance was supposed to cover, or specifically state that the two parties were to be additional insureds. The reference to the parties in a certificate of insurance was insufficient to confer coverage where the policy itself did not cover them, the court concluded. [*Union Mut. Fire Ins. Co. v. Klein*, 2018 N.Y. Misc. LEXIS 804 (Sup. Ct. N.Y. Co. Mar. 5, 2018).]

Court Finds Additional Insured Entitled To Defense, But Indemnity Decision Premature

A contractor was hired to renovate the second floor of a Brooklyn office building for Touro College. The contractor obtained a commercial general liability insurance policy that named Touro as an additional insured. Touro hired another company to upgrade the security system on the building's second floor. An employee of the security company sued Touro, alleging that he was injured while at the site when improperly stored drywall fell on him. Touro contended that it was entitled to coverage as an additional insured under the contractor's insurance policy because the claimant's alleged injury was "caused, in whole or in part, by" the contractor's acts or omissions. The court ruled that Touro was entitled to a defense as an additional insured under the contractor's insurance policy because the employee's allegations suggested "a reasonable possibility of coverage." However, the court held that it could not resolve whether the insurer had to indemnify Touro until it was determined whether the employee's injuries had been caused in whole or in part by the contractor's "negligence or some other act or omission." [*Touro College v. Arch Specialty Ins. Co.*, 2018 N.Y. Misc. LEXIS 1758 (Sup. Ct. N.Y. Co. 2018).]

Court Holds Additional Insured Not Entitled To Indemnification Without Proof Named Insured Was A Proximate Cause Of Injury

A subcontractor's employee sued the construction manager for a Manhattan project for injuries the subcontractor's employee allegedly sustained while working on the project. The construction manager sought a defense and indemnity as an additional insured under the subcontractor's commercial general liability insurance policy. The insurer disclaimed coverage on the ground that there was no evidence that the employee's alleged injuries were "caused, in whole or in part" by the subcontractor or others acting on its behalf, as required by its policy. The action brought by the subcontractor's employee settled and the construction manager sued the insurer, which argued that it had no duty to indemnify the construction manager for the settlement payment it made to the employee. The trial court ruled that the insurer had to indemnify the construction manager. After the New York Court of Appeals decided *Burlington Ins. Co. v. New York City Transit Authority*, 29 N.Y.3d 313 (2017), holding that "where an insurance policy is restricted to liability for any bodily injury 'caused, in whole or in part,' by the 'acts or omissions' of the named insured, the coverage applies to injury proximately caused by the named insured," the insurer asked the court to reconsider its ruling. The court did so, and it vacated its earlier ruling that the insurer had to indemnify the construction manager. The court explained that it had not been decided whether the subcontractor's acts or omissions were a proximate cause of its employee's injuries. The court opined that the subcontractor's acts or omissions were not necessarily a proximate cause of its employee's injuries simply because the employee worked for

the subcontractor. [*Tishman Const. Corp. of N.Y. v. Scottsdale Ins. Co.*, 2018 N.Y. Misc. LEXIS 1998 (Sup. Ct. N.Y. Co. May 17, 2018.]

Appellate Division Finds Owner Not Entitled To Additional Insured Coverage Under Tenant's Policy For Claim That Did Not Arise Out Of Leased Property

A student sued the owner of a school he attended, alleging that he was injured when he fell while walking down an exterior staircase at the building. The student obtained a default judgment against the owner. The owner was an additional insured under a tenant's insurance policy, and the student sued that insurer to recover the amount of the judgment. The Supreme Court, Kings County, granted summary judgment in favor of the student, and the insurer appealed. The Appellate Division, Second Department, reversed, explaining that the additional insured provision in the tenant's insurance policy provided coverage to the owner as an additional insured "only with respect to liability arising out of the ownership, maintenance or use" of the property leased to the tenant. The Second Department then observed that the tenant did not lease the staircase the student was descending when he allegedly fell, and the student was not the tenant's invitee at the time of the accident. The court concluded that the student's alleged injury was not a bargained-for risk and that the insurer was entitled to summary judgment. [*Lissauer v. GuideOne Specialty Mut. Ins.*, 161 A.D.3d 974 (2d Dep't 2018).]

Insurer Had Duty To Defend Additional Insureds Where Facts Established Reasonable Possibility Of Coverage, First Department Rules

An underlying personal injury action was filed against Alma Tower, LLC and Vordonia Contracting & Supplies Corp., and they filed third-party actions against S&S HVAC Corp., the subcontractor for whom the injured claimant was working. S&S's insurer filed a declaratory judgment action, arguing that it had no duty to defend Alma and Vordonia as additional insureds under S&S's policy because the injury was not proximately caused by S&S. The trial court held that the insurer was obligated to defend Alma and Vordonia in the underlying personal injury action. The Appellate Division, First Department, affirmed, reasoning that Alma and Vordonia "demonstrated that [the insurer] had actual knowledge of facts establishing a reasonable possibility of coverage." The First Department also denied the insurer's request for a stay pending resolution of its separate action to rescind the policy, reasoning that the policy was still in effect when the underlying action was filed. [*Indian Harbor Ins. Co. v. Alma Tower LLC*, 165 A.D.3d 549 (1st Dep't 2018).]

No Additional Insured Coverage For School District Under Named Insured's Policy Where Named Insured Did Not Cause Its Employee's Injury, 4th Department Rules

An employee of a company that contracted to provide janitorial services to a school district was allegedly injured when she slipped on snow or ice in the school parking lot. The injured worker sued the district, which filed a third-party action against the worker's employer. The district sought additional insured coverage under the employer's policy. The Appellate Division, Fourth Department, held that the employer's insurer did not have a duty to defend or to indemnify the district as an additional insured because the employee's injury was not proximately caused, in whole or in part, by the named insured/employer's conduct. The court reasoned that the employer was not responsible for clearing snow and ice from the parking lot and if the contractor told its employee what door to use to exit the school, the instructions "merely furnished the occasion for the injury" but did not cause it. [*Pioneer Central Sch. Dist. v. Preferred Mut. Ins. Co.*, 165 A.D.3d 1646 (4th Dep't 2018).]

CONDITIONS PRECEDENT/LATE NOTICE

Insurer Did Not Induce Insured To File Untimely Suit, Fourth Department Rules

Kotecki's Grandview Grove Corporation, the insured, reported a loss to its insurance broker, which prepared a property loss notice listing the date of loss as June 10, 2013. The insurer investigated the claim, partially denied it in October 2013, and reaffirmed that denial in February 2014. The insurer's correspondence listed the date of loss as June 10, 2013. The insured sued the insurer on June 3, 2015. After learning that the actual date of loss was May 28, 2013, the insurer moved for summary judgment, maintaining that the insured had not commenced its suit within two years of the date of loss as required by the policy. The Supreme Court, Erie County, denied the motion. The Appellate Division, Fourth Department, reversed, finding the insured's lawsuit untimely and that the insured had not been induced by the insurer to refrain from filing a timely suit. The Appellate Division pointed out that the insurer incorrectly listed the date of loss as a result of incorrect information provided by the insured's broker and that the insured was "aware of the actual date of loss." [*Kotecki's Grandview Grove Corp. v. Acadia Ins. Co.*, 158 A.D.3d 1306 (4th Dep't 2018).]

COVERAGE GRANT

Excess Policy Not Triggered, Second Department Decides

Fordham University was sued after a contractor's employee had a fatal accident while working on Fordham's roof. Fordham filed a third-party action against his employer, the contractor, seeking, among other things, common law and contractual indemnification. The contractor was covered under a primary general liability policy for the contractual indemnity claim and a worker's compensation /employer's liability policy for the common law claim. The excess insurer argued that its excess policy could not be triggered because the worker's compensation/employer's liability

policy provided unlimited liability coverage, and the excess policy was expressly excess to the underlying general liability policy and "other insurance." The Appellate Division, Second Department, agreed with the excess insurer that its excess policy was not triggered. [*Arthur Vincent & Sons Constr., Inc. v. Century Surety Ins. Co.*, 156 A.D.3d 853 (2d Dep't 2017).]

Alleged Injury Resulted From "Accident" From Insured's Point Of View, Third Department Rules

The insured alleged that he tried to stop an acquaintance he believed was not fit to drive by placing his foot in the driver's side of the car and grabbing the keys from the driver, but that the driver said that he was going to "cut [the insured's] leg off," "threw the car in drive" and "screeched" away, dragging the insured. The insurer denied the insured's claim for uninsured motorist benefits, asserting that his injuries resulted from intentional acts and, therefore, were not due to a covered "accident". The Appellate Division, Third Department, ruled that, whatever the driver's intent and criminal liability, the incident was "an accident from the insured's point of view," since having his leg trapped and being dragged was "sudden" and "unexpected, unusual and unforeseen." [*Matter of Arbitration between Progressive Advanced Ins. Co. and Widdecombe*, 157 A.D.3d 1047 (3d Dep't 2018).]

Second Circuit Holds Policy's Definition Of "Bodily Injury" Did Not Include Mental Injury Without Independent Physical Injury

The Incorporated Village of Old Westbury filed a declaratory judgment action against its insurer seeking coverage for an underlying action alleging mental injury. The United States Court of Appeals for the Second Circuit held that "mental injury" without physical injury was not covered "bodily injury" under the Village's policy. The policy defined "bodily injury" as including "mental injury . . . resulting from bodily injury." The Second Circuit explained that a 1992 decision by the New York Court of Appeals that held that purely mental injuries were bodily injuries did not govern the Village's claim because that decision interpreted an insurance contract that did not limit coverage for mental injury to mental injury that resulted from bodily injury, and thus allowed the inference that bodily injury and mental injury were distinct under the definition at issue. [*Incorporated Vill. of Old Westbury v. American Alternative Ins. Corp.*, 710 Fed. Appx. 504 (2d Cir. 2018).]

Second Circuit Decides Violation Of Dram Shop Statute Was An "Occurrence"

Central Terminal Restoration Corporation ("CTRC") obtained a temporary license to sell liquor at a fundraising event and allegedly served alcohol to Thomas Gilray on the evening he struck two pedestrians with his vehicle. The pedestrians sued CTRC under New York's Dram Shop statutes, alleging that it served alcohol to Gilray while he was visibly intoxicated. The United States Court of Appeals for the Second Circuit ruled that a violation of the Dram Shop statutes qualified as an "occurrence" or accident under CTRC's commercial general liability insurance policy. The court reasoned that CTRC's intentional selling of alcohol to Gilray did not render the subsequent injuries expected or intended by CTRC. Commercial general liability insurance policies "cover injuries where an accident at issue is the unintended result of an intentional act," the Second Circuit concluded. [*Philadelphia Indem. Ins. Co. v. Central Terminal Restoration Corp.*, 722 Fed. Appx. 79 (2d Cir. 2018).]

Owner Of Three-Family Property Loses Bid For Coverage Under Policy Defining Insured Location As Two-Family Dwelling

Claimant was allegedly injured when she fell in front of a home in Staten Island, and she sued the owner. The owner's insurer disclaimed coverage, and the court granted the insurer's motion for summary judgment. The court explained that the policy excluded coverage for bodily injury arising out of premises that are not an "insured location," defined as the "residence premises," which the policy went on to define as a two-family dwelling where the owner resided in at least one of the family units. The court held that the home was a three-family dwelling rather than a two-family dwelling and, therefore, there was no coverage under the policy. [*Tower Ins. Co. of New York v. Cummings*, 2018 N.Y. Misc. LEXIS 1643 (Sup. Ct. N.Y. Co. May 3, 2018).]

Court Says Insurer Had No Coverage Obligation For Contractual Indemnity Claim, But That It Was Premature To Decide Coverage As To Common Law Indemnity Claim

An employee of Service Star LLC sued Lufthansa Cargo AG for personal injuries allegedly sustained while at work. Lufthansa then sued Service Star for contractual and common law indemnification. The insurer that issued a workers' compensation and employer's liability insurance policy to Service Star asked a New York state court to declare that it had no duty to defend or to indemnify Service Star in connection with Lufthansa's claims. The court agreed with the insurer that the policy's exclusion for liability assumed by a contract precluded coverage for Lufthansa's contractual indemnification claim. However, the court denied as premature the insurer's motion for summary judgment with respect to Lufthansa's common law indemnification claim. The court reasoned that the insurer covered Service Star's liability for common law indemnification, which turned on whether the employee sustained a "grave injury," an issue to be determined in the underlying action. [*Granite State Ins. v. Service Star LLC*, 2018 N.Y. Misc. LEXIS 2589 (Sup. Ct. N.Y. Co. June 20, 2018).]

Third Department Finds Insurer Not Entitled To Summary Judgment Where Insured Intentionally Assaulted Claimant And Allegedly Failed To Properly Maintain Premises

The claimant was assaulted by her then-boyfriend, and he was convicted of several crimes. The claimant sued him, alleging that he negligently rendered her partially incapacitated and that, after she was in this condition, she tripped and fell due to a defective condition on the property. The assailant's insurer disclaimed based on no "occurrence" and intentional acts exclusion in the policy. The Supreme Court, Fulton County, ruled that the insurer did not have to defend or indemnify the insured, but the Appellate Division, Third Department, reversed. The court reasoned that the claimant alleged that, in addition to the injuries she suffered in the assault, she may have suffered additional injuries due to the insured's negligence in failing to maintain the property. [*State Farm Fire and Casualty Co. v. McCabe*, 162 A.D.3d 1294 (3d Dep't 2018).]

Second Circuit Affirms $5.8 Million Award To Insured In Email Spoofing Case

In a summary order, the United States Court of Appeals for the Second Circuit affirmed the decision by the United States District Court for the Southern District of New York awarding Medidata Solutions Inc. $5.8 million in damages and interest. The award came after Medidata sought coverage under a computer fraud provision in its insurance policy for losses it suffered when an employee in its accounts payable department wired $4,770,226 to a bank account after receiving an email she erroneously believed to be from Medidata's president. The district court found that Medidata's losses were a direct result of "computer fraud" that had been achieved by entry into Medidata's email system with a spoofed email armed with a computer code that masked the thief's identity and that changed data from Medidata's president's true email address to spoof the email recipient. The Second Circuit agreed, reasoning that the policy's computer fraud provision covered losses stemming from any "entry of Data into" or "change to Data elements or program logic of" a computer system. The Second Circuit noted that although no "hacking" occurred, the thief "crafted a computer-based attack that manipulated Medidata's email system" and implicated its computer system. The Second Circuit also found that the spoofing attack was the proximate cause of Medidata's loss, concluding that the actions by the Medidata employee to effectuate the transfer were insufficient to "sever the causal relationship" between the spoofing attack and Medidata's loss. [*Medidata Solutions Inc. v. Federal Ins. Co.*, 729 Fed. Appx. 117 (2d Cir. 2018).]

Insureds Not Entitled To Coverage For SEC Disgorgement Payment, First Department Rules

In 2006, the Securities and Exchange Commission notified Bear Stearns that it intended to bring civil proceedings seeking monetary sanctions of $720 million. Bear Stearns agreed to settle by paying, among other things, "disgorgement in the total amount of $160,000,000." Bear Stearns' professional liability insurers denied coverage and Bears Stearns sued. The Appellate Division, First Department, ruled that the SEC disgorgement was an "uninsurable penalty" and not a covered "loss" as defined by the insurance policies. The disgorgement, the First Department explained, was a "punitive sanction intended to deter." In its opinion, to allow a wrongdoer to pass on its loss to insurers – "thereby shielding the wrongdoer from the consequences of its deliberate malfeasance" – undermined this goal and violated the "fundamental principle" that no one should be permitted to take advantage of his or her own wrong. [*J.P. Morgan Sec., Inc. v. Vigilant Ins. Co., 166 A.D.3d 1* (1st Dep't 2018).]

DUTY TO DEFEND/INDEMNIFY

New York Court Of Appeals Holds That Insurer Need Not Indemnify Insured For Property Damage Attributable To Periods When Liability Insurance Was Unavailable

Keyspan Gas East Corporation sought indemnification for the costs of cleaning up environmental contamination caused by two gas plants in New York. The environmental contamination occurred before, during, and after the insurer's policy periods at issue, including during periods when Keyspan claimed it had no insurance because pollution property damage liability was commercially unavailable. The insurer maintained that any covered costs should be allocated pro rata over the entire period during which the property damage at each site occurred and that it was not responsible for the property damage outside its policy periods. Keyspan did not dispute that a pro rata time-on-the-risk allocation applied under the policies, but argued that the insurer's share should not be reduced by factoring in the years in which coverage was unavailable in the marketplace. New York's highest court, the Court of Appeals, rejected Keyspan's argument and held that, under the "pro rata time-on-the-risk" method of allocation, Keyspan, not the insurer, must bear the risk for those years during which coverage was unavailable. The Court pointed out that the policies limited the insurer's liability to "occurrences" happening "during the policy period" and that "it would be incongruous to include harm attributable to years of non-coverage within the policy periods" as it "would effectively provide insurance coverage to policyholders for years in which no premiums were paid and in which insurers made the calculated choice not to assume or accept premiums for the risk in question." [*Keyspan Gas E. Corp. v. Munich Reins. Am., Inc.*, 31 N.Y.3d 51 (2018).]

Second Department Finds Questions Of Fact As To Duty To Indemnify School District And Officials In Religious Discrimination Case

Five students sued a school district and its administrators alleging that they violated the students' civil rights by being deliberately indifferent to anti-Semitic harassment and discrimination perpetrated by other students against them. The district's insurer provided a defense but disclaimed any duty to indemnify. After the parties agreed to settle the students' action for $3,000,000 in compensatory damages and $1,480,000 in attorneys' fees, the insurer asked a court to declare that it was not obligated to indemnify the defendants. The Appellate Division, Second Department, noted that the students alleged that the defendants "deliberately ignored complaints and their own observations of student-on-student anti-Semitic harassment and discrimination or responded in an unreasonable or inadequate manner to such complaints and observations." The court concluded that whether the alleged incidents were covered accidents presented questions of fact that could not be determined on a motion to dismiss. [*Graphic Arts Mut. Ins. Co. v. Pine Bush Cent. Sch. Dist.*, 159 A.D.3d 769 (2d Dep't 2018).]

Stop Work Order Deemed Insufficiently Coercive Or Adversarial To Be A "Suit"

After excavation work began on a property in Manhattan, the New York City Department of Buildings issued a stop work order to the construction manager and property owners because of damage to an adjacent building. The construction manager and owners sought a defense from the commercial general liability insurer of the excavation company, arguing that the stop work order was a covered "suit" seeking "damages" because of "property damage." The court ruled that the stop work order was insufficiently "coercive" or "adversarial" to constitute the functional equivalent of a "suit." The court noted that the construction manager and owners were not directed to perform remediation work and were not advised that they were facing a lawsuit or imminent financial consequences for failing to comply with the stop work order. In the court's opinion, the stop work order was more like "an invitation to voluntary action". Accordingly, the court concluded that the insurer did not have to defend the stop work order. [*Aspen Specialty Ins. Co. v. Zurich Am. Ins. Co.*, 2018 N.Y. Misc. LEXIS 4063 (Sup. Ct. N.Y. Co. Sept. 18, 2018).]

EXCLUSIONS

Auto Exclusion Precluded Coverage For Action By Contractor's Employee, District Court Decides

A contractor's employee allegedly was injured at a construction site while removing ductwork from his employer's truck and delivering it to the construction site. As a result, he sued another contractor. The other contractor filed a contractual indemnity claim against the employer, whose insurer disclaimed coverage, relying upon the policy's auto exclusion. The exclusion precluded coverage for bodily injury arising out of the use, including the loading and unloading, of any auto. The United States District Court for the Eastern District of New York held that the exclusion precluded coverage because the employee's alleged injury occurred during the loading and unloading as the claimant was injured prior to the ultimate delivery of the goods. [*Striker Sheet Metal II Corp. v. Harleysville Ins. Co.*, 2018 U.S. Dist. LEXIS 15892 (E.D.N.Y. Jan. 31, 2018).]

Second Circuit Rules Professional Services Exclusion In D&O Policy Barred Coverage For Facebook Investors' Claims Against NASDAQ

After conducting the initial public offering for Facebook, Inc., the NASDAQ public stock exchange was sued. NASDAQ settled for $26.5 million. An insurer that issued a directors and officers policy to NASDAQ contended that the claims against NASDAQ were excluded by the policy's exclusion for customer claims arising out of the rendering of professional services. A federal district court in New York agreed. NASDAQ appealed to the United States Court of Appeals for the Second Circuit, which affirmed. The Second Circuit reasoned that Facebook's retail investors were NASDAQ's "customers," and that the claims against NASDAQ arose out of NASDAQ providing professional services. [*Beazley Ins. Co. v. ACE Am. Ins. Co.*, 880 F.3d 64 (2d Cir. 2018).]

Absolute Pollution Exclusions Precluded Coverage For Release Of Chlorine Gas, Federal Court Concludes

Ben Weitsman & Son of Scranton, LLC, was sued for injuries allegedly suffered as a result of the release of a "toxic cloud of chlorine gas" from a scrap-metal recycling facility it operated in Scranton, Pennsylvania. Weitsman's insurer denied coverage based on the absolute pollution exclusions in its policies, which precluded coverage for injury from the "release" of and/or "exposure" of pollutants, among other things. The United States District Court for the Northern District of New York granted the insurer's motion for summary judgment, reasoning that the exclusions were "stated in clear and unmistakable language." [*Ben Weitsman & Son of Scranton, LLC v. Hartford Fire Ins. Co.*, 2018 U.S. Dist. LEXIS 22970 (N.D.N.Y. Feb. 13, 2018).]

Court Finds That Professional Services Exclusion Barred Additional Insured Coverage To Property Owner And Contractor

After a worker was fatally injured at a construction site, the owner of the property and a contractor hired by the owner to construct a hotel at the site brought an action seeking additional insured coverage under an insurance policy issued to an engineering consultant. The policy provided additional insured coverage for liability due to the consultant's negligence under its contract, but excluded coverage for bodily injury "arising out of the rendering or failure to render any professional services." The court held that the insurer did not owe additional insured coverage to the owner or contractor because the engineer's consulting work at the project constituted "professional services." [*New York Marine & Gen. Ins. Co. v. American Empire Ins. Co.*,

2018 N.Y. Misc. LEXIS 882 (Sup. Ct. N.Y. Cty. Mar. 13, 2018).]

Exclusions Preclude Coverage For Grubhub's $8 Million Settlement Of TCPA Suit

The plaintiff sued Grubhub Seamless Inc., alleging that it sent unauthorized text messages to thousands of consumers in violation of the Telephone Consumer Protection Act ("TCPA"). The parties settled, with Grubhub consenting to an $8 million judgment payable only from its insurance policy. The plaintiff sued Grubhub's insurer, which moved to dismiss. The United States District Court for the Southern District of New York granted the motion. The court ruled that the plaintiff's claim that Grubhub sent text messages "*en masse* to thousands of customers in violation of the TCPA" was excluded from coverage by the policy exclusion for claims based on an "unsolicited electronic dissemination of . . . communications by or on behalf of the Insured to multiple, actual or prospective customers." The court also decided that the plaintiff's claims were precluded by the exclusion for claims based on any "violation of consumer protection laws," concluding that the TCPA "is a consumer protection statute." [*Flores v. ACE Am. Ins. Co.*, 2018 U.S. Dist. LEXIS 73629 (S.D.N.Y. Apr. 30, 2018).]

Court Holds Pollution And Asbestos Exclusions Did Not Preclude A Duty To Defend Suits For Injuries Sustained During World Trade Center Clean-Up

The owner of a building in lower Manhattan that was damaged on 9/11 was sued by workers for injuries they allegedly sustained in the World Trade Center clean-up. A primary insurer for the building's owner disclaimed any duty to defend on the ground that coverage was barred by pollution and asbestos exclusions. An excess insurer defended the building owner and sued the primary insurer, seeking reimbursement. The court granted the excess insurer's motion for summary judgment. The court found that the primary insurer had not met its "heavy burden" of proving that the dispersal of pollutants "alone" caused the claimants' injuries and ruled that the total pollution exclusion in its policy did not bar coverage in the "unprecedented" situation involving the attack on the World Trade Center. The court also found that the primary policy's asbestos exclusion did not bar coverage, reasoning that the allegations against the building owner asserted exposure to things other than asbestos. Accordingly, the court concluded that the primary insurer had a duty to defend the building owner in the underlying actions. [*National Union Fire Ins. Co. of Pittsburgh, PA v. Burlington Ins. Co.*, 2018 N.Y. Misc. LEXIS 1503 (Sup. Ct. N.Y. Co. Apr. 27, 2018).]

Construction Contractor Exception To Professional Services Exclusion Did Not Apply, Federal Court Rules

The Washington State Department of Transportation ("WSDOT") hired WSP USA, Inc. ("WSP") to evaluate whether to repair or replace a Seattle highway, and its sub-subcontractor drilled and installed several water wells along the highway. Years later, the WSDOT contracted with Seattle Tunnel Partners ("STP") to work on a tunnel project to replace the highway, and STP's tunnel boring machine was allegedly damaged when it struck the steel casing of one of the water wells. STP sued WSP for professional negligence, and WSP's insurer disclaimed based upon a "professional liability" exclusion with an exception for "construction contractor" services. The court granted summary judgment in favor of the insurer, reasoning that WSP's agreements with WSDOT did not require WSP to act in the capacity of a construction contractor. The court added that the exception would not apply even if WSP had been engaged in construction-related services because the exception also required that any such services be "employed ... in connection with your operations in your capacity as a construction contractor." [*Liberty Ins. Corp. v. WSP USA, Inc.*, 2018 U.S. Dist. LEXIS 107896 (S.D.N.Y. June 27, 2018).]

AUTO/UNINSURED/UNDERINSURED MOTORIST

Claimant Loses Bid For SUM Benefits Under Same-Sex Partner's Policy

A claimant injured in a motor vehicle accident sought supplementary uninsured/underinsured motorist ("SUM") benefits under a policy issued to her same-sex partner. The insurer maintained that she was not a "resident relative" of the insured's household on the date of the accident and, therefore, she was not entitled to SUM benefits under that policy. The court agreed with the insurer, reasoning that the claimant and the named insured under the policy were not legally married when the accident occurred. [*Matter of Gov't Employees Ins. Co. v. Minton,* 58 Misc. 3d 601 (Sup. Ct. Suffolk Co. 2017).]

Auto Policy Covers Suit Alleging Passenger Tripped After Bus Arrived At Location, First Department Says

After a bus arrived at its destination, the driver unloaded the luggage. A passenger allegedly tripped while looking for her suitcase and sued the bus company. The Appellate Division, First Department, held that the bus company was entitled to a defense and indemnity under its auto policy which provided coverage for bodily injury caused by an accident and resulting from the ownership, maintenance or use of a covered auto. The appellate court found that the accident resulted from the bus company's use of its bus, regardless of whether the claimant tripped over a suitcase unloaded by the bus driver or tripped on the curb while looking for her suitcase. [*Peter Pan Bus Lines, Inc. v. Hanover Ins. Co.*, 157 A.D.3d 610 (1st Dep't 2018).]

Post-Loss Assignments By Insureds To Auto Body Shop Deemed Valid

An auto body shop sued an automobile insurance company to recover for repairs the shop claimed it made to insureds' vehicles after the insureds assigned their rights to the shop. The insurer moved to dismiss, contending that it had not consented to the assignments by its insureds and, as a result, the shop could not enforce their rights. The court denied the motion, finding the post-loss assignments by the insureds to the auto body shop were valid, reasoning that such post-loss assignments losses do not "materially increase [ ] the risk to the insurer." [*M.V.B. Collision Inc. v. State Farm Ins. Co.*, 59 Misc. 3d 406 (Dist. Ct. Nassau Co. 2018).]

No Coverage For Injury That Allegedly Occurred While Employee Was Loading Parked Truck

An employee of a contractor performing construction at a public school in the Bronx was allegedly injured while loading material onto a parked flatbed truck. He sued the New York City School Construction Authority ("NYCSCA"), which sued the contractor's auto insurer, seeking defense and indemnity. The policy defined "insured" to include an organization with respect to liability for "acts or omissions of any person covered … while driving [the contractor's] covered auto" or anyone else "driving [the contractor's] insured auto" with permission. The court granted the insurer's motion for summary judgment, reasoning that the alleged injury to the employee did not occur while he was "driving" the insured truck. The court was not persuaded by NYCSCA's argument that it had coverage under the policy for injuries occurring while the truck was being loaded and unloaded. The court concluded that even if the policy covered loading and unloading, it did so only for the insured company and not for NYCSCA or any other third party. [*New York City School Constr. Auth. v. New South Ins. Co.*, 2018 N.Y. Misc. LEXIS 5247 (Sup. Ct. N.Y. Co. Nov. 7, 2018).]

FIRST PARTY PROPERTY

Fourth Department Decides That "Surface Water" Exclusion Did Not Bar Coverage For Water Damage To Home

The insureds' home was damaged by water after a water main break on their street. Their insurer denied their claim based on the policy's "surface water" exclusion, and the insureds sued. The trial court granted summary judgment in favor of the insurer, but the Appellate Division, Fourth Department, reversed. The Fourth Department explained that the policy did not define the term "surface water" and stated that it meant "the accumulation of natural precipitation on the land and its passage thereafter over the land until it either evaporates, is absorbed by the land or reaches stream channels." The Fourth Department added that the statement in the policy that the water damage exclusion applied "whether the water damage [was] caused by or result[ed] from human or animal forces or any act of nature" did not change the definition of surface water. The court concluded that the insureds had established as a matter of law that their home was not damaged by surface water. [*Smith v. Safeco Ins. Co. of America*, 159 A.D.3d 1536 (4th Dep't 2018).]

Third Department Finds No Coverage For Water Damage To Building, Rejecting Proposed Expert's Affidavit

An Albany hotel was damaged in August 2011 during Hurricane Irene when wind drove rainwater into the building. The insured filed a claim for the damage, which the insurer denied, citing the policy's wear and tear exclusion. The insured sued and the insurer moved for summary judgment, relying on an expert engineer's affidavit and report. In opposition, the insured submitted the affidavit of a proposed window expert who opined that rain entered the building as a result of high winds, a covered cause of loss. The Third Department affirmed sum-mary judgment to the insurer based upon the wear and tear exclusion, rejecting the affidavit of the insured's proposed window expert as "lack[ing] probative value." The Appellate, Division, Third Department, pointed out that the insured's proposed expert inspected the hotel several years after the hurricane, and added that neither his resume nor his affidavit demonstrated that he had engineering training or specific knowledge or education in identifying the causes of window failure. [*Superhost Hotels Inc. v. Selective Ins. Co. of Am.*, 160 A.D.3d 1162 (3d Dep't 2018).]

Second Circuit Vacates Decision Awarding Summary Judgment To Insurer In Superstorm Sandy Case

After the insured's business was damaged by storm surges caused by Superstorm Sandy, it made a claim under its business property policy. The insurer denied most of the claimed amount, reasoning that storm surge damage was excluded by the policy's flood exclusion. The United States District Court for the Eastern District of New York granted summary judgment to the insurer, and the insured appealed, contending that "windstorm" was a covered peril under the policy and that the anti-concurrent causation ("ACC") clause in the policy's windstorm endorsement encompassed losses caused by storm surge, a wind-driven peril. The United States Court of Appeals for the Second Circuit vacated the district court's decision and remanded the case to the district court to assess whether the ACC clause conflicted with or otherwise created an ambiguity *vis-à-vis* the policy's flood exclusion. The Second Circuit stated that, in making this determination, the district court should "be mindful of well-established precedents" requiring exclusions to be set out in "clear and unmistakable language" and to be accorded a "strict and narrow construction." [*Madelaine Chocolate Novelties, Inc. v. Great Northern Ins. Co.*, 2018 U.S. App. LEXIS 29821 (2d Cir. Oct. 23, 2018).]

Policy Did Not Cover Fire Damage To House Where Owner Did Not "Reside" There

After a fire at his house in Washingtonville, New York, the owner sought coverage for the damage from his insurer. The insurer denied the claim on the ground that the owner did not reside at the house, as required by the policy. The owner sued, contending that he was "at" the property "on a regular basis, including most weekends," and that he "performed construction work" and "stored personal items, fixtures and furniture" there. The court ruled against the owner, reasoning that the standard for determining residency required "something more" than temporary or physical presence and "at least some degree of permanence and intention to remain." The court noted that the owner vacated the house approximately eight years before the loss, leased it to tenants, began a cosmetic renovation project after the tenants' departure, and began using the garage area for storage on an unspecified date. The court pointed out that the owner did not claim that he resided, lived, ate or slept at the house. The court concluded that the owner's "mere future intention" to reside at the house was "insufficient" to satisfy the policy's residence premises requirement. [*Aschmoneit v. Adirondack Ins. Exch.*, 2018 N.Y. Misc. LEXIS 3418 (Sup. Ct. N.Y. Co. Aug. 7, 2018).]

Third Department Finds Coverage For House Fire, Citing Exception To Business Pursuits Exclusion

Several residents were killed in a fire in a house used as a certified respite home for elderly and special needs adults, and the owners of the house were sued. Their homeowners insurer disclaimed coverage, relying on the policy's business pursuits exclusion. Default judgments were entered against the owner insureds, and the plaintiffs sued the insurer under Insurance Law §3420(a)(2). The New York Appellate Division, Third Department, found coverage based on an exception to the business pursuits exclusion for bodily injury resulting from "activities in conjunction with business pursuits which are ordinarily considered non-business in nature." The court reasoned that the impetus for the fire was the act of the insureds' son and other children playing with a gas grill lighter and accelerants. The court opined that the fire would have occurred regardless of the insureds' operation of a respite home and, therefore, the decedents' deaths were not caused solely by acts that fell within the business pursuits exclusion. [*Waddy v. Genessee Patrons Coop. Ins. Co.*, 164 A.D.3d 1055 (3d Dep't 2018).]

Policy Did Not Cover Fire Damage Where Insured Breached Concealment Or Fraud And Cooperation Conditions

After a fire damaged a two-unit residence in Lancaster, New York, the insured sought coverage for the damage from his insurer. The insurer moved for summary judgment, arguing that the insured breached the policy's Concealment or Fraud and Cooperation conditions by misrepresenting his ownership and financial interest in the property. The court granted the motion, reasoning that the insured misrepresented material facts regarding the deed and mortgage in connection with his claimed loss with the intent to defraud his insurer. [*D'Andrea v. Encompass Ins. Co. of Am.*, 2018 U.S. Dist. LEXIS 146446 (W.D.N.Y. Aug. 28, 2018).]

Assignee Of Winning Bid At Foreclosure Sale Not Entitled To Insurance Proceeds For Water Damage To The Property

A bank that was the highest bidder at a foreclosure sale assigned its bid to Wilmington Savings Fund Society, and Wilmington received a referee's deed for the property. After a water pipe burst in the dwelling located on the property, Wilmington claimed that it was entitled to the insurance proceeds under a home-owners policy issued to the original owner. The court granted the insurer's motion for summary judgment, explaining that the insurance policy never insured Wilmington as the new owner of the property. The court noted that Wilmington was not a named insured or additional insured on the policy. The court also noted that Wilmington was not a mortgagee on the property because its insurable interest was extinguished after it obtained title and failed to obtain a deficiency judgment for any debt that may have remained after the foreclosure. [*Wilmington Savings Fund Soc. v. Automobile Ins. Co. of Hartford*, No. 50708/2017 (Sup. Ct. Dutchess Co. Nov. 27, 2018).]

Water Exclusion Barred Coverage For Superstorm Sandy Claim

Superstorm Sandy flooded a catering hall in downtown Manhattan, and the insured made a claim with its insurer for business income loss and damage to business property. Relying on the policy's water exclusion, the insurer denied the claim, and the insured sued. The court granted summary judgment in favor of the insurer, finding that the water exclusion barred coverage. The court reasoned that the exclusion precluded coverage for any loss or damage from flood waters, water driven by wind, and storm surge, all of which resulted from Sandy, causing the damage to the catering hall. The court added that even if an electrical surge was responsible for some of the damage to the catering hall's elevators, the policy made it "clear" that there was no coverage for loss or damage from an excluded cause "regardless of any other cause or event that contributes". Finally, the court rejected the insured's argument that the water exclusion did not apply to coverage under the policy's equipment breakdown endorsement because the endorsement stated that "all exclusions in the Causes of Loss Forms" applied except as otherwise provided in the endorsement. [*Glazier Group, Inc. v. Nova Cas. Co.*, 2018 N.Y. Misc. LEXIS 4591 (Sup. Ct. N.Y. Co. Oct. 5, 2018).]

Insurance Policy For Townhouse Was Void Where Applicants Misrepresented That It Would Be Owner-Occupied, Second Department Rules

The insureds made a claim under their homeowners' insurance policy after a pipe broke and water damaged their townhouse in Monsey, New York. Their insurer discovered that the insureds had never lived at the townhouse and that it was occupied by their daughter and her family. The insurer disclaimed coverage and voided the policy, and the insureds sued. The Supreme Court, Kings County, granted judgment in favor of the insurer, finding that the insureds made material misrepresentations on their insurance application and, therefore, the policy was void *ab initio* and provided no coverage for the insureds' claim. The Appellate Division, Second Department, affirmed. The Second Department reasoned that the insureds' insurance application contained a material misrepresentation regarding whether the townhouse would be owner-occupied and the insurer demon-strated that it would not have issued the policy if it had known that it was not owner-occupied. The Appellate Division, Second Department, rejected the insureds' argument that the insurer had to establish that their misrepresentation was "willful." [*Piller v. Otsego Mut. Fire Ins. Co.*, 164 A.D.3d 534 (2d Dep't 2018).]

WAIVER/ESTOPPEL/3420(d)

Businessowners Policy Did Not Cover Owned Auto, Second Circuit Confirms

After a company-owned van was involved in an accident and the driver of the other vehicle sued, the company sought coverage under its business owners and umbrella insurance policies. The United States Court of Appeals for the Second Circuit found no coverage under the businessowners policy because it did not provide coverage for an owned auto. The court also concluded that the umbrella policy did not afford coverage for an owned auto and that New York's timely disclaimer requirement in New York Insurance Law §3420(d) did not apply because the underlying insurance – the business-owners policy – did not apply to an owned auto. The court reasoned that the auto exclusion in the umbrella policy did not trigger the timely disclaimer requirement because there was no coverage in the first place and the exclusion was "belt and suspenders." [*Citizens Ins. Co. of Am. v. Risen Foods, LLC*, 880 F.3d 73 (2d Cir. 2018).]

Appellate Division Remands Case To Determine If § 3420(d) Triggered By Insured's "Substantial Business Presence" In New York

A subcontractor's employee used the general contractor for alleged injuries sustained while working on a New York City subway station construction project. The subcontractor's insurer disclaimed additional insured coverage to the general contractor based on an exclusion, and the general contractor sought a declaration that the insurer owed it a defense and indemnity. The general contractor asserted that the insurer failed to disclaim within a reasonable time, as required by New York Insurance Law § 3420(d)(2). In response, the insurer argued that § 3420(d)(2) only applies to insurance policies "issued or delivered in New York" and that its policy was not "issued or delivered" in New York because it was a New Jersey insurer and the general contractor was a New Jersey company. The Supreme Court, Bronx County, agreed with the insurer, and the general contractor appealed. The Appellate Division, First Department, reversed. The First Department, citing the New York Court of Appeals' decision in *Carlson v. American International Group, Inc.*, 30 N.Y.3d 288 (2017), opined that the applicability of § 3420(d)(2) in the case depended on (1) whether the policy covers risks in New York, as it did in this case, and (2) whether the insured was located in New York, which required that the insured have a "substantial business presence" in New York. The First Department remanded the case to the trial court to determine whether the subcontractor had a "substantial business presence" in New York. [*Vista Engineering Corp. v. Everest Indemnity Ins. Co.*, 161 A.D.3d 596 (1st Dep't 2018).]

Foreign Risk Retention Group Does Not Have To Comply With New York Insurance Law §3420(d)(2)

A worker allegedly injured while working at a construction project in Brooklyn sued the general contractor, which sought additional insured coverage under an insurance policy issued to a subcontractor by a risk retention group ("RRG") organized under Montana law. The RRG disclaimed coverage but the general contractor contended that the disclaimer was untimely under New York Insurance Law § 3420(d)(2). The Supreme Court, New York County, ruled in favor of the RRG and the general contractor appealed. The Appellate Division, First Department, held that a foreign RRG does not have to comply with § 3420(d)(2) because it is preempted by the federal Liability Risk Retention Act of 1986. [*Nadkos, Inc. v. Preferred Contractors Ins. Co. Risk Retention Group LLC*, 162 A.D.3d 7 (1st Dep't 2018).]

Insurers That Defended Building Owner For Years Without Reserving Right To Disclaim Were Estopped From Denying Coverage Just Before Trial, Second Department Decides

In February 2008, a building owner's insurers agreed to defend and to indemnify the owner in a personal injury action. The insurers learned of a defense to coverage no later than 2009 but continued to defend the owner for almost four more years, without reserving their right to disclaim coverage. In 2013, after jury selection in the personal injury action, the insurers disclaimed coverage on the basis that the owner was not an additional insured at the time of the accident. The owner paid $250,000 to settle the action and then sought declaratory relief to recoup the settlement payment from the insurers. The Supreme Court, Nassau County, granted summary judgment in favor of the owner, and the Appellate Division, Second

Department, affirmed. The Second Department agreed that the insurers were estopped from denying coverage under the circumstances. [*Mazl Building, LLC v. Greenwich Ins. Co.*, 162 A.D.3d 655 (2d Dep't 2018).]

Insurer Failed To Disclaim As Soon As "Reasonably Possible," Second Department Concludes

The plaintiffs, alleging that they were injured in a motor vehicle accident on July 28, 2008, sued the owner and operator of the other vehicle. The defendants' insurer sent letters dated December 20, 2010 advising them of their responsibility to cooperate in the investigation and defense of the action. On January 20, 2011, the insurer disclaimed coverage based on the defendants' failure to cooperate. The plaintiffs obtained a judgment against the defendants and sued the insurer. The trial court granted the insurer's motion for summary judgment, and the plaintiffs appealed. The Appellate Division, Second Department, reversed, finding the insurer's disclaimer of coverage untimely. According to the appellate court, the insurer had sufficient information to support its disclaimer of coverage on the basis of noncooperation as of September 20, 2010 at the latest, when one of the defendants affirmatively refused to cooperate and the other missed multiple deposition dates and could not be located. Accordingly, the court concluded, the insurer did not disclaim coverage as soon as "reasonably possible" within the meaning of Insurance Law § 3420(d)(2). [*Robinson v. Global Liberty Ins. Co. of N.Y.*, 164 A.D.3d 1385 (2d Dep't 2018).]

BAD FAITH/EXTRA-CONTRACTUAL

Fourth Department Concludes That Trial Court Should Have Dismissed Doctor's Action Against Insurer For Settling Malpractice Claim

A doctor sued her medical malpractice insurer after it settled a malpractice claim on her behalf, seeking to void her written consent to settle. The doctor claimed that the insurer's employees fraudulently induced her consent. The trial court denied the insurer's motion to dismiss the complaint, but the Appellate Division, Fourth Department, reversed. The Fourth Department explained that the doctor's claim under General Business Law Section349 had to be dismissed because this was "merely a private contract dispute" not affecting "the consuming public at large." It ruled that her breach of contract claim had to be dismissed because it was "undisputed" that the doctor received the benefit of the insurer "investigating the claim, negotiating the settlement, paying the settlement in full, and securing a general release." The doctor's fraud and negligent misrepresentation claims also had to be dismissed, the Fourth Department concluded, because the doctor failed to allege that she had suffered any actual pecuniary damage as a result of her insurer's conduct. [*Ullman v. Medical Liab. Mut. Ins. Co.*, 159 A.D.3d 1498 (4th Dep't 2018).]

Court Rejects Insured's Bad Faith Claim Seeking Consequential Damages

The insured's manufacturing plant was destroyed in a fire. Its insurers asked a New York trial court to declare that coverage for the insured's business interruption loss was limited to $15.1 million. The insured counterclaimed for breach of the covenant of good faith and fair dealing, and sought actual and consequential damages including attorneys' fees. The court ruled that the insured was not entitled to recover consequential damages or attorneys' fees. The court noted that the insurers paid the insured's business interruption claims up to the policy limits, and that the valuation of the insured's property damage claim was submitted to an appraisal proceeding. The court found it was "fatal" to the insured's claim for extra-contractual consequential damages that the insured alleged only conclusory facts that the insurers failed to investigate its claims honestly and pay promptly. [*Certain Underwriters at Lloyd's, London v. Bioenergy Dev. Group LLC*, 2018 N.Y. Misc. LEXIS 4827 (Sup. Ct. N.Y. Co. Oct. 17, 2018).]

MISCELLANEOUS

New York Court Of Appeals Rules That "Per Occurrence" Limit In Reinsurance Contract Does Not Necessarily Cap Reinsurer's Obligations

The New York Court of Appeals, in response to a question certified by the United States Court of Appeals for the Second Circuit, has ruled that there is neither a rule of construction nor a presumption under New York law that a "per occurrence" liability limitation in a facultative reinsurance contract caps all obligations of the reinsurer, such as payments made to reimburse the reinsured's defense costs. Rather than adopting a "blanket rule," the Court held that a facultative reinsurance contract that is "complete, clear and unambiguous on its face must be enforced according to the plain meaning of its terms." The Court concluded that a court must "look to the language of the policy" above all else. [*Global Reinsurance Corp. of Am. v. Century Indem. Co.*, 30 N.Y.3d 508 (2017).]

Insured's Misrepresentation About His "Earned Annual Income" Dooms Widow's Bid For Life Insurance Benefits

The insured's application for a $150,000 term life insurance policy indicated that his "earned annual income" was $50,000. The insured died within the two-year contestable period, and his widow claimed the policy proceeds. The insurer determined that the insured reported $0 in income on his tax returns, and denied the claim based on the insured's misrepresentation of his earned annual income. His widow sued. The court granted the insurer's motion for summary judgment, finding that "earned annual income" was not ambiguous and that the insured made a material misrepresentation within the meaning of New York Insurance Law § 3105(b) when he represented on the application that he had $50,000 in earned annual income when he actually had $0.

The court concluded that it was "of no moment" that the insured may have innocently misrepresented his earned annual income, as even innocent misrepresentations provide a basis for rescission of an insurance policy, as long as they are material. [*Han v. Metropolitan Life Ins. Co.*, 2018 N.Y. Misc. LEXIS 2485 (Sup. Ct. N.Y. Co. June 21, 2018).]

Fourth Department Holds That Standing Of Claimant To Bring Direct Action Against Insurer Under New York Insurance Law Limited To Policy Limits

Plaintiff obtained a $350,000 judgment against the insureds. Plaintiff then brought a direct action against their insurer under Insurance Law §§ 3420(a)(2) and (b)(1) and was awarded a judgment in the amount of the insureds' $50,000 policy limits. Thereafter, the insureds assigned their rights against the insurer to plaintiff, who sued the insurer for bad faith damages excess of the policy limits. The Appellate Division, Fourth Department, held that plaintiff's failure to litigate the bad faith claim in his earlier action did not preclude him from subsequently litigating that claim. The court noted that the doctrine of *res judicata* may bar a plaintiff from litigating a claim that could have been raised in the prior litigation. However, the court found that plaintiff was not in a position to assert the bad faith claim in the prior litigation because an injured party's standing to bring a direct action against an insurer under the New York Insurance Law is limited to recovering the policy limits, and the insureds had not yet assigned their bad faith claims against their insurer at the time of the first action. [*Corle v. Allstate Ins. Co.*, 162 A.D.3d 1489 (4th Dep't 2018).]

Excess Coverage Was Not Triggered Where Primary Policy Had Not Been Exhausted

A former officer of the insured company sued its excess insurer to recover legal expenses he had incurred under the company's liability policy for its directors and officers. The insurer moved to dismiss the complaint, asserting that coverage under the excess policy had not been triggered because the underlying primary policy had not been exhausted. The court granted the motion. The court ruled that excess coverage did not attach until all underlying primary policy limits are exhausted by payment of claims, not by just incurred amounts. The court added that the former officer's settlement with a primary insurer for a below-limit amount did not exhaust the primary limits unless he absorbed the gap between the settlement amount and the primary policy limit. [*Jiang v. Ping An Ins.*, 2018 N.Y. Misc. LEXIS 2885 (Sup. Ct. N.Y. Co. July 7, 2018).]

Court Rules That Series Of Dishonest Acts Allegedly Committed By Insured's Employee Constituted One "Occurrence" Under Policy Language

The insured company alleged that, between 2012 through 2017, a bookkeeper stole about $500,000 by making unauthorized purchases with company credit cards, making unauthorized withdrawals from the company's line of credit, and taking company inventory for personal use. The insured submitted a claim for its loss to its insurer under its "employee dishonesty" coverage. The insurer, relying on policy language stating that any loss "[i]nvolving a single act or series of acts" was one occurrence, deemed the bookkeeper's course of dishonest acts to be one occurrence subject to the $15,000 policy limit applicable to losses arising from employee dishonesty. The insured sued, contending that, under the so-called "unfortunate event" test used to resolve whether a set of circumstances amounted to one or multiple occurrences, the bookkeeper's separate and distinct acts of theft committed over a multi-year period constituted multiple occurrences. The court disagreed, granting the insurer's motion for summary judgment. The court reasoned that the unfortunate event test applied only where the policy was silent on how to treat separate incidents to determine the number of occurrences, but that the policy in this case addressed that issue. According to the court, the policy clearly intended to aggregate into a single "occurrence" all losses resulting from the bookkeeper's "series of [dishonest] acts" over a multi-year period, notwithstanding that they involved several different methods of theft. Finally, the court decided that the policies' "anti-stacking" provisions barred the insured from allocating its total losses among the various policies that were in effect at the time of the losses, and capped the insured's recovery at $15,000. [*Dan Tait, Inc. v. Farm Family Casualty Ins. Co.*, 60 Misc. 3d 886 (Sup. Ct. Albany Co. 2018).]

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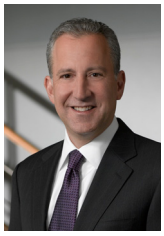

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