

## INSURANCE LAW

**Dan D. Kohane, Esq.<sup>†</sup> & Audrey A. Seeley, Esq.<sup>††</sup>**

### CONTENTS

INTRODUCTION .....	1000
I. ATTORNEY-CLIENT PRIVILEGE AND WORK PRODUCT PROTECTION.....	1000
II. ADDITIONAL INSURED COVERAGE.....	1004
III. DIRECT ACTION AGAINST INSURER .....	1007
IV. PERSONAL INJURY PROTECTION BENEFITS (NO FAULT BENEFITS) .....	1010
V. ESTOPPEL .....	1015
VI. CLAIMS AGAINST INSURANCE AGENTS.....	1016
VII. UM/SUM COVERAGE .....	1016
VIII. PROPERTY INSURANCE .....	1019
IX. EXCESS INSURANCE.....	1022
X. CONFLICT OF INTEREST .....	1023
CONCLUSION.....	1025

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† Dan D. Kohane, a Senior Member of the New York law firm of Hurwitz & Fine, P.C., is a nationally recognized insurance coverage counselor who serves as an expert witness, and conducts extensive training, consultation, and in-house seminars on this highly specialized practice. Mr. Kohane is known in the industry for his comprehensive newsletter, *Coverage Pointers*, a bi-weekly publication summarizing important insurance coverage decisions. An accomplished trial lawyer and litigator, Mr. Kohane also has extensive experience mediating complex casualty and insurance coverage disputes. He teaches Insurance Law as an adjunct professor at the University at Buffalo Law School and heads the firm's Insurance Coverage practice group.

†† Audrey A. Seeley, Esq. is a Member of Hurwitz & Fine, P.C., in its Buffalo, N.Y. office, where she focuses on insurance coverage, no-fault coverage, and SUM/UM coverage. Ms. Seeley routinely provides counseling to property-casualty insurers on a national and state basis. She also handles declaratory judgment actions in federal and state court across New York State. Ms. Seeley is the team leader of the firm's No-Fault, SUM, and UM practice group. She is currently the Chair of the Insurance Law Committee of Defense Research Institute (DRI). Ms. Seeley has been recognized in *Best Lawyers of America*, *Who's Who in the Law*, and has been named in the Upstate New York Super Lawyers list.

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## INTRODUCTION

The New York State Court of Appeals and the Appellate Departments remained active in 2015, with regard to insurance coverage decisions, and these opinions continue to guide insurance claims handling. Decisions impacting and eroding the attorney-client privilege and the attorney-work product doctrine have given insurance companies and their attorneys particular pause this year.

## I. ATTORNEY-CLIENT PRIVILEGE AND WORK PRODUCT PROTECTION

In *Lalka v. ACA Insurance Co.*, the court continued to erode an insurer's right to attorney-client privilege and work product protection.<sup>1</sup>

The plaintiff commenced an action to recover supplementary motorist coverage pursuant to an automobile liability insurance policy issued by an insurer.<sup>2</sup> The plaintiff then moved for an order compelling the insurer to disclose its entire claims file or, in the alternative, to produce all documents claimed to be privileged and/or confidential for in camera inspection.<sup>3</sup> The "Supreme Court granted that part of the motion seeking those portions of the claim file generated before the date of commencement of the action 'with the exception of those materials reviewed in camera.'"<sup>4</sup>

The Appellate Division, Fourth Department, concluded, "the court properly denied that part of plaintiff's motion seeking disclosure of documents in the claim file created after commencement of the action."<sup>5</sup> However, the court agreed with the plaintiff, "that the court abused its discretion in denying that part of her motion seeking disclosure of those documents submitted to the court for in camera review."<sup>6</sup> The court held that "[i]t is well settled that the payment or rejection of claims is a part of the regular business of an insurance company. Consequently, reports which aid it in the process of deciding which of the two indicated actions to pursue are made in the regular course of its business."<sup>7</sup> Citing *Bombard v. Amica Mutual Insurance Co.*, the court concluded that:

Reports prepared by . . . attorneys before the decision is made to pay

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1. *Lalka v. ACA Ins. Co.*, 128 A.D.3d 1508, 1509, 9 N.Y.S.3d 504, 505 (4th Dep't 2015).

2. *Id.* at 1508, 9 N.Y.S.3d at 505.

3. *Id.*

4. *Id.*

5. *Id.*

6. *Lalka*, 128 A.D.3d at 1508, 9 N.Y.S.3d at 505.

7. *Id.* at 1508-09, 9 N.Y.S.3d at 505 (internal quotation marks omitted) (citing *Nicastro v. N.Y. Cent. Mut. Fire Ins. Co.*, 117 A.D.3d 1545, 1546, 985 N.Y.S.2d 806, 808 (4th Dep't 2014)).

2016]

**Insurance Law**

1001

or reject a claim are thus not privileged and are discoverable . . . even when those reports are mixed/multi-purpose reports, motivated in part by the potential for litigation with the insured.<sup>8</sup>

The court found that the documents submitted to the court for in camera review constituted “multi-purpose reports motivated in part by the potential for litigation with plaintiff, but also prepared in the regular course of defendant’s business in deciding whether to pay or reject plaintiff’s claim.” Therefore, the court unanimously ordered the insurer to turn over the *entire claims file* simply because the insurer had not yet made a decision on whether or not the claim was covered.<sup>9</sup>

This is yet another case in a series of recent decisions where the courts have been opening up insurance company files to discovery, including the disclosure of communications between an insurer and its coverage counsel. *Lalka* and the two cases that follow represent a growing and disturbing trend that began in the Second Department and has since spread like wildfire to the First Department and now the Fourth Department.

It started with the Second Department’s decision in *Melworm v. Encompass Indemnity Co.*<sup>10</sup> There, Encompass issued a policy insuring the plaintiffs’ boat, and the plaintiffs made a first-party claim under that policy asserting that the boat had been vandalized.<sup>11</sup> Encompass denied the claim.<sup>12</sup> The policyholder “commenced this action, inter alia, to recover damages for breach of the insurance policy, and moved, among other things, to compel the defendants to produce an unredacted copy of an electronic claims diary prepared by an employee of the defendants,” and “certain letters from the defendants’ coverage counsel to the defendants.”<sup>13</sup> The material sought by the plaintiffs had been created prior to the defendants’ denial of the claim, and “the defendants’ counsel drafted the letters while counsel conducted an investigation of the claim on behalf of the defendants.”<sup>14</sup> “In opposition to the motion, the defendants argued that the material was protected by the attorney-client privilege.”<sup>15</sup>

The Second Department held that:

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8. *Id.* at 1509, 9 N.Y.S.3d at 505 (quoting *Bombard v. Amica Mut. Ins. Co.*, 11 A.D.3d 647, 648, 783 N.Y.S.2d 85, 86 (2d Dep’t 2004)).

9. *Id.*

10. *See* 112 A.D.3d 794, 977 N.Y.S.2d 321 (2d Dep’t 2013).

11. *Id.* at 794, 977 N.Y.S.3d at 322.

12. *Id.*

13. *Id.* at 794–95, 977 N.Y.S.2d at 322.

14. *Id.* at 795, 977 N.Y.S.2d at 322.

15. *Melworm*, 112 A.D.3d at 795, 977 N.Y.S.2d at 322.

[t]he payment or rejection of claims is a part of the regular business of an insurance company. Consequently, reports that aid the company in the process of deciding which of the two indicated actions to pursue are made in the regular course of its business. Reports prepared by insurance investigators, adjusters or attorneys before the decision is made to pay or reject a claim are thus not privileged and are discoverable, even when those reports are mixed/multipurpose reports, motivated in part by the potential for litigation with the insured.<sup>16</sup>

The court found that “the materials sought by the plaintiffs were prepared as part of the defendants’ investigation into the claim, and were not primarily and predominately of a legal character.”<sup>17</sup> Therefore, the court ruled that the defendants failed to meet their burden of establishing that the materials sought by the plaintiffs were protected by the attorney-client privilege.<sup>18</sup>

A few months later the First Department addressed this issue in *National Union Fire Insurance Co. of Pittsburgh, Pa. v. TransCanada Energy USA, Inc.* It is particularly interesting because the First Department vacated its February 2014 decision in July 2014.<sup>19</sup> The differences in the two opinions give us some insight into the court’s intentions, perhaps.

“[T]he insurance companies retained counsel to provide a coverage opinion, i.e. an opinion as to whether the insurance companies should pay or deny the claims.”<sup>20</sup> The trial court found that the majority of the documents sought to be withheld are not protected by the attorney-client privilege, the work product doctrine, or as materials prepared in anticipation of litigation.<sup>21</sup>

In its February 2014 decision, the First Department found that “[d]ocuments prepared in the ordinary course of an insurer’s investigation of whether to pay or deny a claim are not privileged, and do not become so ‘merely because [the] investigation was conducted by an attorney’” citing to a 2005 decision of the First Department, *Brooklyn Union Gas Co. v. American Home Assurance Co.*<sup>22</sup>

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16. *Id.* at 795, 977 N.Y.S.2d at 323 (quoting *Bombard v. Amica Mut. Ins. Co.*, 11 A.D.3d 647, 648, 783 N.Y.S.2d 85, 86 (2d Dep’t 2004)).

17. *Id.* at 796, 977 N.Y.S.2d at 323.

18. *Id.*

19. *Nat’l Union Fire Ins. Co. of Pittsburgh, Pa. v. TransCanada Energy USA, Inc.* (*TransCanada I*), 114 A.D.3d 595, 981 N.Y.S.2d 68 (1st Dep’t 2014), *order recalled and vacated*, (*TransCanada II*), 119 A.D.3d 492, 493, 990 N.Y.S.2d 510, 512 (1st Dep’t 2014).

20. *TransCanada I*, 114 A.D.3d at 595–96, 981 N.Y.S.2d at 69–70.

21. *Id.* at 595, 981 N.Y.S.2d at 69.

22. *Id.* at 596, 981 N.Y.S.2d at 70 (quoting *Brooklyn Union Gas Co. v. Am. Home Assurance Co.*, 23 A.D.3d 190, 191, 803 N.Y.S.2d 532, 534 (1st Dep’t 2005)).

2016]

**Insurance Law**

1003

In the July 2014 decision, the First Department added two rather telling sentences to the decision. First, the court noted that the lower court had conducted “an in camera review, and . . . determined that certain documents were privileged because they contained legal advice. As for the remaining documents, the court found that the insurance companies had not met their burden of demonstrating privilege.”<sup>23</sup> Second, conspicuously absent in the first opinion was this observation: “[f]urther, the record shows that counsel were primarily engaged in claims handling—an ordinary business activity for an insurance company.”<sup>24</sup>

Both decisions concluded: “[d]ocuments prepared in the ordinary course of an insurer’s investigation of whether to pay or deny a claim are not privileged, and do not become so merely because [the] investigation was conducted by an attorney.”<sup>25</sup>

The court, in its “new” decision, suggested that the courts will now examine the role the attorney played in claims handling and decision making.<sup>26</sup> On one hand, if the lawyer was part of the team that led to the coverage denial—and was performing claims functions—discovery of the attorney’s communications may be discoverable.<sup>27</sup> On the other hand, communications providing only legal advice would remain privileged.<sup>28</sup>

These cases represent a growing and disturbing new trend that impacts the ability of insurers to secure privileged legal advice. It is one thing to find that investigation reports are of the “mixed use” variety, and therefore discoverable if generated before a claim is denied. It is quite another to compel production of communications between counsel and the insurer when the attorney is assisting the insurer in developing a strategy to respond to a request for coverage.

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23. *TransCanada II*, 119 A.D.3d at 493, 990 N.Y.S.2d at 511.

24. *Id.*

25. *TransCanada I*, 114 A.D.3d at 596, 981 N.Y.S.2d at 70 (quoting *Brooklyn Union Gas Co.*, 23 A.D.3d at 191, 803 N.Y.S.2d at 533); *TransCanada II*, 119 A.D.3d at 493, 990 N.Y.S.2d at 511–12 (quoting *Brooklyn Union Gas Co.*, 23 A.D.3d at 191, 803 N.Y.S.2d at 533).

26. *TransCanada II*, 119 A.D.3d at 493, 990 N.Y.S.2d at 511–12.

27. *Id.*

28. *Id.*

## II. ADDITIONAL INSURED COVERAGE

The First Department continues to expand additional insured coverage by holding where an additional insured endorsement provides coverage for “acts or omissions” of the named insured, coverage is extended even when the named insured was not negligent.<sup>29</sup>

The underlying personal injury action arose from a subway construction project in Brooklyn, for which the New York City Transit Authority (NYCTA) and Metropolitan Transit Authority (MTA) engaged “Breaking Solutions to supply concrete-breaking excavation machines and personnel to operate the machines under NYCTA’s direction.”<sup>30</sup> Pursuant to the insurance requirements of its contract, Breaking Solutions obtained a commercial general liability policy from Burlington, which included endorsements designating NYCTA, MTA, and the New York City as additional insureds, with such additional insured coverage restricted to, in pertinent part, liability for bodily injury “caused, in whole or in part,” by “acts or omissions” of Breaking Solutions.<sup>31</sup>

On February 14, 2009, an explosion occurred in the Brooklyn subway tunnel that was being excavated by a Breaking Solutions machine. The explosion occurred when the excavator came into contact with an energized electrical cable buried below the concrete. It [was] undisputed that it had been NYCTA’s responsibility to identify and mark or protect hazards in advance, so as to enable the excavator operator to avoid them, and to shut off power to electrical cables in the work area. Thomas Kenny, an employee of NYCTA, was injured when he fell from an elevated work platform as a result of the explosion.<sup>32</sup>

Kenny sued Breaking Solutions and the City of New York.<sup>33</sup> “The City was sued as owner of the subway property for alleged violations of its nondelegable duties under Labor Law § 240(1) and § 241(6).”<sup>34</sup> However, “NYCTA was not named in the *Kenny* action, presumably because Kenny, as an NYCTA employee, was barred from suing it under the Workers’ Compensation Law.”<sup>35</sup>

It was undisputed that the named insured, Breaking Solutions, was

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29. *Burlington Ins. Co. v. N.Y.C. Transit Auth.*, 132 A.D.3d 127, 129, 14 N.Y.S.3d 377, 378 (1st Dep’t 2015).

30. *Id.* at 129, 14 N.Y.S.3d at 379.

31. *Id.*

32. *Id.* at 130, 14 N.Y.S.3d at 379.

33. *Id.* at 130–131, 14 N.Y.S.3d at 379–80.

34. *Burlington*, 132 A.D.3d at 131, 14 N.Y.S.3d at 380.

35. *Id.*

2016]

**Insurance Law**

1005

not negligent.<sup>36</sup> There was also no doubt that the non-negligent “act” of the named insured, Breaking Solutions (hitting the unmarked cable with the excavator) led to the explosion.<sup>37</sup>

The question before the court was whether NYCTA and MTA were entitled to additional insured protection from coverage by Burlington in the absence of: (1) Kenny being an employee of the Burlington named insured, Breaking Solutions; and (2) in the absence of any negligence on the part of the Burlington named insured, Breaking Solutions.<sup>38</sup> Nevertheless, the First Department found that coverage extended to NYCTA and MTA.<sup>39</sup>

Upon review of its recent precedents, the court concluded that its most recent precedents have construed additional insured endorsements [where the policy] contain[s] substantially the same “acts and omissions” language as do the endorsements at issue here as providing additional insured coverage where there is a causal link between the named insured’s conduct and the injury, regardless of whether the named insured was negligent or otherwise at fault for causing the accident.<sup>40</sup>

The court cited four cases, to justify its decision, three of which were not on point and one was dicta:

- “In *W & W Glass Systems, Inc. v. Admiral Insurance Company* . . . where the relevant endorsement provided that a general contractor was covered under its subcontractor’s policy ‘only with respect to liability *caused by* [the subcontractor’s] ongoing operations performed for that [additional] insured,’ we held that “[t]he language in the additional insured endorsement granting coverage *does not require a negligence trigger*.”<sup>41</sup> Note: That decision involved an earlier form of endorsement, and did not contain “acts or omissions” language.<sup>42</sup>
- “[I]n *National Union Fire Insurance Company of Pittsburgh, PA v. Greenwich Insurance Company*, where the additional insured endorsement applied to ‘bodily injury caused, in whole or in part, by [the named insured’s] acts or omissions or the acts or omissions of those acting on the [named insured’s] behalf,’ in holding the

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36. *Id.*

37. *Id.* at 131–32, 14 N.Y.S.3d at 380.

38. *Id.* at 128–29, 14 N.Y.S.3d at 378.

39. *Burlington*, 132 A.D.3d at 133, 14 N.Y.S.3d at 381.

40. *Id.* at 129, 14 N.Y.S.3d at 378.

41. *Id.* at 135, 14 N.Y.S.3d at 383 (quoting *W & W Glass Sys., Inc. v. Admiral Ins. Co.*, 91 A.D.3d 530, 530, 937 N.Y.S.2d 28, 29 (1st Dep’t 2012)).

42. *Id.* at 135 n.6, 14 N.Y.S.3d at 383 n.6.

additional insured covered for the loss in question, we expressed the view that ‘the phrase “caused by” “does not materially differ” from the phrase, “arising out of.”’<sup>43</sup> Note: That issue was not before the court in this case.

- “In *Strauss Painting, Inc. v. Mt. Hawley Insurance Company*, we expressly held that a finding of negligence against the named insured was not required to support additional insured coverage where ‘[t]he additional insured endorsement speaks in terms of “acts or omissions,” not negligence. Thus, in the unlikely event that it would be found that some non-negligent act by plaintiff [the named insured] caused the accident, the Met [the additional insured] would still be entitled to coverage under the additional insured endorsement.’<sup>44</sup> Note: That was dicta,<sup>45</sup> and the injured plaintiff was an employee of the named insured.<sup>46</sup>
- “[I]n *Liberty Mut. Ins. Co. v. Zurich Am. Ins. Co.*, the federal district court . . . expressly relying on our above-cited decisions in *W & W Glass, National Union* and *Strauss Painting*— [concluded] that ‘[i]t is not necessary to determine that Schindler [the named insured] was somehow negligent as any act or omission by Schindler or someone acting on its behalf will suffice [to trigger additional insured coverage] if it was “in the performance of [Schindler’s] ongoing operations for the additional insured.”’<sup>47</sup> Note: Yes it did, following only the First Department precedent.<sup>48</sup>

Relying on these precedents, the First Department held that “NYCTA and MTA are additional insureds under the subject policy for purposes of a loss that was ‘caused, in whole or in part,’ by an ‘act[] or omission[]’ of the named insured, even though the named insured’s causal ‘act[]’ was not negligent.”<sup>49</sup> Put more simply, according to the First Department, a blanket “acts or omission” additional insured endorsement is triggered to provide coverage even when the named insured was not negligent.<sup>50</sup>

43. *Id.* at 135, 14 N.Y.S.3d at 383 (quoting *Nat’l Union Fire Ins. Co. of Pittsburgh, Pa. v. Greenwich Ins. Co.*, 103 A.D.3d 473, 474, 962 N.Y.S.2d 9, 10)).

44. *Burlington*, 132 A.D.3d at 136, 14 N.Y.S.3d at 383 (quoting *Strauss Painting, Inc. v. Mt. Hawley Ins. Co.*, 105 A.D.3d 512, 513, 963 N.Y.S.2d 197, 198–99 (1st Dep’t 2013), *mod. on other grounds*, 24 N.Y.3d 578, 2 N.Y.S.3d 390, 26 N.E.3d 218 (2014)).

45. *See Strauss Painting*, 105 A.D.3d at 513, 963 N.Y.S.2d at 198–99.

46. *See Strauss Painting*, 24 N.Y.3d at 585, 26 N.E.3d at 221, 2 N.Y.S.3d at 393.

47. *Burlington*, 132 A.D.3d at 136, 14 N.Y.S.3d at 384 (quoting *Liberty Mut. Ins. Co. v. Zurich Am. Ins. Co.*, 11 Civ. 9357, 2014 U.S. Dist. LEXIS 42471, at \*14–15 (S.D.N.Y. Mar. 28, 2014)).

48. *Liberty Mutual*, 11 Civ. 9357, 2014 U.S. Dist. LEXIS 42471, at \*14–15.

49. *Burlington*, 132 A.D.3d at 134, 14 N.Y.S.3d at 382.

50. *Id.*



The court found that it was “undisputed” that the plaintiff’s injury was “causally connected to an ‘act’ of the named insured,” specifically, its disturbance of the buried electrical cable, which triggered the explosion that led to the accident.<sup>51</sup> The court acknowledged that:

While it is true that, because NYCTA had not warned the Breaking Solutions’ operator of the cable’s presence, [the named insured’s] “act” did not constitute negligence, this does not change the fact that the act of triggering the explosion, faultless though it was on [the named insured], was a cause of Kenny’s injury.<sup>52</sup>

The court further concluded that, “the language of the relevant endorsement, on its face, defines the additional insured coverage afforded in terms of whether the loss was ‘caused by’ the named insured’s ‘acts or omissions,’ without regard to whether those ‘acts or omissions’ constituted negligence or were otherwise actionable.”<sup>53</sup>

Finally, because the City, NYCTA and MTA were all insureds under the same Burlington Policy, anti-subrogation principles precluded cross-claims for indemnity to the extent of policy coverage.<sup>54</sup>

### III. DIRECT ACTION AGAINST INSURER

A direct action by a judgment creditor can only be commenced if the policy was “issued or delivered” in New York.<sup>55</sup> Moreover, the MCS-90 endorsement applies to the named insured only.<sup>56</sup>

In *Carlson v. American International Group, Inc.* (“*Carlson I*”), Carlson commenced a direct action pursuant to Insurance Law section 3420(a)(2) to collect on certain insurance policies after a second amended judgment against MVP Delivery and Logistics, Inc. (“MVP”) and William Porter was entered upon a jury verdict.<sup>57</sup> American Alternative Insurance Company (AAIC) issued a commercial umbrella policy to Airborne, Inc. and later changed the named insured to DHL Express, Risk Management.<sup>58</sup>

Section 3420(a)(2) of the Insurance Law, provides a protocol under which an injured party who has obtained a judgment against an insured

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51. *Id.*

52. *Id.* at 134–35, 14 N.Y.S.3d at 382.

53. *Id.* at 135, 14 N.Y.S.3d at 382.

54. *See Burlington*, 132 A.d.3d at 138, 14 N.Y.S.3d at 385.

55. *Carlson v. Am. Int’l Grp., Inc. (Carlson I)*, 130 A.D.3d 1477, 1477, 16 N.Y.S.3d 637, 638 (4th Dep’t 2015).

56. *Id.* at 1478, 16 N.Y.S.3d at 639.

57. *Id.* at 1477, 16 N.Y.S.3d at 638.

58. *Id.*

(and thereby becomes a judgment creditor) can bring a “Direct Action” against an insurer to enforce the judgment against an insurer it believes has an obligation to satisfy it.<sup>59</sup> The insurer is able to raise its coverage defenses in response to that suit, as long as they have been properly preserved.<sup>60</sup>

Under the terms of that statute, a Direct Action can be commenced against an insurer only when a policy is “issued or delivered” in New York.<sup>61</sup> The Fourth Department found that the parties and the Supreme Court improperly conflated the phrase “issued or delivered” with “issued for delivery,” which was used in the former version of Insurance Law section 3420(d), and therefore the definition of “issued for delivery” was not relevant.<sup>62</sup> The policy was issued in New Jersey and delivered in Seattle, Washington, and then in Florida.<sup>63</sup> It was not issued or delivered in New York.<sup>64</sup> Therefore, the Fourth Department dismissed the first cause of action against AAIC.<sup>65</sup>

Carlson argued in the alternative that he could seek payment of the judgment against AAIC pursuant to the MCS-90 endorsement.<sup>66</sup> However, the court rejected that contention.<sup>67</sup> The MCS-90 endorsement, a federally-mandated endorsement, provides that “the insurer . . . agrees to pay . . . any final judgment recovered against the insured.”<sup>68</sup> The Federal Motor Carrier Safety Administration, which regulates the interstate trucking industry, defined the term “insured” on the MCS-90 endorsement as the named insured only.<sup>69</sup> Accordingly, the Fourth Department held that the MCS-90 endorsement applies to the named insured only.<sup>70</sup>

In a related case, *Carlson v. American International Group, Inc.* (“*Carlson II*”), the Fourth Department held that to be a “hired vehicle,” the company must have control of the *vehicle itself*, not control of the *company operating the vehicle*.<sup>71</sup>

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59. N.Y. INS. LAW § 3420(a)(2) (McKinney 2015).

60. *Id.*

61. N.Y. INS. LAW § 3420(e), (f) (McKinney 2015).

62. *Carlson I*, 130 A.D.3d at 1477–78, 16 N.Y.S.3d at 638.

63. *Id.* at 1478, 16 N.Y.S.3d at 638.

64. *Id.*

65. *Id.*

66. *Id.*

67. *Carlson I*, 130 A.D.3d at 1478, 16 N.Y.S.3d at 638.

68. *Id.*

69. *Id.* at 1478, 16 N.Y.S.3d at 639.

70. *Id.*

71. 130 A.D.3d 1479, 1480–81, 12 N.Y.S.3d 715, 717 (4th Dep’t 2015).

2016]

**Insurance Law**

1009

DHL had a cartage agreement with MVP, whereby MVP provided delivery services for DHL.<sup>72</sup> In the underlying wrongful death action, the jury determined that Porter was negligent in causing the motor vehicle accident that led to the death of plaintiff's decedent, and MVP was statutorily liable for Porter's negligence as the owner of the vehicle.<sup>73</sup> "Plaintiff recovered from MVP's insurer and now seeks to recover under a primary and umbrella policy issued to DHL by defendant National Union . . . and under an umbrella policy issued . . . by [AAIC]."<sup>74</sup>

AAIC did not issue a policy in New York.<sup>75</sup> In the alternative, and with respect to National Union, the court held that the plaintiff could not maintain a section 3420(a)(2) action against it for substantive reasons.<sup>76</sup>

The primary National Union policy defined an insured as, inter alia, "[a]nyone else while using with your permission a covered auto' you own, hire or borrow." The umbrella National Union policy defined an insured as, inter alia, "[a]ny person . . . or organization with respect to any auto owned by you, loaned to you or hired by you or on your [behalf] and used with your permission." The umbrella AAIC policy defined an insured as, inter alia, "any person or organization . . . included as an insured in the Scheduled Underlying Insurance," i.e., in the National Union primary policy.<sup>77</sup>

Thus, the court found that "MVP and Porter may be an 'insured' under the three policies only if the vehicle used by Porter at the time of the accident was 'hired' by DHL and was being used with DHL's permission."<sup>78</sup>

The court held:

[I]n order for the MVP vehicle driven by Porter to be deemed a vehicle "hired" by DHL, there must be a showing that DHL exercised control over the vehicle, and not general control over MVP. Generally, a vehicle owned by an independent contractor who contracts with the insured to perform services for the insured is not a hired automobile.<sup>79</sup>

Simply put, "[t]here is a 'distinction between hiring a company that

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72. *Id.* at 1479, 12 N.Y.S.3d at 716.

73. *Id.*

74. *Id.*

75. *See id.* at 1480, 12 N.Y.S.3d at 717.

76. *Carlson II*, 130 A.D.3d at 1480, 12 N.Y.S.3d at 717.

77. *Id.*

78. *Id.*

79. *Id.* at 1480–81, 12 N.Y.S.3d at 717 (citing 8A STEVEN PLITT ET AL., COUCH ON INSURANCE § 118:52 (3d ed. 2014)).

provides transportation and hiring a truck.’’<sup>80</sup>

#### IV. PERSONAL INJURY PROTECTION BENEFITS (NO FAULT BENEFITS)

In *Viviane Etienne Medical Care v. Country-Wide Insurance Co.*, the Court addressed what constitutes a no-fault plaintiff’s prima facie case on a motion for summary judgment where the insurer has not timely or properly denied the claim.<sup>81</sup> The Court of Appeals held that:

[A] plaintiff demonstrates prima facie entitlement to summary judgment by submitting evidence that payment of no-fault benefits are overdue, and proof of its claim, using the statutory billing form, was mailed to and received by the defendant insurer. Proof evincing the mailing must be presented in admissible form, including where it is applicable, meeting the business records exception to the hearsay rule.<sup>82</sup>

The Court provided a general overview of the workings and purpose of the no-fault scheme and then noted that “even where an insurer is precluded from raising a defense to the proof of claim form because of its failure to timely deny the claim, the plaintiff medical provider must, as an initial matter, demonstrate its entitlement to summary judgment by submission of proof in admissible form.”<sup>83</sup>

Finally, the Court stated:

Contrary to the dissent’s contention, the risk of an insurer paying out fraudulent claims has been recognized by this Court; however, as we have stated that risk is part of the price paid for swift, uncontested resolution of no-fault claims. Where no-fault benefits are not overdue, because of timely denial, the insurer’s compliance with the statute and regulations allows it to retain its right to contest the claims and prevent payment of fraudulent claims. An insurer providing no-fault benefits may not simply sit on its hands until litigation is commenced. Some action is required.<sup>84</sup>

The dissent, written by Judge Stein, and in which Judge Read concurred, was especially interesting and focused on the summary judgment aspect, reasoning that “neither the statutory and regulatory no-fault scheme, nor our cases concerning the preclusion doctrine, obviate a plaintiff’s burden to demonstrate its prima facie entitlement to benefits

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80. *Id.* (quoting *Toops v. Gulf Coast Marine Inc.*, 72 F.3d 483, 487 (5th Cir. 1996)).

81. 25 N.Y.3d 498, 501, 35 N.E.3d 451, 454, 14 N.Y.S.3d 283, 286 (2015).

82. *Id.*

83. *Id.* at 507, 35 N.E.3d at 458–59, 14 N.Y.S.3d at 290–91.

84. *Id.* at 509, 35 N.E.3d at 460, 14 N.Y.S.3d at 292 (citing *Presbyterian Hosp. in the City of New York v. Md. Cas. Co.*, 90 N.Y.2d 274, 285, 683 N.E.2d 1, 6–7, 660 N.Y.S.2d 536, 541–42 (1997)).

2016]

**Insurance Law**

1011

sought, as compared to only proof of billing and nonpayment.”<sup>85</sup> In other words, although the failure to pay or deny within the thirty-day prescribed period carries “substantial consequences” for the insurer, on a motion for summary judgment the plaintiff should still have to meet its prima facie burden showing entitlement, “i.e., that the loss arose from an automobile accident and that the expenses incurred were medically necessary.”<sup>86</sup>

The dissent points out that there is

no language in the Insurance Law or the . . . regulations that compels the conclusion that the Legislature intended to excuse a no-fault plaintiff from demonstrating entitlement to benefits as a penalty to the insurer. The Insurance Law does not provide that, because benefits are “overdue” and the insurer is therefore subject to certain enumerated repercussions, a plaintiff need not proffer admissible evidence establishing the basic elements of a no-fault claim. Rather, the rule now adopted by the majority—that only proof of billing and the absence of timely denial or payment are required to obtain reimbursement—was derived by the Appellate Division Departments from our cases creating and defining the preclusion rule. In my view, the extension of the preclusion doctrine established by the majority in this case is misguided because our preclusion cases did not effectuate a change to a plaintiff’s burden on summary judgment.<sup>87</sup>

Therefore, according to the dissent, the majority “conflates the preclusion rule with the summary judgment burden, effectively eviscerating . . . long-settled summary judgment principles in the no-fault context . . . .”<sup>88</sup>

From the dissent’s viewpoint, the central objective of the no-fault structure is to expedite claims by means of the timing rules and the preclusion doctrine provides the incentive for insurers to comply.<sup>89</sup> The dissent argued that:

[R]equiring a plaintiff to establish its prima facie entitlement to benefits, rather than mere proof of billing, would not place on no-fault claimants an onerous burden that would impede the timely resolution of valid claims or increase no-fault litigation. The statutory NF–3

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85. *Id.* (Stein, J., dissenting).

86. *Viviane Etienne Med. Care*, 25 N.Y.3d at 510–11, 35 N.E.3d at 460–61, 14 N.Y.S.3d at 292–93.

87. *Id.* at 511, 35 N.E.3d at 461, 14 N.Y.S.3d at 293 (citing *Westchester Med. Ctr. v. Progressive Cas. Ins. Co.*, 89 A.D.3d 1081, 1082, 933 N.Y.S.2d 719, 720 (2d Dep’t 2011); *N.Y. & Presbyterian Hosp. v. Selective Ins. Co. of Am.*, 43 A.D.3d 1019, 1020, 842 N.Y.S.2d 63, 64 (2d Dep’t 2007)).

88. *Id.* at 512, 35 N.E.3d at 462, 14 N.Y.S.3d at 294.

89. *Id.* at 513, 35 N.E.3d at 463, 14 N.Y.S.3d at 295.

verification of treatment form is a permissible proof of claim with respect to a non-hospital health care provider.<sup>90</sup>

Since the preclusion rule comes into play only after a plaintiff's prima facie case has been made, the dissent opines that it is not applicable in this case because the defendant was only seeking to hold the plaintiff to its initial summary judgment burden.<sup>91</sup>

For the dissent, the true issue here was the evidentiary admissibility of the NF-3 verification of treatment forms which must be received for their truth to establish the "fact and amount of loss sustained."<sup>92</sup> According to the dissent:

[T]he affidavit of . . . the president of plaintiff's third-party billing service, stated that he had personal knowledge of the mailing of the NF-3 forms to defendant, he had no personal knowledge of plaintiff's record-keeping procedures or practices in creating the documents based on which he compiled those forms. Thus, [he] was unable to lay a sufficient foundation for the admissibility of the NF-3 forms under the business records exception to the hearsay rule and inadmissible hearsay is insufficient to establish a prima facie case entitling plaintiff to summary judgment.<sup>93</sup>

Because the no-fault statutes and regulations do not contain any explicit language eliminating a plaintiff's burden to establish a prima facie case, and because the preclusion doctrine is not triggered until a prima facie showing is made, the dissent opined that there is no basis to diverge from the traditional rules governing summary judgment motions, and therefore would have reversed the Appellate Division's order.<sup>94</sup>

In a string of cases all decided the same day, the First Department held that a carrier must show proof it complied with the thirty-day rule for scheduling Independent Medical Examinations (IMEs) if it wants to deny coverage after an injured party fails to appear for an IME. The same applies for Examinations Under Oath (EUOs).

In *American Transit Insurance Co. v. Longevity Medical Supply*,

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90. *Id.* at 514, 35 N.E.3d at 463, 14 N.Y.S.3d at 295.

91. *Viviane Etienne Med. Care*, 25 N.Y.3d at 515, 35 N.E.3d at 464, 14 N.Y.S.3d at 296.

92. *Id.* at 514, 35 N.E.3d at 463, 14 N.Y.S.3d at 295 (citing N.Y. INS. LAW § 5106 (2009)).

93. *Id.* at 514, 35 N.E.3d at 463-64, 14 N.Y.S.3d at 295-96 (citing *People v. Brown*, 13 N.Y.3d 332, 341, 918 N.E.2d 927, 932, 890 N.Y.S.2d 415, 420 (2009); *People v. Cratsley*, 86 N.Y.2d 81, 90, 653 N.E.2d 1162, 1167, 629 N.Y.S.2d 992, 997 (1995); *In re Leon R.R.*, 48 N.Y.2d 117, 122-23, 397 N.E.2d 374, 377, 421 N.Y.S.2d 863, 866-67 (1979); *Zuckerman v. N.Y.*, 49 N.Y.2d 557, 562, 404 N.E.2d 718, 719-20, 427 N.Y.S.2d 595, 597-98 (1980)).

94. *Id.* at 515, 35 N.E.3d at 464, 14 N.Y.S.3d at 296.

*Inc.*, the no-fault carrier moved for summary judgment, declaring that it had no obligation to provide coverage after the injured party failed to appear for IMEs.<sup>95</sup> The First Department found that the carrier failed to establish its entitlement to deny the defendant's claim.<sup>96</sup> To do so, the court required that the carrier demonstrate that it was in compliance with Insurance Department Regulations 11 New York Codes, Rules and Regulation section 65-3.5(d), which requires an insurer to schedule any IMEs within thirty days of receiving the verification forms.<sup>97</sup> The fact that the carrier had properly mailed notices of the exam and even the injured party's failure to appear did not satisfy the court.<sup>98</sup> The court held that the carrier was required to submit this proof at the onset of its claim, and any belated attempt to submit the information after the fact would be improper.<sup>99</sup>

Justice Friedman heartily disagreed with the conclusions drawn by the majority. He noted that the issue of whether the carrier had complied with the thirty-day time frame had been raised for the first time on appeal.<sup>100</sup> He pointed out that if the carrier had raised the issue at the motion court, the carrier "may well have been able to establish compliance with the regulation . . ." <sup>101</sup> He further explained that there was no reason for the appellate court to assume that the carrier did not follow the timeframe.<sup>102</sup> Most importantly, he noted that no appellate court previously required a carrier to show compliance with the thirty-day time frame unless it was called into question.<sup>103</sup>

In *American Transit Insurance Co. v. Vance*, the court again held that a carrier failed to establish that it was entitled to deny the claim where the injured party failed to appear for independent medical examinations.<sup>104</sup> Although the carrier established that the notices of the scheduled IMEs were properly mailed and that the injured party did not appear, the court found that the carrier failed to show that the scheduling of the IMEs complied with Insurance Department Regulations 11 New York Codes, Rules and Regulations section

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95. 131 A.D.3d 841, 841, 17 N.Y.S.3d 1, 1 (1st Dep't 2015).

96. *Id.*

97. *Id.* at 841, 17 N.Y.S.3d at 2.

98. *Id.*

99. *Id.* at 842, 17 N.Y.S.3d at 2.

100. *Longevity Med. Supply*, 131 A.D.3d at 843, 17 N.Y.S.3d at 3 (Friedman, J., dissenting).

101. *Id.*

102. *Id.* at 844, 17 N.Y.S.3d at 4.

103. *Id.* at 845-46, 17 N.Y.S.3d at 5.

104. 131 A.D.3d 849, 850, 17 N.Y.S.3d 631, 631 (1st Dep't 2015).

65–3.5(d).<sup>105</sup> The court reviewed this issue even though the issue was never raised until appeal.<sup>106</sup> Justice Friedman again dissented for the same reasons he did in *Longevity Medical Supply*.<sup>107</sup>

In *American Transit Insurance Co. v. Clark*, the court unanimously agreed that the carrier “failed to establish prima facie that it was entitled to deny defendant[‘s]” claim because the injured party failed to appear for IMEs.<sup>108</sup> Although the carrier demonstrated that the notices were properly mailed and that the assignor did not appear, it failed to show that the scheduling complied with the thirty-day rule for scheduling IMEs.<sup>109</sup>

*National Liability & Fire Insurance Co. v. Tam Medical Supply Corp.* extended the same principle to EUOs, holding that a carrier must show proof it complied with the thirty-day rule for scheduling EUOs if it wants to deny coverage where an injured party fails to appear for an EUO.<sup>110</sup> The carrier “moved for summary judgment declaring that its policy does not provide coverage” since the injured party failed to appear for an EUO.<sup>111</sup> The court concluded that although the failure to appear for an EUO did constitute a breach that would appear to eliminate coverage, it was persuaded by the fact that the carrier had not established that it had complied with the thirty-day rule.<sup>112</sup> Therefore, the court denied the carrier’s motion for summary judgment because it failed to prove that it complied with the thirty-day rule for scheduling EUOs.<sup>113</sup>

Taken together, these four decisions reinforce that a carrier must show proof that it complied with the thirty-day rule for scheduling IMEs and EUOs if it wants to demonstrate failure to comply with a condition of coverage under the policy.

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105. *Id.*

106. *Id.*

107. *Id.* at 850, 17 N.Y.S.3d at 631–32 (Friedman, J., dissenting).

108. 131 A.D.3d 840, 840, 16 N.Y.S.3d 456, 456 (1st Dep’t 2015).

109. *Id.* at 840–41, 16 N.Y.S.3d at 456–57.

110. 131 A.D.3d 851, 851, 16 N.Y.S.3d 457, 457 (1st Dep’t 2015).

111. *Id.*

112. *Id.*

113. *Id.*



2016]

**Insurance Law**

1015

## V. ESTOPPEL

In a case of first impression, a late noticed disclaimer does not estop insurer from defending and seeking declaratory relief.<sup>114</sup> The supreme court granted CastlePoint Insurance Company's ("CastlePoint") "motion for summary judgment declaring that it had no do duty to defend and indemnify defendants Hilmand Realty, LCC ["Hilmand"]".<sup>115</sup>

On appeal, the appellate division held that the insurer

did not take factually inconsistent positions in hiring counsel to represent its insureds in vacating their default in the personal injury action, thereby allowing for a continued defense and preservation of the insureds' rights, and moving for a declaration that coverage under the policy was vitiated by untimely notice of claim in the event coverage was triggered.<sup>116</sup>

Furthermore, the appellate division affirmed the trial court's grant of CastlePoint's motion, finding that the laws which govern a motion to vacate a default judgment and laws regarding notice of an occurrence upon an insurer differ in that service upon the Secretary of State is not actual notice of a suit for purposes of vacating a default in answering a complaint, but notice upon the Secretary of State is actual notice to the insured for purposes of the notice provisions in the insurance policy.<sup>117</sup>

Moreover, the lower court correctly found that CastlePoint could not be estopped from arguing that Hilmand breached the prompt notice requirement in the policy because it was not a party or in privity with a party in the underlying action.<sup>118</sup> Rather, Hilmand was a party in the underlying action with an attorney hired by CastlePoint to defend it during the pendency of the declaratory judgment action who merely advocated successfully on behalf of Hilmand to vacate the default against it.<sup>119</sup> As such, the appellate division held that Hilmand, the defendant in the underlying action with counsel retained by CastlePoint, was not the same party as CastlePoint, the plaintiff in the instant declaratory judgment action.<sup>120</sup>

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114. *Castlepoint Ins. Co. v. Hilmand Realty, L.L.C.*, 130 A.D.3d 475, 475–76, 13 N.Y.S.3d 406, 406 (1st Dep't 2015).

115. *Id.* at 475, 13 N.Y.S.3d at 406.

116. *Id.* at 476, 13 N.Y.S.3d at 406.

117. *See id.* at 476, 13 N.Y.S.3d at 406–07.

118. *See id.* at 475–76, 13 N.Y.S.3d at 406.

119. *See Castlepoint*, 130 A.D.3d at 475–76, 13 N.Y.S.3d at 406.

120. *See id.*

## VI. CLAIMS AGAINST INSURANCE AGENTS

Where an insurer's agent receives timely notice, its failure to notify the insurer cannot render it liable for late notice since its notice was the insurer's notice.<sup>121</sup>

"Gail Purcell was injured in an automobile accident."<sup>122</sup> It is claimed that she "gave notice of the accident to the defendants, who . . . were agents of the nonparty Progressive Insurance Company [{"Progressive"}], which had issued the plaintiffs' insurance policy."<sup>123</sup> The agent did not give notice to Progressive.<sup>124</sup> Progressive denied coverage and the agent was sued for negligence.<sup>125</sup>

"[T]he insurance policy provided that notice to an agent of Progressive would satisfy the notice provisions of the policy."<sup>126</sup> Since, under the terms of the policy, notice to the agent satisfied the plaintiffs' duty to provide notice of the accident to Progressive, the court held that "the [agent] demonstrated that any failure to communicate notice of the accident to Progressive did not alter the plaintiffs' rights under the terms of the policy or otherwise affect their ability to recover in accordance with its terms."<sup>127</sup> Simply put, since notice to the agent was timely, notice to Progressive was timely. It made no difference if the agent did or did not transmit it to Progressive because as Progressive's agent, it was accepting notice on behalf of Progressive.

## VII. UM/SUM COVERAGE

In *Redeye v. Progressive Insurance Co.*, the court held that a settlement from a dram shop action reduces recovery under Condition 11 of a Supplemental Underinsured Motorist (SUM) policy.<sup>128</sup>

Redeye brought a lawsuit to recover "supplementary uninsured/underinsured motorist (SUM) benefits from defendant," Progressive, his auto insurer.<sup>129</sup> While a pedestrian, he was injured when a drunk driver struck a car that was propelled into him.<sup>130</sup> Redeye sued the drunk driver "as well as a fire company that allegedly served

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121. *Purcell v. M.L. Bruenn Co., Inc.*, 125 A.D.3d 739, 740, 4 N.Y.S.3d 221, 222 (2d Dep't 2015).

122. *Id.* at 739, 4 N.Y.S.3d at 222.

123. *Id.*

124. *See id.*

125. *See id.*

126. *Purcell*, 125 A.D.3d at 740, 4 N.Y.S.3d at 222.

127. *Id.*

128. 133 A.D.3d 1261, 1262, 19 N.Y.S.3d 645, 646 (4th Dep't 2015).

129. *Id.* at 1261, 19 N.Y.S.3d at 645.

130. *Id.*

2016]

**Insurance Law**

1017

the driver alcoholic beverages prior to the accident, and he received a settlement from both.”<sup>131</sup> Progressive “denied [Redeye’s] claim for SUM benefits, stating that coverage was exhausted by the recovery from both the driver and the fire company . . . .”<sup>132</sup>

Redeye conceded “that the SUM coverage is properly reduced by the amount he recovered from the driver’s insurer. He contend[ed], however, that it was improper to reduce the SUM coverage from the amount he received from the fire company under its general liability insurance policy.”<sup>133</sup> The Fourth Department rejected that contention.<sup>134</sup>

“Condition 11(e) of the SUM endorsement under defendant’s policy provided that SUM coverage ‘shall not duplicate . . . any amounts recovered as bodily injury damages from sources other than motor vehicle bodily injury liability insurance policies or bonds.’”<sup>135</sup> Since “the payment plaintiff received from the fire company’s insurer was for bodily injury damages,” the Fourth Department held that “the amount of SUM benefits available to plaintiff was properly reduced by that amount.”<sup>136</sup>

Furthermore, the court found that “the policy is not ambiguous and [C]ondition 11 does not conflict with [C]ondition 6 of the SUM endorsement.”<sup>137</sup> The court explained that:

Condition 6 provides that the maximum payment under the SUM endorsement is the difference between the SUM limit and any payments received from a motor vehicle bodily injury liability policy. It does not state that the difference is “the” SUM payment that is to be given to plaintiff, but rather it states that the difference is the “maximum” payment, which the average insured would understand to mean that it could be further reduced.<sup>138</sup>

Accordingly, the court held that “Condition 6 and [C]ondition 11 together resulted in a reduction in the SUM benefits available by the total settlement received by plaintiff in his prior action.”<sup>139</sup>

It is noted that the plaintiff has requested leave to appeal from the Court of Appeals, which was denied.<sup>140</sup>

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131. *Id.* at 1261–62, 19 N.Y.S.3d at 646.

132. *Id.* at 1262, 19 N.Y.S.3d at 646.

133. *Redeye*, 133 A.D.3d at 1262, 19 N.Y.S.3d at 646.

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. *Redeye*, 133 A.D.3d at 1262, 19 N.Y.S.3d at 646

139. *Id.*

140. *Matter of AAA Carting & Rubbish Removal, Inc. v. Town of Clarkstown*, 132

In some cases, an injury to a firefighter while rescuing an auto accident victim can lead to underinsured motorist (SUM) recovery.<sup>141</sup>

On January 11, 2010, Kenneth Goodman was driving . . . when he lost control of his vehicle and crashed it into a utility pole. When firefighter Kevin Rich’s engine company responded to the scene of the accident, Goodman was trapped inside his vehicle, bleeding, drifting in and out of consciousness, and, when awake, moaning in pain. In order to extract Goodman from the vehicle, the firefighters used the “jaws of life” to cut the vehicle’s roof, and Rich and three other firefighters lifted the roof off of the vehicle. In the process thereof, Rich sustained injuries to his right shoulder.

Rich commenced an action against Goodman, whose insurer later offered to settle in the sum of \$25,000, which constituted the limits of Goodman’s automobile insurance policy. Rich also sought coverage under the supplementary uninsured/underinsured motorists endorsement contained in his own automobile insurance policy issued by . . . Encompass. Encompass denied coverage, concluding that Goodman’s use of his vehicle was not the proximate cause of Rich’s injuries.<sup>142</sup>

Rich filed a demand for arbitration and Encompass brought this proceeding to permanently stay arbitration or, alternatively, to temporarily stay arbitration and to direct Rich to provide . . . discovery. . . .

SUM endorsements provide coverage only when the injuries are “caused by an accident arising out of such underinsured motor vehicle’s ownership, maintenance or use.” Factors to be considered in determining whether an accident arose out of the use of a motor vehicle include whether the accident arose out of the inherent nature of the vehicle and whether the vehicle itself produces the injury rather than merely contributes to cause the condition which produces the injury. “[T]he [vehicle] itself need not be the proximate cause of the injury, but ‘negligence in the use of the vehicle must be shown, and that negligence must be a cause of the injury.’”<sup>143</sup>

“Encompass failed to establish that Rich was not entitled to

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A.D.3d 857, 26 N.Y.3d 918 (2d Dep’t 2016).

141. See *Encompass Indem. Co. v. Rich*, 131 A.D.3d 476, 14 N.Y.S.3d 491 (2d Dep’t 2015).

142. *Id.* at 476–77, 14 N.Y.S.3d at 492.

143. *Encompass Indem.*, 131 A.D.3d at 477, 14 N.Y.S.3d at 492–93 (first quoting N.Y. COMP. CODES R. & REGS. tit. 11, § 60-2.3(f)(II) (2013); then citing *Allstate Ins. Co. v. Reyes*, 109 A.D.3d 468, 469, 970 N.Y.S.2d 560, 561–62 (2d Dep’t 2013); then quoting *Allstate*, 109 A.D.3d at 469, 970 N.Y.S.2d at 562).

coverage under the SUM endorsement.”<sup>144</sup> The court found that “[t]he evidence in the record establish[ed] that Goodman’s negligent use of his vehicle directly caused the accident that led to him being trapped and in obvious need of medical attention, which, in turn, led to Rich’s intervention and resulting injuries.”<sup>145</sup> The court concluded that, “[i]t cannot be said, as a matter of law, that Goodman’s negligent use of his vehicle was not a proximate cause of Rich’s injuries under the doctrine of danger invites rescue.”<sup>146</sup> “Furthermore, Encompass was not entitled to a temporary stay of arbitration [or] an order directing Rich to provide pre-arbitration discovery” since the court found that “Encompass had ample time to seek discovery before commencing this proceeding and unjustifiably failed to do so.”<sup>147</sup>

### VIII. PROPERTY INSURANCE

The ensuing loss exception for explosion does not erode the protections of the subsurface water exclusion.<sup>148</sup>

A water main near the plaintiffs’ property ruptured, causing water to flow into and severely damage their finished basement.<sup>149</sup> “Plaintiffs immediately made a claim under their homeowners’ insurance policy, which was issued by . . . Allstate Indemnity Company” (“Allstate”).<sup>150</sup> The policy excluded “property damage caused by water, with an exception for certain sudden and accidental direct physical losses.”<sup>151</sup> The policy provided, in relevant part:

[Allstate does] not cover loss to the property . . . *consisting of or caused by:*

1. Flood . . .
2. Water . . . that backs up through sewers or drains.
3. Water . . . that overflows from a sump pump, sump pump well or other system designed for the removal of subservice water . . .
4. Water . . . *on or below the surface of the ground, regardless of its*

144. *Id.* at 478, 14 N.Y.S.3d at 493.

145. *Id.* at 478, 14 N.Y.S.3d at 493–94 (citing *Kesick v. N.Y. Cent. Mut. Fire Ins. Co.*, 106 A.D.3d 1219, 1221–22, 965 N.Y.S.2d 216, 219 (3d Dep’t 2013)).

146. *Id.* at 478, 14 N.Y.S.3d at 494.

147. *Id.* at 479, 14 N.Y.S.3d at 494 (citing *Progressive N. Ins. Co. v. Foss*, 96 A.D.3d 855, 855, 947 N.Y.S.2d 317, 318 (2d Dep’t 2012)).

148. *Platek v. Town of Hamburg*, 24 N.Y.3d 688, 691, 26 N.E.3d 1167, 1169, 3 N.Y.S.3d 312, 315 (2015).

149. *Id.* at 690, 26 N.E.3d at 1168–69, 3 N.Y.S.3d at 314.

150. *Id.* at 690, 26 N.E.3d at 1169, 3 N.Y.S.3d at 314.

151. *Id.*

source[,] [including] water . . . which exerts pressure on, or flows, seeps or leaks through any part of the residence premises.

We do cover sudden and accidental direct physical loss caused by fire, explosion or theft resulting from items 1 through 4 listed above.<sup>152</sup>

Upon receipt of the claim, Allstate immediately disclaimed under the “water damage” exclusion.<sup>153</sup> The plaintiffs challenged Allstate’s denial by arguing that the exception for physical loss caused by fire, explosion, or theft caused by water infiltration preserved coverage.<sup>154</sup> The plaintiffs contended that the water damage exclusion did not apply under these facts because there was an “explosion” of the water main.<sup>155</sup> In essence, the plaintiffs argued that although water damage as a whole was removed from coverage, the exception restored coverage for water damage that arose from an explosion.<sup>156</sup>

The Court began its analysis by referencing three important canons of construction in insurance law.<sup>157</sup> The first is that coverage is driven by the actual language of the policy.<sup>158</sup> The second principle is that the carrier has the burden of establishing its coverage defense when such defense is based upon the application of an exclusion.<sup>159</sup> Finally, if a carrier is able to establish the applicability of an exclusion, the burden shifts to the insured to establish that an exception to the exclusion is triggered to save coverage.<sup>160</sup>

In the instant case, the “plaintiffs’ loss occurred when water from a burst water main flowed onto their property, flooding the basement of their home.”<sup>161</sup> Accordingly, the Court held that the water damage exclusion applied to bar coverage.<sup>162</sup>

The Court then discussed, at length, the history of the ensuing loss

152. *Id.* at 690–91, 26 N.E.3d at 1169, 3 N.Y.S.3d at 314–15 (alterations in original) (footnote omitted).

153. *Platek*, 24 N.Y.3d at 691, 26 N.E.3d at 1169, 3 N.Y.S.3d at 315.

154. *Id.*

155. *Id.*

156. *See id.*

157. *Id.* at 693, 26 N.E.3d at 1171, 3 N.Y.S.3d at 316.

158. *Platek*, 24 N.Y.3d at 693, 26 N.E.3d at 1171, 3 N.Y.S.3d at 316 (quoting *Consol. Edison Co. of N.Y. v. Allstate Ins. Co.*, 98 N.Y.2d 208, 221, 774 N.E.2d 687, 693, 746 N.Y.S.2d 622, 628 (2002)).

159. *Id.* at 694, 26 N.E.3d at 1171, 3 N.Y.S.3d at 316 (citing *Seaboard Sur. Co. v. Gillette Co.*, 64 N.Y.2d 304, 311, 476 N.E.2d 272, 275, 486 N.Y.S.2d 873, 876 (1984)).

160. *Id.* (citing *Lavine v. Indem. Ins. Co. of N. Am.*, 260 N.Y. 399, 410, 183 N.E. 897, 900 (1933)).

161. *Id.* at 694, 26 N.E.3d at 1171, 3 N.Y.S.3d at 317.

162. *Id.* (citing *Neuman v. United Servs. Auto. Ass’n*, 74 A.D.3d 925, 925–26, 905 N.Y.S.2d 202, 203 (2d Dep’t 2010)).

exception.<sup>163</sup> The Court explained that ensuing loss exceptions arose out of the great San Francisco earthquake of 1906.<sup>164</sup> Immediately after the earthquake, devastating fires spread across the city sparked by gas emitted from pipes that had been broken by the earthquake.<sup>165</sup> Some insurers denied coverage on the basis that the fires were actually caused by the earthquake (and thus excluded).<sup>166</sup> In response, the California legislature enacted laws “to prevent insurers from disclaiming coverage . . . under such circumstances.”<sup>167</sup> To comply with the law, insurers “added exceptions to their earthquake exclusions to preserve coverage for ensuing fires.”<sup>168</sup>

An ensuing loss provision “preserve[s] coverage for insured losses, such as the fires after the San Francisco earthquake,” but “[does not] create a ‘grant-back’ through which coverage may be had for the original excluded loss.”<sup>169</sup> In other words, an ensuing loss provision requires “‘a new loss to property that is of a kind not excluded by the policy’; it ‘[does not] resurrect coverage for an excluded peril.’”<sup>170</sup> For instance, damage from fire or explosion caused by subsurface water is covered; but the ensuing loss provision does not create coverage for a peril originally excluded by the policy such as flood damage.

In this case, the homeowners argued, in essence, that the exception for explosion created coverage for water damage.<sup>171</sup> In actuality, the exception created coverage for explosions *caused by* water damage.<sup>172</sup> In so holding, the Court noted that the fact that Allstate did not label the exception as “ensuing loss” was irrelevant to the policy language’s otherwise understood meaning.<sup>173</sup> In short, the water damage exclusion clearly evinced intent by the parties to the contract to remove coverage for damage caused by flood waters.<sup>174</sup> To read the exception as

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163. *Platek*, 24 N.Y.3d at 695, 26 N.E.3d at 1171–72, 3 N.Y.S.3d at 317 (quoting 2 BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 21.04[h] (Elisa Alcabes & Karen Cestari eds., 17th ed. 2015)).

164. *Id.* at 695, 26 N.E.3d at 1172, 3 N.Y.S.3d at 317.

165. *Id.*

166. *Id.*

167. *Id.*

168. *Platek*, 24 N.Y.3d at 695, 26 N.E.3d at 1172, 3 N.Y.S.3d at 317.

169. *Id.* at 695, 26 N.E.3d at 1172, 3 N.Y.S.3d at 318 (alteration in original) (quoting James S. Harrington, *Lessons of the San Francisco Earthquake of 1906: Understanding Ensuing Loss in Property Insurance*, 37 BRIEF 28, 32 (2008)).

170. *Id.* (alteration in original) (quoting Harrington, *supra* note 168, at 31, 34).

171. *Id.* at 695–96, 26 N.E.3d at 1172, 3 N.Y.S.3d at 318.

172. *Id.* at 696, 26 N.E.3d 1172, 3 N.Y.S.3d at 318.

173. *Platek*, 24 N.Y.3d at 696, 26 N.E.3d at 1172–73, 3 N.Y.S.3d at 318 (citing *Fiess v. State Farm Lloyds*, 202 S.W.3d 744, 752–53 (Tex. 2006)).

174. *Id.* at 697, 26 N.E.3d at 1173, 3 N.Y.S.3d at 319.

proposed by the plaintiffs would contravene the clear purposes of the exclusion.<sup>175</sup>

#### IX. EXCESS INSURANCE

Since the workers compensation/employers liability policy is unlimited, the excess insurer was not required to provide coverage as the umbrella was never reached.<sup>176</sup>

The plaintiff, Tully Construction Co., Inc. (“Tully”), was a construction company that obtained insurance policies, including a Workers Compensation and Employers Liability policy (“WCEL policy”) from the plaintiff, Zurich American Insurance Company (“Zurich”).<sup>177</sup> Tully also obtained an umbrella policy from defendant, Illinois National Insurance Company (“Illinois”).<sup>178</sup> The excess policy

required Tully to exhaust all insurance available before the excess coverage provided by the umbrella policy would be triggered. The umbrella policy also explicitly stated that, despite the listing of any limits of underlying insurance in the Schedule of Underlying Insurance, if the actual insurance available to Tully exceeded the amounts listed in the schedule, the umbrella policy would not be triggered until those greater amounts were met and exceeded. In the underlying actions, the parties settled for \$9,000,000. Zurich paid \$6,500,000, and Illinois paid \$2,500,000.

The plaintiffs brought this action for a declaration, inter alia, that Illinois is required to indemnify Tully in the underlying actions. Illinois counterclaimed, among other things, for a declaration that it had no obligation under the umbrella policy to indemnify Tully in the underlying actions and, thus, it was not required to indemnify the plaintiffs for the settlement amount which exceeded the limits of the underlying insurance policies obtained by Tully from Zurich. . . .

The WCEL policy contained a New York Limit of Liability Endorsement which provided that in cases of bodily injury to an employee arising out of and in the course of employment that is subject to and is compensable under the Workers’ Compensation Law, Zurich could not limit its liability and, as such, the policy was unlimited in those cases.<sup>179</sup>

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175. *Id.*

176. *Tully Constr. Co. v. Ill. Nat’l Ins. Co.*, 131 A.D.3d 598, 599, 15 N.Y.S.3d 404, 406 (2d Dep’t 2015) (citing *Merchs. Mut. Ins. Co. v. N.Y. State Ins. Fund*, 85 A.D.3d 1686, 1688, 926 N.Y.S.2d 783, 785 (4th Dep’t 2011)).

177. *Id.* at 598–99, 15 N.Y.S.3d at 405.

178. *Id.*

179. *Id.* at 599–60, 15 N.Y.S. at 405–406 (citing *Oneida Ltd. v. Utica Mut. Ins. Co.*,



“In light of the unlimited nature of the WCEL policy,” the appellate division held that “the Supreme Court properly concluded that the limits of the underlying insurance policies were never met and, as such, the excess coverage provided by the umbrella policy was never triggered.”<sup>180</sup>

#### X. CONFLICT OF INTEREST

The Appellate Division, Third Department, faced the interesting question of who makes the decision as to what is in the insured’s best interests.<sup>181</sup> According to the Third Department, it is not the insured.<sup>182</sup>

Landon was hurt while performing construction services on a home owned by Austin.<sup>183</sup>

The project also involved equipment owned by, and several employees of, defendant Austin Construction, Inc. [“ACI”]. Austin and his wife are the sole shareholders and officers of ACI, and Austin cross-claimed against ACI for contribution and/or indemnification.

ACI has commercial liability insurance coverage, and its carrier selected Smith, Sovik, Kendrick & Sugnet P.C. [“SSKS”] to provide a defense. Austin is also entitled to a defense under the terms of his homeowners insurance policy, and a separate law firm was retained to represent him. Upon the previous appeals in this matter, we determined that plaintiff was entitled to partial summary judgment as to his Labor Law [section] 240(1) claim against Austin, but that questions of fact regarding “ACI’s status as a contractor (or agent) on the day in question” precluded a similar award against it.

Approximately three weeks before the trial in this matter was to begin, Austin moved to disqualify SSKS as counsel for ACI. Austin argue[d] that he is the “alter ego” of ACI, and that SSKS is impermissibly placing the interests of ACI’s insurance carrier ahead of his stated wishes. Austin fear[ed] that the damages awarded at trial [would] exceed the liability limits of his homeowners insurance policy and that, should ACI not be held liable, he [would] be personally responsible for some of the award. He . . . accordingly argued that he was acting in his corporate capacity in the lead-up to the injury, which would render ACI liable and bring the liability limits of its commercial liability insurance policy into play. SSKS rejected the

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263 A.D.2d 825, 827, 694 N.Y.S.2d 221, 224 (3d Dep’t 1999).

180. *Id.* (citing *Merchs. Mut. Ins. Co. v. N.Y. State Ins. Fund*, 85 A.D.3d 1686, 1688, 926 N.Y.S.2d 783, 785 (4th Dep’t 2011)).

181. *See Landon v. Austin*, 129 A.D.3d 1282, 1282–83, 11 N.Y.S.3d 721, 723 (3d Dep’t 2015).

182. *See id.*

183. *Id.* at 1282, 11 N.Y.S.3d at 723.

demands of Austin that it endorse that strategy, and has instead argued that ACI is not liable because Austin was acting solely in his individual capacity.<sup>184</sup>

Supreme Court denied the motion to disqualify and the Third Department affirmed.<sup>185</sup>

The court began its analysis by noting that,

Although SSKS was retained by the insurer for ACI, “the paramount interest [SSKS] represents is that of [ACI] . . . [and] [t]he insurer is precluded from interference with counsel’s independent professional judgments in the conduct of the litigation on behalf of its client.” Disqualification is therefore appropriate “where a conflicting interest [between the insurer and insured] may, even inadvertently, affect, or give the appearance of affecting, the obligations of the professional relationship.” A conflicting interest exists . . . “where the defense attorney’s duty to the insured would require that he [or she] defeat liability on any ground and his [or her] duty to the insurer would require that he [or she] defeat liability only upon grounds which would render the insurer liable.”

. . . SSKS . . . consistently argued that ACI is not liable at all.<sup>186</sup>

Although the court noted that “this defense could harm the personal financial interests of Austin if [successful], SSKS . . . never represented Austin in his individual capacity.”<sup>187</sup> The court found that “[t]he defense advanced by SSKS clearly furthers the corporate interests of ACI,” and that, “the record is devoid of any indication that its actual goal is to recoup funds for the insurer’s benefit from ACI or its principals.”<sup>188</sup> Therefore, the court held that no conflict of interest existed.<sup>189</sup>

While not inconsistent with the same Third Department’s decision in *Nelson Electrical Contracting Corp. v. Transcontinental Insurance Co.*,<sup>190</sup> a parallel question is raised. There, the court decided that where the interests of the insured and insurer are in conflict, the insured may

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184. *Id.* at 1282–83, 11 N.Y.S.3d at 723.

185. *Id.* at 1283, 11 N.Y.S.3d at 723.

186. *Id.* at 1283, 11 N.Y.S.3d at 723–24 (alterations in original) (first quoting *Feliberty v. Damon*, 72 N.Y.2d 112, 120, 527 N.E.2d 261, 265, 531 N.Y.S.2d 778, 782 (1988); then quoting *In re Kelly*, 23 N.Y.2d 368, 376, 244 N.E.2d 456, 460, 296 N.Y.S.2d 937, 943 (1968); then quoting *Pub. Serv. Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 401 n.\*, 425 N.E.2d 810, 815 n.\*, 442 N.Y.S.2d 422, 427 n.\* (1981)).

187. *Landon*, 129 A.D.3d at 1283, 11 N.Y.S.3d at 723–24 (citing *Talvy v. Am. Red Cross*, 205 A.D.2d 143, 149, 618 N.Y.S.2d 25, 29 (1st Dep’t 1994)).

188. *Id.*

189. *Id.* at 1284, 11 N.Y.S.3d at 724.

190. 231 A.D.2d 207, 209, 660 N.Y.S.2d 220, 222 (3d Dep’t 1997).

2016]

**Insurance Law**

1025

select counsel and it retains the right to make “tactical decisions.”<sup>191</sup>  
The court explained that:

Inherent in this rule is the axiom that when such a conflict exists, the interests of the insured are paramount. To hold, as defendant urges, that counsel, having been employed for the very purpose of safeguarding the interests of the insured, must nonetheless obtain the insurer’s consent before pursuing a course of action tailored to serve that end, or risk a loss of coverage for “failure to cooperate”, [sic] would be untenable; it would effectively enable the insurer to take control of the defense and subordinate the insured’s interests to its own. This would not only defeat the purpose of assigning independent counsel, it would pose an ethical dilemma for the insured’s attorney, who, being bound to “exercise professional judgment solely on behalf of the client disregard[ing] the desires of others that might impair the lawyer’s free judgment,” cannot permit the insurer “to direct or regulate his or her professional judgment in rendering such legal services.”<sup>192</sup>

Therefore, the question becomes, who makes the tactical decisions on behalf of the insured corporation? Would the result have been different if the corporate board voted to direct counsel to admit its corporate responsibility? Would counsel have to withdraw because of irreconcilable conflict? If so, what does the next attorney do differently?

**CONCLUSION**

In 2015, the courts remained heavily engaged in insurance law and 2016 will most likely result in continued litigation in areas protecting the sacrosanct attorney-client privilege as well as the attorney work product doctrine.

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191. *Id.*

192. *Id.* at 210, 660 N.Y.S.2d at 222 (alterations in original) (first citing *Feliberty*, 72 N.Y.2d at 120, 527 N.E.2d at 265, 531 N.Y.S.2d at 782; and then quoting MODEL CODE OF PROF’L RESPONSIBILITY EC 5-21, DR 5-107(B) (AM. BAR ASS’N 2014)).