2003 Update on Issues Affecting Accidents Involving Uninsured And/Or Underinsured Motorists

BY JONATHAN A. DACHS

This eleventh consecutive annual review[1] of uninsured motorist (UM), underinsured motorist (UIM), and supplementary uninsured motorist (SUM) decisions by New York courts during the past calendar year provides a digest of another busy year in this ever-changing, highly complex area of the law.

GENERAL ISSUES

Insured Persons

"Named Insured" The term "named insured" applies only to persons or entities listed on the declarations page of the policy. Where a policy is taken out on a corporate or government-owned vehicle, and the policyholder is a legal entity, rather than an individual, a question may arise about who is the "named insured."

In *Travelers Indemnity Co. of America v. Venito*,[2] the court held that the respondent, an officer of the named insured corporation, could not make claim for SUM benefits under a policy issued to the corporation because he was not listed as a "named insured" and did not meet the definition of that term as defined in the policy.[3]

In *State Farm Mutual Automobile Ins. Co. v. Russell*,[4] the claimant attempted to establish that he was a family member residing with the "named insured" under the policy issued by the petitioner and, therefore, entitled to seek SUM benefits. The evidence submitted – an "Auto Renewal" form the petitioner sent to the insured – did not say the relative was an additional insured or even an additional driver. Rather, the form said it was for informational purposes only and that the relative was a licensed driver listed in the policy. In the view of the court, "this was insufficient to warrant a determination that the petition should have been dismissed, and, in fact, actually created a factual question as to [the relative's] status" and, thus, as to the claimant's status as well, since his status was directly dependent upon the relative's status.

Resident The definition of an "insured" under the SUM endorsement includes a relative of the named insured, and, while residents of the same household, the spouse and relatives of either the named insured or spouse.

In *GEICO v. Paolicelli*,[5] the court noted that "the standard for determining residency for purposes of insurance coverage 'requires something more than temporary or physical presence and requires at least some degree of permanence and intention to remain.'" The court also noted that usually, the issue of residency is a question of fact to be determined at a hearing. In this case, the defendant's father testified that the defendant left the father's residence and moved in with his girlfriend. Although the defendant maintained that he was living at both residences on a part-time basis at the time of the accident, the court found such testimony to be "equivocal with respect to the amount of time that he lived at his father's residence." In addition, there was no documentary evidence to support the claim that the defendant still resided with his father, or that he had intended to remain in his father's household at the time of the accident. The Appellate Division reversed the decision of the trial court and found that the defendant was not a covered person under the terms of his father's automobile insurance policy. Therefore, GEICO was not obliged to defend or indemnify the defendant in the underlying lawsuit.

In *Lindner v. Wilkerson*,[6] the 25-year-old defendant was living with his then-girlfriend at the time of his au-

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tomobile accident. He returned to his girlfriend's house after the accident. When he was not living with his girlfriend, he lived in hotels upstate, where he was put up by his employer depending upon where his job happened to be located. He testified at his deposition that he had moved out of the house where he grew up, which was owned by his grandmother, when he was in high school, because he did not want to abide by his grandmother's rules. His mother, aunt and grandmother testified that he was in that house only occasionally in 1999 (the year of the accident) and that he had removed most of his possessions from that house, leaving behind just a television and some clothing. The defendant testified that he did not have a permanent address but used his grandmother's address on the accident report, police report and hospital report, and received mail at that address. The court held that the defendant was *not* a resident of his grandmother's house and, therefore, was not a covered person under a policy issued to his aunt, who resided with the defendant's grandmother in that house.

"Use or Operation"/Accidents The UM/SUM endorsements provide benefits to "insured persons" who sustain injury caused by "accidents" "arising out of the ownership, maintenance or use" of an uninsured motor vehicle.

In *National Grange Mutual Ins. Co. v. Vitebskaya,*[7] the court held that when "loss is the result of an intentional act, there is no coverage," and that "an intentional act may void coverage even if not committed by the claimant." Thus, even though the claimant may be an innocent victim of an intentional or fraudulent collision, the SUM insurer will not be obliged to provide benefits if the collision was the result of an intentional act, rather than an accident.

In *GEICO v. Shaulskaya,*[8] the respondent's claim for SUM benefits under a policy issued to the owner of the vehicle in which he was a passenger was denied because it was established that the collision was "a deliberate occurrence perpetrated in furtherance of an insurance fraud scheme." The court held that the disclaimers by both the insurer of the host vehicle and the insurer of the other vehicle involved in the collision were valid "regardless of whether the intentional collision was motivated by fraud or malice."[9]

In *Farm Family Casualty Ins. Co. v. Trapani,*[10] a driver lost control of her car and struck a utility pole. The impact moved the pole, causing its power lines to short out and rain sparks and hot pieces of wire onto the claimant, a 75-year-old woman who was standing in her garden along the roadway. In attempting to run away from this hazard, the claimant fell and injured herself. After settling with the driver's insurer for its policy limits, the claimant sought additional benefits under her SUM policy. The insurer denied the claim on the basis that the claimant's injuries did not arise out of the use, maintenance or operation of a motor vehicle. The court disagreed, however, holding that "the determinative issue here is whether [the driver's] car was a proximate cause of [the claimant's] injuries." Here, in the court's view, the impact of the car with the utility pole

> was not a cause so remote in either time or space from [the claimant's] injuries "as to preclude recovery as a matter of law," and neither the shorting powerlines nor [the claimant's] flight were so extraordinary or unforeseeable that they should "be viewed as superceding acts which, as a matter of law, break the causal link."[11]

Thus, the court found the proximate causal nexus to allow the claim to proceed.

In *Empire Ins. Co. v. Schliessman,*[12] the court held that injuries sustained by the insured's tenant while he was trying to help his 4-year-old son off of the insured's truck did not arise from "use or operation" of the truck, absent allegations that the truck itself was used negligently, or that the condition of the truck contributed in any way to the accident. Rather, the truck was merely the location of, and incidental to, the accident. "'[N]ot every injury occurring in or near a motor vehicle is covered by the phrase "use or operation." The accident must be connected with the use of an automobile *qua* automobile.'"[13]

Duty to Provide Timely Notice of Claim

UM, UIM and SUM endorsements require the claimant, as a condition precedent to the right to apply for benefits, to give timely notice to the insurer of an intention to make a claim. Although the mandatory UM endorsement requires such notice to be given "within ninety days or as soon as practicable," Regulation 35-D's SUM endorsement requires simply that notice be given "as soon as practicable." A failure to satisfy the notice requirement vitiates the policy and the insurer need not demonstrate any prejudice before it can assert the defense of noncompliance with the notice provisions.[14]

The interpretation of the phrase "as soon as practicable" was a hot topic once again in 2003.

In *Merchants Mutual Ins. Co. v. Falisi,*[15] the Court of Appeals held that notice should be liberally construed in the claimant's favor.[16] Thus, in *Falisi,* the Court held that the requirement that claimants provide their insurer with timely notice of an uninsured motorist claim was met by the submission of a form given to the insurer 11 days after the accident, which detailed the claim. That form listed a numerical code indicating that the offending vehicle was insured under the Assigned Risk Plan. That form, however, also indicated "NONE" in response to the inquiry regarding the insurance company of the other motorist.

In *C.C.R. Realty of Dutchess, Inc. v. New York Central Mutual Fire Ins. Co.*,[17] the Second Department stated that the duty to give notice arises "'when, from the information available relative to the incident, an insured could glean a reasonable possibility of the policy's involvement.'" The court added that "knowledge of an occurrence obtained by an agent charged with the duty to report such matters is imputed to the principal."

In *Banks v. American Manufacturers Mutual Ins. Co.*,[18] the claimant/insured was informed of the tortfeasor's bodily injury liability limits 25 months after the accident, and 16 months after the personal injury action against the tortfeasor was commenced. Claimant/insured first notified the SUM carrier of his claim seven days later. The court held that

> it cannot be said that this delay establishes as a matter of law that plaintiff failed to give notice "[a]s soon as practicable." In the underinsurance context, the phrase "as soon as practicable" is construed to require the insured to "give notice with reasonable promptness after the insured knew or should reasonably have known that the tortfeasor was underinsured" (*Matter of Metropolitan Prop. & Cas. Ins. Co. v. Mancuso*, 93 N.Y.2d 487, 495). Moreover, "underinsurance analyses are intensely fact specific and therefore particularly well suited for determinations of timeliness of notice on a case-by-case basis" (*Id.* at 404-405).[19]

Thus, the court held that "fact-finding proceedings are required to determine whether the delay in plaintiff's ascertaining the limits of the tortfeasor's coverage was due to any lack of diligence on his part."

It is also interesting to note that in *Banks*, the court specifically rejected the contention that the provision in the first-party PIP section of the policy requiring that notice be given no more than 90 days after the accident could be relied upon to defeat the SUM claim, because "such provision is not part of the SUM endorsement, and therefore does not apply to SUM coverage."

In *Hermitage Ins. Co. v. Alomar*,[20] the claimant was injured in August 2000 while a passenger on a motorcycle operated by the petitioner's insured. The insurer did not learn of the personal injury action commenced by the claimant against the motorcycle driver until January 2001, when it received a copy of a motion for default made by the claimant. The insurer immediately sent a letter to the motorcycle driver stating that it was providing "no coverage" for the accident "because of multiple breaches of the policy provisions pertaining to timely notice." This disclaimer caused the claimant to seek UM benefits from the MVAIC, but in June 2001 the MVAIC rejected the claim on the ground that the motorcycle driver's policy provided SUM coverage that was triggered by the insurer's disclaimer of coverage for lack of cooperation. It was only then that the claimant, who was not the owner of the policy and, therefore, had no opportunity to discover its contents because of the motorcycle driver's default in the personal injury action, could have reasonably known of the existence of SUM coverage in that policy. Thus, the court held that the claimant's service of a Demand for Arbitration on the insurer in June 2001, immediately after the MVAIC's denial of UM benefits, was timely and proper, as it was undertaken "as soon as practicable."

In *Murphy v. New York Central Mutual Fire Ins. Co.*,[21] the plaintiff did not seek medical attention on the date of the accident. A few days later, she began to suffer a tingling in her arm and a facial droop. She eventually sought medical attention, and five months after the accident an MRI revealed bone spurs with herniated cervical discs. She claimed that her medical providers did not tell her that her problems were related to the accident. She did not miss any time from work until 14 months after the accident. Her first contact with an attorney was 12 months after the accident, and that contact was motivated by concerns about no-fault payments. Her condition deteriorated significantly 14 months after the accident, to the point that her doctor characterized her as "totally disabled." She commenced a lawsuit against the offending driver a few weeks later, and notified the SUM carrier of her claim three days thereafter. The court found a factual issue regarding whether the plaintiff was reasonably aware, prior to 14 months after the accident, that she sustained a "serious injury" causally related to the accident.

In *State Farm Mutual Automobile Ins. Co. v. Gallo*,[22] the claimant/insured first learned of the limits of the tortfeasor's policy 11 months after the accident. He informed the SUM insurer of his intent to seek SUM benefits within 15 days thereafter. Under the circumstances, the court held that an issue of fact existed regarding the timeliness of the notice, and the claimant/insured's "due diligence" in ascertaining the extent of his injuries and the liability limits of the tortfeasor's policy. The court remanded the case to the Supreme Court for a hearing on those issues.

By contrast, in *State Farm Mutual Automobile Ins. Co. v. King*,[23] the court held that where there was no proof of compliance with the policy provision requiring a sworn notice of claim, or any excuse for such non-compliance, there was no coverage and no basis for any framed issue hearing.

In *Medina v. State Farm Mutual Automobile Ins. Co.*,[24] the court held that the plaintiff established that a 27-month delay in notifying the defendant of her SUM claim was reasonable and that she acted with due diligence in ascertaining the medical facts underlying her SUM claim. Evidence established that she was initially

diagnosed with a neck sprain and thereafter underwent two arthroscopic surgeries on her shoulder; that she was diagnosed with a herniated disc seven months after the accident, but even then, her doctors expected that, with physical therapy, she would make a full recovery. It was not until 12 months later that her chiropractor told her that her condition had become chronic and that full recovery was unlikely. She gave notice shortly thereafter.

In *New York Central Mutual Fire Ins. Co. v. Szymaszek*,[25] the court held that a delay of more than three years in giving notice of a SUM claim was unreasonable as a matter of law. The claimant not only failed to demonstrate a reasonable excuse for the delay in giving notice, but also failed to establish due diligence in ascertaining the insurance coverage of the offending vehicle.

"While a party is entitled to a rebuttable presumption of receipt based upon proof of regular mailing, the respondent failed to submit sufficient evidence attesting to the mailing of the letter . . ."

In *State Farm Mutual Automobile Ins. Co. v. Cybulski*,[26] the court held that the claimant failed to meet his burden of establishing a reasonable excuse for the more than two-year delay in giving notice of his SUM claim where "[t]he extent of [claimant's] injury did not change from the time of the accident until the time when [claimant] provided Petitioner with notice of the SUM claim." The court also held that the claimant did not demonstrate that he acted with "due diligence" in attempting to ascertain the insurance coverage of the tortfeasor, where the record established that he retained an attorney one month after the accident, but did not reflect the efforts of that attorney, if any, to obtain the necessary information.[27]

In *Phoenix Ins. Co. v. Tasch*,[28] the SUM insurer denied receipt of the claimant/insured's notice of intent to file an underinsured motorist claim. In holding that the claimant/insured "failed to establish that he provided timely written notice of the underinsured motorist claim," the court stated: "While a party is entitled to a rebuttable presumption of receipt based upon proof of regular mailing, the respondent failed to submit sufficient evidence attesting to the mailing of the letter . . . , or to the existence of an office practice geared to ensure the proper addressing or mailing of this letter."[29] In *Varella v. American Transit Ins. Co.*,[30] however, the plaintiff submitted an affidavit of service by mail, and the defendant's claims manager did not deny receiving the papers. The court held that the plaintiff's affidavit of service raised a presumption that a proper mailing occurred, and the defendant's papers failed to raise an issue of fact regarding service.

In *Tri-State Consumer Ins. Co. v. Yaskin*,[31] the court restated the general rule that "[a]n insured's reasonable, good faith belief in nonliability may excuse a delay in notifying the insurer of an accident."[32]

Notice of Legal Action

In addition to the basic notice requirement, the UM and SUM endorsements also require, as a condition precedent to coverage, that the insured or his or her legal representative "immediately" forward to the insurer a copy of the summons and complaint and/or other legal papers served in connection with the underlying lawsuit against the tortfeasor.

In 2002, in *Brandon v. Nationwide Mutual Ins. Co.*,[33] the Court of Appeals held, for the first time, that the insurer must prove that it has been prejudiced by the breach of the Notice of Legal Action condition. This new rule is in contradistinction to the "no prejudice" rule applicable to other types of required notice.[34]

In *Mark A. Varrichio & Assocs. v. Chicago Ins. Co.*,[35] the Second Circuit Court of Appeals examined the scope and effect of *Brandon* – specifically, whether its application was limited to notice of suit provisions in SUM policies, or whether it applied to all notice of suit provisions and "marks the death of New York's traditional no-prejudice rule for notice of suit provisions where there has been a timely notice of claim." The Second Circuit stated that if it were to decide the issue, it would likely conclude "that the general principles that the New York Court of Appeals adopted in *Brandon* suggest that the court would not apply the no-prejudice rule" in the situation where, in a non-SUM contest, the insured complied with the notice of claim provision, but not the notice of legal action provision. However, because the court could not be sure whether a shift to a general prejudice requirement is under way in New York, it certified the following question to the New York Court of Appeals:

> Where an insured has already complied with a policy's notice of claim requirement, does New York require the insurer to demonstrate prejudice in order to disclaim coverage based on the insured's failure to comply with the policy's notice of claim requirement?

This certified question was accepted by the Court of Appeals in 2002,[36] but was subsequently withdrawn[37] because the case was settled by the parties. Thus, this important certified question was never answered.

Discovery The UM and SUM endorsements also contain provisions requiring, upon request, a statement under oath, examination under oath, physical examinations, authorizations and medical reports and records. The provision of each type of discovery, if requested, is a condition precedent to recovery.

In *GEICO v. Rosenfarb*,[38] the Second Department held that the lower court had improvidently exercised its discretion in granting a temporary stay of arbitration for the purpose of allowing discovery where the record indicated that "the insurance carrier had ample time to seek discovery" but "unjustifiably failed to do so in that time." The same result was obtained in *New York Central Mutual Fire Ins. Co. v Gershovich*.[39]

On the other hand, in *GEICO v. Annamanthadoo*,[40] the Second Department held that the lower court "should have granted the petitioner's request for the disclosure required by the terms of [the] policy."

Once a prima facie case of coverage is established, the burden shifts to the opposing party to come forward with evidence to the contrary.

Petitions to Stay Arbitration

Arbitration vs. Litigation In *Mahmood v. Fidelity & Guaranty Ins. Co.*,[41] the Second Department, following up on the Fourth Department's decision last year in *Cacciatore v. New York Central Mutual Fire Ins. Co.*,[42] held that under the terms of the SUM endorsement, if the limits of UM coverage are $25,000/$50,000, then any disagreement with respect to the value of the claim "shall" be settled by arbitration. Thus, in such cases, arbitration of the dispute is mandatory.

Filing and Service CPLR 7503(c) provides, in pertinent part, that "[a]n application to stay arbitration must be made by the party served within twenty days after service upon him of the notice [of intention to arbitrate] or demand [for arbitration], or he shall be so precluded." It is, of course, well-established that the failure to make a timely application to stay arbitration will result in the denial of the application as untimely and constitutes a bar to judicial intrusion into the arbitration proceeding.

In *Eagle Ins. Co. v. Pierre-Louis*,[43] the court noted that "[t]he 20-day period in which to apply for a stay of arbitration pursuant to CPLR 7503(c) is measured from the date of receipt of the demand for arbitration."

In *American Transit Ins. Co. v. Carillo*,[44] the court found:

> Jurisdiction over a nonparty to a proceeding to stay arbitration cannot be obtained by the service upon it of the notice of petition and petition by either ordinary mail or certified mail, whether or not such service is authorized by a court order. . . . Once added to the proceeding by the court as an additional respondent, proper service could only [be] effectuated . . . by court-ordered service of a supplemental notice of petition, and a supplemental petition, pursuant to CPLR 1003.[45]

CPLR 7503(c) provides that a Demand for Arbitration or a Notice of Intention to Arbitrate "shall be served in the same manner as a Summons or by registered or certified mail, return receipt requested." In *Blue Ridge Ins. Co. v. Russo*,[46] the claimant served his Demand for Arbitration by regular mail, rather than by registered or certified mail. The petitioner/insurer's contention that the manner of service rendered the demand a nullity was rejected by the court, which held, citing a 1983 decision by the Court of Appeals, that the service did not render the demand a nullity and that the matter could proceed notwithstanding the defect in service.[47]

Burden of Proof An insurer seeking to stay arbitration of an uninsured motorist claim has the burden of establishing that the offending vehicle was insured at the time of the accident. Once a *prima facie* case of coverage is established, the burden shifts to the opposing party to come forward with evidence to the contrary. So held the Second Department in *Lumbermens Mutual Casualty Co. v. Quintero*[48] and *CGU Ins. Co. v. Greatheart*.[49]

In *Eagle Ins. Co. v. Kapelevich*,[50] the court held that the petitioner/insurer could establish a *prima facie* case of coverage for the offending vehicle by submitting a portion of a New York State Department of Motor Vehicles Registration Expansion Record showing that such coverage existed for the pertinent time period.[51]

In *Allstate Ins. Co. v. Anderson*,[52] the court held that Allstate made a *prima facie* showing that the offending vehicle was insured on the date of the accident through the submission of the police report and DMV registration records indicating such coverage. In response, the claimant/respondent submitted a copy of a disclaimer letter from the purported insurer. The court held that the disclaimer letter "merely raised issues of fact as to whether [the insured] timely and validly disclaimed coverage of the offending vehicle [citations omitted]." Thus, it held that the insurer "must be joined as party respondent to the proceeding" and, thus, remitted the matter to the Supreme Court for an evidentiary hearing to resolve the issues.

In *American Alliance Ins. Co. v. Eagle Ins. Co.*,[53] an officer of the agent and underwriter for Eagle Insurance

Company testified in detail about the cancellation procedures it followed in terminating a policy for non-payment. This witness established that he had the requisite knowledge to testify with authority regarding those procedures. This testimony was held to be sufficient to prove a proper cancellation in accordance with Ins. Law § 3426(c)(1).

In *Eagle Ins. Co. v. Villegas*,[54] the respondent insurer opposed the Petition to Stay Arbitration by asserting that it had disclaimed coverage due to lack of cooperation by its insured. The court held that this disclaimer raised triable issues as to the propriety and effectiveness of the disclaimer, and that, therefore, the petition should not have been granted without first joining the Respondent insurer, the owner and operator of the vehicle and the insurer for the operator as necessary parties, without affording each of those parties the opportunity to submit evidence, and without conducting an evidentiary hearing in order to determine the factual basis and validity of the disclaimer.[55]

Arbitration Awards

Issues for the Arbitrator In *GEICO v. Sherman*,[56] the court noted that in a SUM arbitration, the arbitrator may properly determine the issues of liability and damages.

In *AIU Ins. Co. v. Cabreja*,[57] the court held that where the driver or owner of the vehicle identified by the claimant denies any involvement in the accident, "there is an obvious conflict as to whether the offending vehicle was properly identified," which poses an issue for judicial (not arbitral) resolution – *i.e.*, a framed issue hearing.

In *National Grange Mutual Ins. Co. v. Vitebskaya*,[58] the court stated, "If there is at least one arbitrable issue, arbitration should proceed."

Scope of Review In *State Farm Mutual Automobile Ins. Co. v. Arabov*,[59] the court noted, "'It is well settled that where a party who has participated in arbitration seeks to vacate the award, vacatur may only be granted upon the grounds that the rights of that party were prejudiced by corruption, fraud or misconduct in procuring the award, partiality of an arbitrator, that the arbitrator exceeded his power or failed to make a final and definite award, or a procedural failure that was not waived.'"[60]

In *Seligman v. Allstate Ins. Co.*,[61] the court granted the claimant/insured's motion to vacate an arbitration award against him on the basis of the arbitrator's failure to disclose a 20-year employment history with the respondent insurer, even though there was a 25-year gap between the arbitrator's employment with the insurer and the date of the arbitration. As noted by the court,

> In order to protect the integrity of the arbitral process the arbitrator and the American Arbitration Association [AAA] had a duty to disclose any facts within their knowledge which might in any way support an inference of bias. An arbitrator's failure to disclose any information that may reasonably support an inference of bias may be grounds to vacate the arbitration award so long as the relationship was not a trivial one.[62]

Moreover, "[a]n existing or past attorney-client relationship requires disclosure in order to afford the parties the opportunity to make an independent judgment as to whether the past relationship should serve as a basis to challenge the arbitrator. In this court's view a twenty year relationship is not so trivial as to preclude disclosure even with the twenty-five year gap."[63]

In *GEICO v. Sherman*, the court held that the arbitrator did not exceed his authority or commit misconduct in allowing the insurer to call two witnesses despite its failure to comply with the notice requirements of the AAA rules (the "15-day" rule). The court noted, "Although it may have been better if the arbitrator had not allowed [the witnesses] to testify at the hearing . . . , the [respondents] failed to prove by clear and convincing evidence that doing so constituted misconduct within the meaning of CPLR 7511(b)(1)(i)."[64] Rather, any error in allowing the witnesses to testify was deemed by the court to be "harmless" because it was obvious that the arbitrator's decision was not based upon the testimony of those witnesses, but, rather, upon the Respondent's testimony. On the other hand, in *Marcano v. Allstate Ins. Co.*,[65] the court held that where the Claimant neglected to comply with court-ordered discovery by failing to appear for a physical examination and/or to provide the insurer with documents and authorizations, and also failed to comply with the AAA's 15-day rule for the submission of evidence, the arbitrator's award dismissing the claim was "supported by the evidence, not arbitrary and capricious and not in excess of the arbitrator's powers."

In *New York Central Mutual Fire Ins. Co. v. Pinckney*,[66] the arbitrator awarded the respondent $40,000 in an underinsured motorist arbitration. Thereafter, in response to a subsequent letter from the respondent's attorney, the arbitrator amended the initial award by increasing the award to $65,000. The court rejected that amendment and increase, noting that there was no support for the respondent's contention that there had been a miscalculation of figures in the initial award. The court further noted that there was "no other valid basis for amending the award," and that the petitioner had not been afforded its due process right to be heard in opposition to the respondent's request for modification.

Res Judicata/Collateral Estoppel In *Searchwell v. L.G.A. Transportation, Inc.*,[67] the court rejected the claimant's contention that because the arbitrator awarded less than the full available amount (there,

$10,000), the award must be presumed to constitute her total recovery for non-economic loss, and she should be barred from seeking any additional recovery from joint-tortfeasors for the same injuries. Although case law has established that where an arbitrator awards less than the policy amount, "such award must be considered, *prima facie*, to be the total damages due for noneconomic loss" unless the arbitrator indicates that it is limited to the damages caused by the uninsured vehicle.[68] The court noted that "the language of the arbitration award in this case reflected an intention to limit damages to the uninsured vehicle's apportioned share of liability." Thus, there was no bar to the pursuit of additional damages by the claimant. The court also noted that "since the language of the award does not indicate that it was intended to represent the total compensation to which the plaintiff is entitled for her injuries, it cannot be accorded preclusive effect under the doctrines of res judicata and collateral estoppel."

Interest on Arbitration Award In *Church Mutual Ins. Co. v. Kleingardner*,[69] the court noted, "Upon confirmation of an arbitration award, interest should be provided from the date of the award." The court added that "a party may move to confirm an arbitration award despite the fact that payment has been tendered by the respondent [citations omitted]. However, interest in such an action is limited to the period of time from the arbitrator's award to the tender of payment."

Statute of Limitations In *Allstate Ins. Co. v. Venezia*,[70] the court reminded that the statute of limitations applicable to UM/SUM claims is the six-year contract statute of limitations.

UNINSURED MOTORIST ISSUES

Insurer's Duty to Provide Prompt Written Notice of Denial or Disclaimer (Ins. L. § 3420(d))

Insurance Law § 3420(d) requires liability insurers to "give written notice as soon as is reasonably possible of . . . disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant." The statute applies when an accident occurs in the State of New York.

Where notice is provided directly by the injured party, the disclaimer must address with specificity the grounds for disclaiming coverage applicable to both the injured party and the insured. However, where the insured is the first to notify the insurer, even if that notice is untimely, any subsequent information provided by the injured party is superfluous for notice purposes and need not be addressed in the notice of disclaimer issued by the insurer.[71]

In *GEICO v. Moreno*,[72] the court noted, "While [the insurer] may have properly disclaimed coverage as to the owner of [the] vehicle, the scope of the policy's coverage extended to permissive users of the vehicle. Since the [insurer] never properly disclaimed coverage as to the driver of the offending vehicle, coverage for the vehicle existed. . . ."

In *A.J. McNulty & Co., Inc. v. Lloyds of London*,[73] the court noted that "the timeliness of an insurer's disclaimer is measured from the point in time when the insurer first learns of the grounds for disclaimer of liability or denial of coverage." This is so even where the insured has, in the first instance, failed to give timely notice of the claim or the underlying accident.[74]

In *Uptown Whole Foods, Inc. v. Liberty Mutual Fire Ins. Co.*,[75] the court held that a 57-day delay in disclaiming was unreasonable as a matter of law where "the basis alleged for the disclaimer [late notice] was obvious on the face of the summons and complaint, affidavit of service, and the order granting the motion for leave to enter judgment on default . . . ." Further, the court rejected the insurer's attempt to justify its delay on the ground that it had to investigate the claim, because it found that the investigation was "unrelated to the disclaimer based on late notice."

In *Varella v. American Transit Ins. Co.*,[76] the court held that a delay of more than three months in disclaiming on the ground of late notice was unreasonable as a matter of law.[77]

In *Lehrer McGovern Bovis, Inc. v. Investors Underwriting Managers, Inc.*,[78] the court held that the insurer's failure to disclaim liability insurance coverage for two months after the occurrence where the plaintiff failed to directly notify the insurer of the occurrence, as required by the policy, and the plaintiff was aware that the insurer had already timely declined the claim by the named insured, was not unreasonable. In *Travelers Ins. Co. v. Volmar Construction Co., Inc.*,[79] the court held that a 14-day delay after the insurer became aware of the pertinent facts was not unreasonable.

In *Peters v. State Farm Fire & Casualty Co.*,[80] the Court of Appeals held that where the insurer first learned of a claim that evoked its exclusion from coverage for bodily injury which is "either expected or intended by an insured" or "which is the result of willful and malicious acts of an insured," in January 1992, issued a reservation of rights letter in February 1992, and concluded its investigation and disclaimed coverage on April 9, 1992, that disclaimer was timely.

In *New York University v. Jetco Contracting Corp.*,[81] the Second Circuit Court of Appeals stated:

> Under New York Law, it is clear that insurers are afforded the opportunity to investigate an insured's

> claim in order to determine whether coverage is appropriate. New York courts accordingly have found that an insurer's general need to conduct such investigations in a thorough manner constitutes a sufficient reason for delayed notification.
>
> Courts have also concluded that notification delays are reasonable when an external factor beyond the insurer's control unexpectedly interferes with the insurers' ability to investigate the claim in a timely fashion.[82]
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> By contrast, courts have deemed insurers' explanations for delayed notification insufficient where the basis for denying coverage was or should have been readily apparent to the insurer even before the onset of the delay.[83]
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>
> [T]he New York Court of Appeals has held that unexcused delays of 60 days or more are unreasonable as a matter of law. There remains some ambiguity, however, as to whether the unreasonableness of a delay as a matter of law is gauged from the length of the delay, or by the lack of explanation by the insurer, or by both.
>
> New York courts seem to be in general agreement that a delay in notification by an insurer is unreasonable as a matter of law when the delay is both two months or longer *and* unexplained.
>
> Yet, some courts have interpreted *Hartford* as indicating that even a delay of *less than* two months, if unexplained or unpersuasively explained, can be unreasonable as a matter of law.[84]

Noting the significance of these issues and their likely recurrence, the Second Circuit certified the following two questions to the New York Court of Appeals:

> 1. Under N.Y. Ins. Law § 3420(d), may an insurer who has discovered grounds for denying coverage wait to notify the insured of denial of coverage until after the insurer has conducted an investigation into alternate, third-party sources of insurance benefitting the insured, although the existence or non-existence of alternate insurance sources is not a factor in the insurer's decision to deny coverage?
>
> 2. If an investigation into alternate sources of insurance is not a proper basis for delayed notification under N.Y. Ins. Law § 3420(d), is an unexcused delay in notification of 48 days unreasonable as a matter of law under § 3420(d)?[85]

The Court of Appeals accepted those certified questions.[86]

On November 20, 2003, the Court of Appeals held in *First Financial Ins. Co. v. Jetco Contracting Corp.*,[87] that an unexcused or unexplained delay of 48 days in giving written notice of disclaimer is unreasonable as a matter of law. As explained by the Court of Appeals, "timeliness of an insurer's disclaimer is measured from the point in time when the insurer first learns of the grounds for disclaimer of liability or denial of coverage," and "an insurer's explanation is insufficient as a matter of law where the basis for denying coverage was or should have been readily apparent before the onset of the delay." Moreover, "[a]n insurer who delays in giving written notice of disclaimer bears the burden of justifying the delay. While Insurance Law § 3420(d) speaks only of giving notice 'as soon as reasonably possible,' investigation into issues affecting an insurer's decision whether to disclaim coverage obviously may excuse delay in notifying the policyholder of a disclaimer." However, "[w]e cannot accept . . . that delay simply to explore other sources of insurance for the policyholder – an excuse unrelated to the insurer's own decision to disclaim – is permissible."

The New York courts have repeatedly held that for the purpose of determining whether a liability insurer has a duty to promptly disclaim in accordance with Ins. Law § 3420(d), a distinction must be made between (1) policies that contain no provisions extending coverage to the subject loss, and (2) policies that do contain provisions extending coverage to the subject loss, and which would thus cover the loss but for the existence, elsewhere in the policy, of an exclusionary clause. It is only in the former case that compliance with Ins. Law § 3420(d) may be dispensed with. In *Lumbermens Mutual Casualty Co. v. Quintero*,[88] the court noted: "An insurer has no obligation to timely disclaim in those situations in which coverage does not exist. Therefore, the appellants' insurer was not required to timely disclaim, as the uninsured motorist coverage of the policy would not attach unless and until it was established that the offending vehicle was uninsured on the date of the accident."[89]

In *State Farm Mutual Automobile Ins. Co. v. Cooper*,[90] the court noted that a notice of disclaimer "must properly apprise the injured party or [any other] claimant, with a high degree of specificity, of the ground or grounds on which the disclaimer is predicated." An insurer which has denied liability on a specific ground may not thereafter shift the basis for its disclaimer to another ground known to it at the time of its original repudiation.[91] Thus, in *Cooper*, the court held that a disclaimer sent to the insured based upon the insured's late notice was invalid as to the injured party because it did not refer to the injured party's late notice.[92]

In *A.J. McNulty & Co., Inc. v. Lloyds of London*,[93] the court held that the service of an answer to a declaratory judgment complaint 20 days after service of the complaint constituted valid and timely notice of disclaimer.

A notice of disclaimer may be sent to the insured's attorney.[94]

Cancellation of Coverage

One category of an "uninsured" motor vehicle is where the policy of insurance for the vehicle had been canceled before the accident. Generally speaking, in order to effectively cancel an owner's policy of liability insurance, an insurer must strictly comply with the detailed and complex statutes, rules and regulations governing notices of cancellation and termination of insurance, which differ depending upon whether, for example, the vehicle at issue is a livery or private passenger vehicle, whether the policy was written under the Assigned Risk Plan, and/or was paid for under premium financing contract.

In *Crump v. Unigard Ins. Co.*,[95] the court held that a cancellation in accordance with Banking Law § 576 occurred when the notice of cancellation sent by a premium finance agency was actually received by the insurer, and not on the date stated in the notice of cancellation. The court specifically concluded that Banking Law § 576, as amended in 1978, did not abrogate the common-law rule requiring that an insurer actually receive the notice before the cancellation becomes effective.[96]

In *General Electric Capital Corp. v. Volchyok*,[97] the insurer attempted to cancel its policy for non-payment of premiums by mailing a notice of cancellation to its insured, the lessee of the vehicle, but not to the lessor. The cancellation notice specifically provided that it was required to be mailed at least 15 days before the effective date of the cancellation to the named insured shown on the declarations page. Since the lessor/owner was named as an additional insured and as a loss payee, the court held that it, too, was entitled to receive notice of cancellation. Thus, the lessor/owner was entitled to summary judgment on its cause of action against the insurer to recover damages for breach of the insurance policy.

In *AIU Ins. Co. v. Mensah*,[98] the court noted that pursuant to Vehicle & Traffic Law § 313(2)(a), in order to effectively cancel an auto insurance policy as against an innocent third party, the insurer must file the notice of cancellation with the Department of Motor Vehicles. The court further noted that "an ineffective notice of cancellation will cause the policy to continue in force after its stated expiration date."[99]

In *McGuiness v. Shamrock Auto Center*,[100] the court held that the insurer properly canceled its liability policy due to the insured's failure to make payment within 15 days of receipt of notice of cancellation, where the insured attempted to make payment to its own broker, who was not an agent of the insurer, one day late.

Hit-and-Run

One of the requirements for a valid uninsured motorist claim based upon a hit-and-run is "physical contact" between an unidentified vehicle and the person or motor vehicle of the claimant.

In *Great Northern Ins. Co. v. Ballinger*,[101] the court stated:

> Physical contact is a condition precedent to an arbitration based upon a hit-and-run accident involving an unidentified vehicle. While direct contact between the insured and the unidentified vehicle is not required, the physical contact, as contemplated by Insurance Law § 5217, must involve the continued transmission of force indirectly or simultaneously through an intermediate agency, and the initial impact must be that of a collision between the unidentified vehicle with the complainant, the vehicle occupied by him, an obstruction, or other object causing the bodily injury. Arbitration is not foreclosed when the accident originates with the unidentified vehicle.[102]

Where, as here, the police report fails to indicate that there was any contact with the unidentified vehicle, but the claimant/insured raises an issue of fact in that regard by supplying an affidavit attesting to such contact, a hearing should be held to determine the issue.

In *Eveready Ins. Co. v. Scott*,[103] the court stated: "The failure of the police accident report to mention contact with another vehicle raises a factual issue as to whether there actually was physical contact between [the claimant's vehicle] and a 'hit and run' vehicle." Thus, in such cases, a hearing is required to resolve that issue.

In *State-Wide Ins. Co. v. Chardon*,[104] the police were called to the scene of a three-vehicle accident by the claimant. After attending to some of the injures, the investigating police officer motioned to the operator of the third vehicle to come over and produce his license and registration. That operator subsequently fled the scene without providing the pertinent information. Although the claimant had spoken briefly to the operator of the third vehicle, he did not obtain his identification, believing that the police would accomplish that task. Under these circumstances, the court held that the claimant acted reasonably in calling the police and once they arrived they could not have anticipated that the driver of the offending vehicle would ignore the explicit directions of the police officer and leave the scene without the requisite exchange of information. Thus, the court allowed the claimant to proceed with his uninsured motorist claim.

In *Eagle Ins. Co. v. Brown*,[105] the court held that since the petitioner made an unopposed showing that the respondent failed, among other things, to report the alleged hit-and-run accident to the police within 24 hours, and failed to notify the insurer of the UM claim as soon

as practicable, the Petition to Stay Arbitration should have been granted.

In *Eveready Ins. Co. v. Farrell*,[106] the court held that where two notice provisions in a policy, pertaining to the filing of a statement under oath with respect to a hit-and-run claim – *i.e.*, where one part of the policy requires a claimant to file a statement under oath within 90 days after an accident, and another part of the policy requires a claimant to furnish sworn written proof of claim after written request by the company – "the two notice provisions of the policy are ambiguous, and must be construed against the [insurer]."

Insurer Insolvency

The SUM endorsement under Regulation 35-D includes within the definition of an "uninsured" motor vehicle a vehicle whose insurer "is or becomes insolvent."

"An ineffective notice of cancellation will cause the policy to continue in force after its stated expiration date."

In *American Manufacturers Mutual Ins. Co. v. Morgan*,[107] the court held that, under Regulation 35-D, any situation wherein the tortfeasor's carrier has become insolvent (in liquidation) – whether covered by the Security Fund or not; whether the Fund has money or not – is an uninsured motorist situation and the claimant is entitled to pursue UM benefits under his or her policy.

Pursuant to *Morgan*, in a Regulation 35-D case involving insurer insolvency, the claimant can proceed to SUM arbitration. If the SUM carrier wishes to pursue a subrogation claim against the tortfeasor and the insolvent insurer, *it* would then have to pursue a claim from the Security Fund, with its attendant delays and risks of non-payment. As stated by the court, quoting the superintendent of insurance,

> The individual insured for supplementary uninsured motorists coverage should not be required to wait for a recovery from the Security Fund on behalf of the insolvent insurer. Because the SUM insurer has a subrogation right against the insolvent insurer, the Security Fund would still remain liable, but the insured would be provided a more prompt recovery from his or her own insurer.[108]

Note: Several courts noted in 2003 that the *Morgan* rule applies only in the context of Regulation 35-D SUM endorsements, but that in non-Regulation 35-D SUM cases, which are governed by the basic, mandatory UM endorsement under Ins. Law § 3420(f)(1) the old rule, which distinguishes between covered and non-covered insolvencies, still applies.[109]

UNDERINSURED MOTORIST ISSUES

Trigger of Coverage In *GEICO v. Annamanthadoo*,[110] the court held that where the bodily injury limits of the claimant's policy exceed the bodily injury limits of the tortfeasor's policy, underinsurance coverage is triggered.

Reduction in Coverage In *Graphic Arts Mutual Ins. Co. v. Dunham*,[111] the court held that the reduction in coverage language of the SUM policy limited SUM benefits to the difference between the SUM limits and the motor vehicle bodily injury liability insurance or bond payments received by the insured. In this case, application of that language resulted in a complete offset and, thus, no SUM exposure existed.

Priority of Coverage In *GEICO v. Shlomy*,[112] the court referred to and applied the "Priority of Coverage" provision of the SUM endorsement, which provides that where an insured may be covered for uninsured or supplementary uninsured motorist coverage under more than one policy, the maximum amount recoverable may not exceed the highest limit of coverage for any one vehicle under any one policy. In such cases, the following order of priority applies: (1) the policy covering the vehicle occupied by the claimant, (2) the policy identifying the claimant as a named insured, and (3) any other policy covering the claimant.

1. *See* Jonathan A. Dachs, *2002 Update on Issues Affecting Accidents Involving Uninsured and/or Underinsured Motorists*, N.Y. St. B. J., Vol. 75, No. 5, at 32 (June 2003); *A Review of Uninsured Motorist and Supplementary Uninsured Motorist Cases Decided in 2001*, N.Y. St. B.J., Vol. 74, No. 6, at 20 (Jul./Aug. 2002); *Actions by Courts and Legislature in 2000 Address Issues Affecting Uninsured and Underinsured Drivers*, N.Y. St. B.J. 26, (Sept. 2001); *Summing Up 1999 "SUM" Decisions: Courts Provide New Guidance on Coverage Issues for Motorists*, 72 N.Y. St. B.J. 18 (Jul./Aug. 2000); *Decisions in 1998 Clarified Issues Affecting Coverage for Uninsured and Underinsured Motorists*, 71 N.Y. St. B.J. 8 (May/June 1999); *Legislative and Case Law Developments in UM/UIM/SUM Law – 1997*, 70 N.Y. St. B.J. 46 (Sept./Oct. 1998); *Developments in Uninsured and Underinsured Motorist Coverage*, 69 N.Y. St. B. J. 18 (Sept./Oct. 1997); The Parts of the SUM: Uninsured and Underinsured Motorist Coverage in 1995, 68 N.Y. St. B.J. 42 (Jul./Aug. 1996); *Uninsured and underinsured Motorist Cases in 1994*, 67 N.Y. St. B.J. 24 (Nov. 1995); *Uninsured and Underinsured . . . But Not Underlitigated: 1993: An Important Year for UM/UIM Coverage*, 66 N.Y. St. B.J. 13 (Sept./Oct. 1994).
2. 303 A.D.2d 592, 756 N.Y.S.2d 484 (2d Dep't 2003).
3. *See Buckner v. MVAIC*, 66 N.Y.2d 211, 495 N.Y.S.2d 952 (1985); *Royal Ins. Co. v. Bennett*, 226 A.D.2d 1084 (4th

Dep't 1976); *Hogan v. Cigna Prop. & Cas. Co.*, 216 A.D.2d 442 (2d Dep't 1995).

4. 1 A.D.3d 371, 766 N.Y.S.2d 594 (2d Dep't 2003).
5. 303 A.D.2d 633, 756 N.Y.S.2d 653 (2d Dep't 2003).
6. 2 A.D.3d 500, 769 N.Y.S.2d 551 (2d Dep't 2003).
7. 1 Misc. 3d 774, 766 N.Y.S.2d 320 (Sup. Ct., Kings Co. 2003).
8. 302 A.D.2d 522, 756 N.Y.S.2d 79 (2d Dep't 2003).
9. *See also State Farm Mut. Auto. Ins. Co. v. Laguerre*, 305 A.D.2d 490, 759 N.Y.S.2d 531 (2d Dep't 2003) ("A deliberate collision caused in furtherance of an insurance fraud scheme is not a covered accident").
10. 301 A.D.2d 740, 741, 753 N.Y.S.2d 198 (3d Dep't 2003).
11. *Id.* at 741 (citations omitted).
12. 306 A.D.2d 512, 763 N.Y.S.2d 65 (2d Dep't 2003).
13. *Id.* at 513 (citing *Olin v. Moore*, , 518 (2d Dep't 1991)).
14. *See Maxi-Aids, Inc. v. Gen. Accident Ins. Co. of Am.*, 303 A.D.2d 469, 756 N.Y.S.2d 431 (2d Dep't 2003).
15. 99 N.Y.2d 568, 755 N.Y.S.2d 703 (2003).
16. *See Greenburgh Eleven Union Free Sch. Dist. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 304 A.D.2d 334, 758 N.Y.S.2d 291 (1st Dep't 2003).
17. 1 A.D.3d 304, 766 N.Y.S.2d 856 (2d Dep't 2003).
18. 306 A.D.2d 120, 762 N.Y.S.2d 586 (1st Dep't 2003).
19. *Id.* at 121–22.
20. 301 A.D.2d 465, 754 N.Y.S.2d 15 (2d Dep't 2003).
21. 307 A.D.2d 689, 763 N.Y.S.2d 177 (3d Dep't 2003).
22. 305 A.D.2d 1063, 759 N.Y.S.2d 412 (4th Dep't 2003).
23. 304 A.D.2d 390, 756 N.Y.S.2d 752 (1st Dept, 2003).
24. 303 A.D.2d 987, 757 N.Y.S.2d 18 (4th Dep't 2003).
25. 305 A.D.2d 988, 758 N.Y.S.2d 572 (4th Dep't 2003).
26. 1 A.D.3d 905, 767 N.Y.S.2d 739 (4th Dep't 2003).
27. *See* Norman H. Dachs & Jonathan A. Dachs, *SUM Notice in the Context of Uncertain or Undetermined Injuries*, N.Y.L.J., Sept. 9, 2003, p. 3, col. 1.
28. 306 A.D.2d 288, 762 N.Y.S.2d 99 (2d Dep't 2003).
29. *See Fireman's Ins. Co. of Newark v. Sorto*, 303 A.D.2d 502, 756 N.Y.S.2d 436 (2d Dep't 2003) (claimant's counsel's affirmation in opposition to the petition, in which he contended that notice of the UM claim was given just two days after the accident, was made "without personal knowledge of whether the letter was in fact mailed" and was, therefore, held to be incompetent as evidence of timely notice).
30. 306 A.D.2d 464, 762 N.Y.S.2d 253 (2d Dep't 2003).
31. 304 A.D.2d 560, 756 N.Y.S.2d 906 (2d Dep't 2003).
32. *See C.C.R. Realty of Dutchess, Inc. v. N.Y. Gen. Mut. Fire Ins. Co.*, 1 A.D.3d 304, 766 N.Y.S.2d 856 (2d Dep't 2003).
33. 97 N.Y.2d 491, 743 N.Y.S.2d 53 (2002).
34. *See* Norman H. Dachs & Jonathan A. Dachs, *Notice of Legal Action and the Requirement of Prejudice*, N.Y.L.J., July 9, 2002, p. 3, col. 1; *see also Merchants Mut. Ins. Co. v. Falisi*, 99 N.Y.2d 568, 755 N.Y.S.2d 703 (2003); *Banks v. American Mfrs. Ins. Co.*, 306 A.D.2d 120, 762 N.Y.S.2d 586 (1st Dep't 2003).
35. 312 F.3d 544 (2d Cir. 2002).
36. *See* 99 N.Y.2d 545, 753 N.Y.S.2d 805 (2002).
37. *See* 328 F.3d 50 (2d Cir. 2003); 100 N.Y.2d 527, 760 N.Y.S.2d 761 (2003).
38. 306 A.D.2d 478, 761 N.Y.S.2d 512 (2d Dep't 2003).
39. 1 A.D.3d 364, 766 N.Y.S.2d 596 (2d Dep't 2003).
40. 302 A.D.2d 460, 755 N.Y.S.2d 404 (2d Dep't 2003).
41. 303 A.D.2d 385, 755 N.Y.S.2d 667 (2d Dep't 2003).
42. 301 A.D.2d 253, 750 N.Y.S.2d 712 (4th Dep't 2002).
43. 306 A.D.2d 344, 762 N.Y.S.2d 249 (2d Dep't 2003).
44. 307 A.D.2d 220, 763 N.Y.S.2d 561 (2d Dep't 2003).
45. *Id.* at 220 (citations omitted).
46. 2 A.D.3d 728, 769 N.Y.S.2d 592 (2d Dep't 2003).
47. *See Initial Trends, Inc. v. Campus Outfitters, Ins.*, 58 N.Y.2d 896, 460 N.Y.S.2d 500 (1983). ("The consequence of failure to strictly comply with the provisions of CPLR 7503 (subd. [c]) in serving a demand for arbitration is to toll the time limit on an application to stay arbitration."). *But see Commercial Union Ins. Co. v. Buckman*, 58 Misc. 2d 164, 295 N.Y.S.2d 16 (Sup. Ct., Monroe Co. 1968) (where demand for arbitration under uninsured motorist policy was served by regular mail only and not by registered or certified mail, demand was a nullity).
48. 305 A.D.2d 684, 762 N.Y.S.2d 82 (2d Dep't 2003).
49. 301 A.D.2d 649, 753 N.Y.S.2d 883 (2d Dep't 2003).
50. 307 A.D.2d 927, 762 N.Y.S.2d 896 (2d Dep't 2003).
51. *See Eagle Ins. Co. v. Villegas*, 307 A.D.2d 879, 764 N.Y.S.2d 15 (1st Dep't 2003) (*prima facie* showing of coverage made by submission of DMV Registration Record Expansion report and Police Accident Report).
52. 303 A.D.2d 496, 755 N.Y.S.2d 724 (2d Dep't 2003).
53. 304 A.D.2d 465, 757 N.Y.S.2d 730 (1st Dep't 2003).
54. 307 A.D.2d 879, 764 N.Y.S.2d 15 (1st Dep't 2003).
55. *See Atlantic Mut. Ins. Co. v. Matera*, 304 A.D.2d 572, 756 N.Y.S.2d 889 (2d Dep't 2003).
56. 307 A.D.2d 967, 763 N.Y.S.2d 649 (2d Dep't 2003).
57. 301 A.D.2d 448, 754 N.Y.S.2d 253 (1st Dep't 2003).
58. 1 Misc. 3d 774, 766 N.Y.S.2d 320 (Sup. Ct., Kings Co. 2003).
59. 2 A.D.3d 531, 767 N.Y.S.2d 905 (2d Dep't 2003).
60. *Id.* at 532 (quoting *GEICO v. Sherman*, 307 A.D.2d 967, 763 N.Y.S.2d 649 (2d Dep't 2003)). *See* CPLR 7511(b)(1).
61. 195 Misc. 2d 553, 756 N.Y.S.2d 403 (Sup. Ct., Nassau Co. 2003).
62. *Id.* at 557 (citations omitted).
63. *Id.* (citations omitted). *See* Norman H. Dachs & Jonathan A. Dachs, *Arbitrator's Obligations of Impartiality and Disclosure*, N.Y.L.J., May 13, 2003, p. 3, col. 1.
64. 307 A.D.2d 967, 969, 763 N.Y.S.2d 649 (2d Dep't 2003).
65. 309 A.D.2d 608, 766 N.Y.S.2d 41 (1st Dep't 2003).
66. 303 A.D.2d 757, 756 N.Y.S.2d 869 (2d Dep't 2003) (citations omitted).
67. 307 A.D.2d 348, 762 N.Y.S.2d 830 (2d Dep't 2003).
68. *See Leto v. Petruzzi*, 81 A.D.2d 296, 298, 440 N.Y.S.2d 343 (2d Dep't 1981); *Velasquez v. Water Taxi*, 66 A.D.2d 691, 411 N.Y.S.2d 261 (1st Dep't 1978), *aff'd*, 49 N.Y.2d 762 (1980); *Gibe v. Hajek*, 166 A.D.2d 502, 561 N.Y.S.2d 50 (2d Dep't 1990).
69. ___ Misc. 2d ___, ___ N.Y.S.2d ___, 2003 WL 22964792 (Sup. Ct., Oswego Co. 2003).

70. 305 A.D.2d 405, 758 N.Y.S.2d 500 (2d Dep't 2003).
71. *See State Farm Mut. Auto. Ins. Co. v. Cooper*, 303 A.D.2d 414, 756 N.Y.S.2d 87 (2d Dep't 2003) (disclaimer sent to insured based upon insured's late notice was invalid as to injured party because it did not refer to the injured party's late notice); *Fisco v. Provident Washington Ins. Co.*, 303 A.D.2d 451, 755 N.Y.S.2d 893 (2d Dep't 2003).
72. 306 A.D.2d 281, 281, 760 A.D.2d 361 (2d Dep't 2003) (citations omitted).
73. 306 A.D.2d 211, 762 N.Y.S.2d 372 (1st Dep't 2003).
74. *See Colonial Coop. Ins. Co. v. Desert Storm Constr. Corp.*, 305 A.D.2d 363, 757 N.Y.S.2d 894 (2d Dep't 2003); *Blue Ridge Ins. Co. v. Cook*, 301 A.D.2d 598, 754 N.Y.S.2d 41 (2d Dep't 2003).
75. 302 A.D.2d 592, 756 N.Y.S.2d 251 (2d Dep't 2003).
76. 306 A.D.2d 464, 762 N.Y.S.2d 253 (2d Dep't 2003).
77. *See Cosgriff v. Allstate Ins. Co.*, 303 A.D.2d 680, 757 N.Y.S.2d 319 (2d Dep't 2003) (unexplained delay of 17 months was unreasonable as a matter of law); *Heegan v. United Int'l Ins. Co.*, 2 A.D.3d 403, 767 N.Y.S.2d 861 (2d Dep't 2003) (no excuse by insurer for failing properly to commence investigation).
78. 303 A.D.2d 278, 757 N.Y.S.2d 27 (1st Dep't 2003).
79. 300 A.D.2d 40, 752 N.Y.S.2d 286 (1st Dep't 2003).
80. 100 N.Y.2d 634, 769 N.Y.S.2d 195 (2003).
81. 322 F.3d 750 (2d Cir. 2003).
82. *Id.* at 754–55 (citations omitted).
83. *Id.* at 755 (citations omitted).
84. *Id.* at 756–57 (citations omitted).
85. *Id.* at 750 (citations omitted).
86. *See First Fin. Ins. Co. v. Jetco Contr. Corp.*, 99 N.Y.2d 649, 760 N.Y.S.2d 98 (2003).
87. 1 N.Y.3d 64, 769 N.Y.S.2d 459 (2003).
88. 305 A.D.2d 684, 762 N.Y.S.2d 82 (2d Dep't 2003).
89. *Id.* at 685 (citations omitted). *See Chumsky v. Danna Constr. Corp.*, 304 A.D.2d 604, 757 N.Y.S.2d 471 (2d Dep't 2003).
90. 303 A.D.2d 414, 756 N.Y.S.2d 87 (2d Dep't 2003).
91. *See Merchants Mutual Ins. Co. v. Falisi*, 293 A.D.2d 678, 741 N.Y.S.2d 273 (2d Dep't 2002), *rev'd on other grounds*, 99 N.Y.2d 568, 755 N.Y.S.2d 703 (2003).
92. *See Fisco v. Provident Washington Ins. Co.*, 303 A.D.2d 451, 755 N.Y.S.2d 893 (2d Dep't 2003).
93. 306 A.D.2d 211, 762 N.Y.S.2d 372 (1st Dep't 2003).
94. *See Fisco*, 303 A.D.2d 451.
95. 291 A.D.2d 692, 738 N.Y.S.2d 425 (3d Dep't 2002), *aff'd*, 100 N.Y.2d 12, 760 N.Y.S.2d 71 (2003).
96. *Id.* at 693 (citing *Savino v. Merchants Mut. Ins. Co.*, 44 N.Y.2d 625, 628–29, 407 N.Y.S.2d 468 (1978), and relying upon the rationale underlying the statute and the common law rule, which is "to protect the insured and third parties by preventing gaps in coverage").
97. 2 A.D.3d 777, 770 N.Y.S.2d 419 (2d Dep't 2003).
98. 307 A.D.2d 921, 762 N.Y.S.2d 898 (2d Dep't 2003).
99. *See Material Damage Adjustment Corp. v. King*, 1 A.D.3d 439, 766 N.Y.S.2d 695 (2d Dep't 2003).
100. 302 A.D.2d 502, 756 N.Y.S.2d 76 (2d Dep't 2003).
101. 303 A.D.2d 503, 757 N.Y.S.2d 309 (2d Dep't 2003).
102. *Id.* at 504 (citations omitted).
103. 1 A.D.3d 436, 767 N.Y.S.2d 31 (2d Dep't 2003).
104. N.Y.L.J., Aug. 11, 2003, p. 17, col. 2 (Sup. Ct., Nassau Co.).
105. 309 A.D.2d 749, 765 N.Y.S.2d 273 (2d Dep't 2003).
106. 304 A.D.2d 830, 757 N.Y.S.2d 859 (2d Dep't 2003).
107. 296 A.D.2d 491, 746 N.Y.S.2d 726 (2d Dep't 2002).
108. *Id.* at 493–94.
109. *See Eagle Ins. Co. v. Persaud*, 1 A.D.3d 356, 766 N.Y.S.2d 571 (2d Dep't 2003); *Eagle Ins. Co. v. St. Julian*, 297 A.D.2d 737, 747 N.Y.S.2d 773 (2d Dep't 2002). *See also Country-Wide Ins. Co. v. Rashed*, ___ Misc. 2d ___, ___ N.Y.S.2d ___, 2003 WL 22207634 (Sup. Ct., Queens Co. 2003); Norman H. Dachs & Jonathan A. Dachs, *On the 'Top 10,' No-Fault Update, Insolvency and SUM Coverage*, N.Y.L.J., Mar. 11, 2003, p. 3, col. 1.
110. 302 A.D.2d 460, 755 N.Y.S.2d 404 (2d Dep't 2003).
111. 303 A.D.2d 1038, 757 N.Y.S.2d 204 (4th Dep't 2003).
112. 305 A.D.2d 504, 762 N.Y.S.2d 297 (2d Dep't 2003).