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2007 Insurance Law Update

Uninsured, Underinsured and Supplementary Uninsured Motorist Law – Part II

By Jonathan A. Dachs

This article is the second of two that survey general issues concerning coverage and claims; it will report on developments in uninsured motorist (UM), underinsured motorist (UIM) and supplementary uninsured motorist (SUM) law addressed by the courts in 2007, as well as other issues more specific to these separate categories of coverage.

Conflicts of Law

In *Progressive Ins. Co. v. Ramnarain*,[1] the respondent (claimant) was a New York resident. At the time of the accident, he was operating a vehicle registered in New York and insured by a New York policy. The accident took place in Pennsylvania and the offending vehicle was registered in Pennsylvania. The rental contract for the adverse vehicle was entered into in Pennsylvania and the insurance policy on that vehicle was contracted in Pennsylvania. Under New York law (applicable at the time), vicarious liability attached to the owner of a vehicle negligently operated in New York.

Under Pennsylvania law, however, vicarious liability does not attach because to impose liability on a person for an injury resulting from the operation of a motor vehicle, he or she must either be in the actual operation or control thereof, or stand in the relation of master or principal to the person whose act occasions the injury (unless liability is otherwise imposed by statute). Further, under Pennsylvania law, a lessor of a motor vehicle is generally not liable for the negligence of a lessee while operating the vehicle, unless it can be demonstrated that the lessor was negligent in leasing the vehicle to a person whom the lessor knew to be incompetent. Since New York and Pennsylvania laws conflicted on the issue of vicarious liability, the court was forced to engage in a choice of law analysis.

The court applied the analysis set forth in *Neumeier v. Kuehner*,[2] *i.e.*, the rule that "the conduct of a domiciliary within their own state which does not cast them liable, should not result in liability by reason that liability would be imposed under the tort law of the state of the victim's domicile" and that "[i]f the parties are domiciled in different states with conflicting laws, the law applied will usually be determined by the situs of the tort, unless displacing it will advance the relevant substantive law purposes without impairing the smooth working of the multi-state system or producing great uncertainty for litigants." The court held that Pennsylvania law applied and determined that vicarious liability could not be imposed upon the owner of the offending vehicle, and thus its insurer was not obligated to provide indemnification.

In *Jones v. AIG Ins. Co.*,[3] the defendant issued a Florida insurance policy covering a vehicle that was registered in Florida to the tortfeasor, who was purportedly a Florida resident. The plaintiff, who was injured in an accident in New York, submitted a claim for no-fault benefits to the defendant, which claim was denied on the ground that the policy was revoked for material misrepresentation – *i.e.*, that the insured actually resided and garaged his

vehicle in New York. New York law does not allow for retroactive cancellation. Insofar as Florida law allows for the retroactive cancellation of an insurance policy where a material misrepresentation is contained within the insurance application, there was a clear conflict between the laws of Florida and New York that the court had to resolve. To do so, the court applied the conflict of law rules relevant to contracts, *i.e.*, the "center of gravity" or "grouping of contacts" inquiry, to determine which state had the most significant contacts to the dispute. This analysis focused on the place of contracting, the place of negotiation and performance of the contract, the location of the subject matter of the contract and the domicile or place of business of the contracting parties. The court concluded that Florida law should apply.

The court explained,

> Defendant issued its insurance policy to [the insured] in Florida, who purportedly was a resident of Florida, for a vehicle registered in Florida, which terms incorporated Florida law. The only connection between the policy and New York is that [the insured] was driving the vehicle in New York at the time of the accident.[4]

Moreover, Florida's significant contacts with the subject contract and legitimate governmental interest in protecting its honest policyholders from bearing the burden of paying claims incurred by dishonest policyholders outweighed New York's governmental interest in protecting innocent third parties from being deprived of insurance coverage. This was especially true since New York statutes provide the means to ensure compensation to persons injured, due to the fault of uninsured motorists within the state, by requiring New York policyholders to purchase uninsured motorist coverage,[5] and by establishing and providing insurance through the Motor Vehicle Accident Indemnification Corp. (MVAIC).[6]

In *Atlantic Mutual Ins. Co. v. Goglia*,[7] the court applied the New Jersey law governing the definition of a hit-and-run, which did not require physical contact, rather than New York's definition, which required physical contact. The accident at issue occurred in New Jersey when a New York resident was caused to swerve to avoid a vehicle that came to a short stop in front of him and struck a utility pole, which then fell across his vehicle and trapped him inside it. Relying upon Ins. Law § 5103(e), which provides that every automobile insurance policy procured in New York must provide the minimum uninsured motorist coverage mandated by the law of another state when the insured automobile is involved in an accident in that state, the court held that "the statutory and regulatory scheme contemplates that the New Jersey requirements for uninsured motorists coverage should be incorporated into [this] New York contract."[8]

Worth Construction Co. Inc. v. Admiral Ins. Co.[9] involved the issue of coverage for a construction accident. The court used the "center of gravity" analysis to conclude that the law of New York – where the accident occurred and the underlying personal injury action was pending, rather than the law of New Jersey, where the subject policy was issued – was applicable. Thus, the court held that the additional insured's notice of the accident almost 15 months after learning of it was untimely as a matter of law, and did not apply New Jersey's prejudice rule, which would have resulted in a contrary finding, unless the insurer could demonstrate prejudice.

Statute of Limitations

In *Preferred Mutual Ins. Co. v. Rand*,[10] the court held that "[c]laims made under the uninsured motorist endorsement of automobile insurance policies are governed by the six-year statute of limitations applicable to contract actions. [Furthermore, t]he claim accrues either when the accident occurred or when the allegedly offending vehicle thereafter becomes uninsured."[11] Here, the six-year statute of limitations began to run when it was determined that the vehicle was stolen. In *One Beacon Ins. Co. v. Espinoza*,[12] the court noted that the demand for arbitration was not barred by the statute of limitations since it was made within six years after the accident took place.

Uninsured Motorist Issue: Self-Insurance

The court in *ELRAC, Inc. v. Suero* stated that "[f]rom an injured claimant's perspective, '[t]he right to obtain uninsured motorist protection from a self-insurer is no less than the corresponding right under a policy issued by an insurer.'"[13] Further, the court held that a claim for uninsured motorist benefits against a self-insured vehicle owner, while statutorily mandated, remains contractual rather than statutory in nature and is, thus, subject to a six-year statute of limitations.

Insurance Law § 3420(d) speaks to an insurer's duty to provide prompt written notice of denial or disclaimer. A vehicle is considered "uninsured" where the offending vehicle was, in fact, covered by an insurance policy at the time of the accident, but the insurer subsequently disclaimed or denied coverage. In *Topliffe v. U.S. Art Co.*[14] and *Only Natural, Inc. v. Realm National Ins. Co.*,[15] the court held that Ins. Law § 3420(d) does not apply to claims that do not involve "death or bodily injury."

In *Schulman v. Indian Harbor Ins. Co.*,[16] the court reaffirmed that

> Insurance Law § 3420(d) requires an insurer to provide a written disclaimer "as soon as is reasonably possible." The reasonableness of the delay [in disclaiming] is measured from the time when the insurer "has sufficient knowledge of facts entitling it to disclaim, or knows it will disclaim coverage." The insurer bears the burden of justifying any delay.

> [Furthermore, w]hile Insurance Law § 3420(d) speaks only of giving notice "as soon as is 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.[17]

Based upon the record before it, the *Schulman* court concluded that the defendant failed to establish satisfactorily that the delay in disclaiming was occasioned by its need to conduct a thorough and diligent investigation. The complaint in the underlying personal injury action, and the circumstances surrounding the initial cursory inquiry by the defendant's claim analyst, provided sufficient criteria that the insured may have breached the applicable notice requirements or that a more thorough investigation would have revealed whether that was so. The disclaimer was issued approximately 10 months after the insurer acknowledged the untimely notice of claim, and almost five months after it learned that the insured may have been untruthful as to his knowledge of the claim and commenced investigation into the facts. Thus, the disclaimer was held to be untimely.

On the other hand, in *Tully Construction Co. v. TIG Ins. Co.*,[18] the court observed that

> it is the insurer's responsibility to explain its delay in giving written notice of disclaimer, and an unsatisfactory explanation will render the delay unreasonable as a matter of law. However, an insurer's delay in notifying the insured of a disclaimer may be excused when the insurer conducts an "investigation into issues affecting [its] decision whether to disclaim coverage." In that case, the burden is on the insurer to demonstrate that its delay was reasonably related to its completion of a thorough and diligent investigation.[19]

In *Tully Construction*, the court held that a delay of 42 days was not unreasonable where the insurer conducted a thorough and diligent investigation into whether it had grounds for a disclaimer based on late notice. The facts and circumstances of this case presented an issue that warranted further investigation.

In *Hermitage Ins. Co. v. Arm-ing, Inc.*,[20] the court held that a delay of two months, occasioned by the insurer's need to investigate the claim to determine when its insured received notice of the accident, was reasonable under the circumstances. In *Ace Packing Co., Inc. v. Campbell Solberg Assocs., Inc.*,[21] the court held that where the insurer, upon receipt of late notice, immediately retained an investigator to investigate the claim and the issue of late notice (*i.e.*, when the plaintiff first learned of the accident and/or lawsuit, whether the plaintiff would claim that prior notice was given), the adjuster sought to interview the plaintiff about those issues, but the plaintiff refused to cooperate with the adjuster for 30 days, and the insurer disclaimed eight days after it received the pertinent information from the plaintiff, the court held that the 38-day delay in disclaiming was reasonable.

Where the initial notice to the insurer did not make it readily apparent that the claim was being asserted under the claimant's father's policy, rather than his own policy, the court, in *New York Central Mutual Fire Ins. Co. v. Gordon*,[22] held that notice was insufficient to commence the time running on the insurer's disclaimer, based upon an exclusion from coverage under the father's policy.[23] In *Massot v. Utica First Ins. Co.*,[24] the court held that a disclaimer was sufficiently specific where it identified the applicable policy exclusion and set forth the factual basis for the insurer's position that the claim fell within that exclusion. It is well established that

> [a]n insurance carrier that seeks to disclaim coverage on the ground of lack of cooperation must demonstrate that it acted diligently in seeking to bring about the insured's cooperation; that the efforts employed by the insurer were reasonably calculated to obtain the insured's cooperation; and that the attitude of the insured, after his [or her] cooperation was sought, was one of "willful and avowed obstruction."[25]

The court upheld the insurer's lack of cooperation defense in *New South Ins. Co./GMAC Ins. v. Krum*,[26] where the evidence established that the insurer placed unsuccessful calls to the insured at his home and work numbers, sent three certified and regular-mail letters to his last-known address, personally visited his home on two occasions and left a message with his mother to stress the importance of his cooperation, but the insured never responded.[27]

Similarly, in *Continental Casualty Co. v. Stradford*,[28] the insured ignored a series of written correspondence and telephone calls from its insurer's representatives and from defense counsel, repeatedly refused to provide requested documents, records and evidence, and unreasonably refused to consent to a recommended settlement based upon adverse findings of experts. Notwithstanding his own request for new counsel, he refused to execute stipulations consenting to a change of attorney. He also failed to appear for scheduled depositions and meetings. Two letters sent to him, advising that he risked a disclaimer of coverage if he continued to breach the cooperation clause of his policy, were returned as "unclaimed."

In two other claims, Continental obtained orders in a declaratory judgment action relieving it of its duty to defend and indemnify as a result of the insured's failure to cooperate in the defense of those claims. Under these circumstances, the court held that the insurer carried its burden to establish that it acted diligently in seeking to bring about the insured's cooperation; its efforts were reasonably calculated to obtain the insured's cooperation;

and the attitude of the insured after his cooperation was sought was one of "willful and avowed obstruction."[29] The court further held, however, that the insurer's disclaimer for lack of cooperation was untimely. The court reasoned that the lapse of time, in excess of two months from the date it was readily apparent that the insurer's efforts to obtain the insured's cooperation were fruitless, until the date it sent its disclaimer, was, without explanation, not "as soon as is reasonably possible" within the contemplation of Ins. Law § 3420(d). The court specifically rejected the excuse that the insurer "was consulting with claims counsel to determine whether the six-year-long, well-documented pattern of willful non-cooperation warranted a disclaimer of coverage."[30]

One of the investigators stated that the insured's principal avoided all attempts by the investigator to contact him for approximately one month.

In *Preferred Mutual Ins. Co. v. SAV Carpentry, Inc.*,[31] the insurer presented evidence that it sent the insured numerous letters regarding its discovery obligations and hired two separate investigators to locate and interview the insured's principal. One of the investigators stated that the insured's principal avoided all attempts by the investigator to contact him for approximately one month. The court held that this demonstrated that the insurer diligently sought the insured's cooperation by means reasonably calculated to obtain such cooperation, and that the insured's non-cooperation consisted of willful and avowed obstruction. Therefore, the court upheld the non-cooperation defense.

On the other hand, in *State Farm Mutual Automobile Ins. Co. v. Campbell*,[32] the court held that the insurer failed to establish that it was sufficiently diligent or that its efforts were reasonably calculated to bring about its insured's cooperation. In addition, the non-action of the insured did not constitute "'willful and avowed obstruction.'"[33]

In *Wood v. Nationwide Mut. Ins. Co.*, the court observed that "mere inaction by an insured does not by itself justify a disclaimer of coverage on the ground of lack of cooperation."[34] Thus, where the insurer offered no explanation for the failure of its field investigator to travel to the plaintiff's house, for the failure of its private investigator to obtain a statement from the plaintiff or for its failure to attempt to obtain a transcript of the hearing before the Workers' Compensation Board, the court concluded that the insurer was not entitled to invoke a non-cooperation defense. In addition, the court held that the insurer's 19-month delay in disclaiming coverage was unreasonable as a matter of law.

In *Maldonado v. C.L.-M.I. Properties, Inc.*, the court held that "where an injured party fails to exercise the independent right to notify an insurer of the occurrence, a disclaimer issued to an insured for failure to satisfy the notice requirement of the policy will be effective as against the injured party as well."[35] In that case, there was no evidence that the injured plaintiff ever gave notice to the insurer, and the insurer's disclaimer also specified the plaintiff's failure to provide timely notice as a separate ground for disclaiming coverage.

However, in *Schlott v. Transcontinental Ins. Co.*,[36] notice of the accident, claim and lawsuit was (untimely) provided to the insurance company first – and only – by the injured parties, as opposed to the insured. The insurer's disclaimer letter was addressed to the insured with a "cc" to the injured parties and only mentioned the insured's failure to provide any notice, but did not separately mention the injured party's late notice. This is notwithstanding numerous prior decisions, including the Court of Appeals's decision in *General Accident Ins. Group v. Cirucci*[37] and several decisions of the Appellate Division, including the First Department.[38] All of these consistently held that where notice is provided first (or only) by or on behalf of the injured party, pursuant to his or her independent right to give notice pursuant to Ins. Law § 3420(a)(3), the notice of disclaimer must address with specificity the grounds for disclaiming as to *both* the injured party *and* the insured. In *Schlott*, the First Department concluded that Transcontinental "complied with the mandate of section 3420(d) when it gave notice of disclaimer to the insured and sent a copy to the injured party."[39]

Without citing to any case law and without attempting to distinguish the above-cited precedents, or the Pattern Jury Charge based thereon (NYPJI 4:79), which states, "[a] disclaimer is ineffective as to the injured person where it relies solely on the insured's failure to give timely notice and does not refer to the injured party's allegedly untimely notice," the First Department in *Schlott* held that a disclaimer based solely upon the insured's late notice will not be effective against the injured party. The court concluded, "The fact that Defendant omitted from that notice any specific reference to the injured party's own failure to afford the insurer timely notice did not prejudice Plaintiffs."[40] (It is unclear where, how and/or why the court obtained the impression that the plaintiffs were required to demonstrate prejudice as a result of the defendant's improper disclaimer under the facts and circumstances of this case, insofar as no case had ever previously so held in the context of a case governed by Ins. Law § 3420(d).)

In *GEICO Co. v. Wingo*,[41] the court held that where neither the insured nor the injured claimants provided

the insurer with notice of the commencement of litigation by providing a copy of the papers served in the lawsuit, there was no need to timely disclaim on that ground until after the insurer first learned of the action, upon receipt of a copy of a motion for default sent to it by the injured parties. In *Commercial Union Ins. Co. v. Liberty Mutual Ins. Co.*,[42] the court held that "since there was no coverage in the first instance, there was no requirement for [the insurer] to provide a timely disclaimer."[43] The Second Department, in *Auerbach v. Otsego Mutual Fire Ins. Co.*,[44] reiterated the general rule that an insurer is not entitled to insist upon strict adherence to the terms of its policy after it repudiates liability by disclaiming coverage.

In *New York Central Mutual Fire Ins. Co. v. Hildreth*,[45] the court restated the well-established rule that a reservation of rights letter is not a disclaimer. Still, a reservation of rights letter may be used to rebut a claim that the carrier waived the right to disclaim by defending its insured. In that case, the court held that the carrier did, in fact, waive the right to disclaim by continuing to defend the insured for more than one year after it learned of the grounds for disclaimer, *i.e.*, settlement of the underlying action without consent. In *Progressive Northeastern Ins. Co. v. Heath*,[46] the fact that the insurer paid no-fault benefits did not establish that it waived the right to disclaim coverage on a UM claim (on the basis of a late notice defense).

A reservation of rights letter may be used to rebut a claim that the carrier waived the right to disclaim by defending its insured.

Cancellation of Coverage

One category of an "uninsured" motor vehicle is where the policy of insurance for the vehicle had been canceled prior to the accident. Generally speaking, in order to cancel an owner's liability insurance policy, 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, *e.g.*, 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 *Auto One Ins. Co. v. Santos*,[47] the court held that the 12-point type requirement be used in cancellation notices is "unambiguous and absolute," thereby indicating that there must be strict compliance with that statutory condition. In *Halycon Ins. Co. v. Fox*,[48] the court credited the testimony of the Assistant Vice President of Claims of a company that handled claims on behalf of the insurer, in which he described the manner in which his company stored and printed its electronic records, and gave a detailed explanation as to why the point size on the version of the notice of cancellation initially submitted to the court differed from the version of the notice of cancellation sent to the insured, which did, in fact, comply with the statutory point size requirements. The fact that the witness did not personally print the replica of the notice of cancellation went to the weight to be accorded to the replica, not its admissibility.

In *Government Employees Ins. Co. v. Lopez*,[49] the court held that a premium finance agency that sought to cancel an assigned risk policy because of the insured's failure to make required payments under the premium finance agreement did *not* have to advise the insured of a particular "right of review" in order for the cancellation to be valid.

> While Banking Law § 576(1)(c) and (d) sets forth detailed requirements for the form and content of the cancellation notice that a premium finance company must send to the insured, these provisions do not require the agency to advise the insured that he or she has the right to have the NYAIP's Governing Committee review the cancellation of the assigned risk automobile insurance policy.[50]

In *Thibeault v. Travelers Ins. Co.*,[51] the court held that the insurer met its initial burden of proving that its policy had been canceled by describing the office practice it used to ensure that notices of cancellation are properly mailed. This raised a presumption that the insureds had received the notice, which shifted the burden to the insureds to rebut the presumption. While noting that "an insured's denial of receipt, standing alone, is insufficient to rebut the presumption,"[52] the court noted that the insureds submitted additional evidence that there was an omission in the address as stated on the policy application and used by the insurer, *i.e.*, omitting the name of the insured's business under which the post office box was registered. The court found that this prevented delivery of the notice, which was sufficient to rebut the presumption and raise an issue of fact as to delivery of the notice.

In *Progressive Classic Ins. Co. v. Kitchen*,[53] the court held that in the absence of proof that the insurer filed a copy of its notice of cancellation with the Department of Motor Vehicles within 30 days of the effective date of the cancellation, the cancellation was ineffective as against persons other than the named insured and members of the named insured's household. In *Jones v. AIG Ins. Co.*,[54] the court noted that New York law does not allow for retroactive cancellation of motor vehicle liability insurance polices.

Stolen Vehicle

Automobile insurance policies generally exclude coverage for damages caused by drivers of stolen vehicles and/or drivers operating without the permission or consent of the owner. In such situations, the vehicle at issue is considered "uninsured" and the injured claimant

will be entitled to make an uninsured motorist claim. In *McDonald v. Rose*,[55] the court determined, as a matter of law, that the offending vehicle was stolen, based upon documentary evidence consisting of a theft report from the date of the accident, an affidavit of theft filed with the insurer, the accident report indicating that the accident occurred 11 days after the vehicle was reported stolen and that the driver fled the scene, and the affidavit of the insured's husband, who had borrowed the vehicle on the day it was stolen and asserted facts relating to the theft.

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. "The insured has the burden of establishing that the loss sustained was caused by an uninsured vehicle, namely that physical contact occurred, that the identity of the owner and operator of the offending vehicle could not be ascertained, and that the insured's efforts to ascertain such identity were reasonable." In *Kobeck v. MVAIC*,[56] the court observed that the requisite physical contact must result from a collision and that "[t]he physical contact requirement is intended to prevent against fraudulent claims, hit-and-run claims being by their nature 'easy to allege and difficult to disprove.'"[57]

Another requirement for a valid "hit-and-run" claim is a report of the accident within 24 hours or as soon as reasonably possible to a police officer, peace or judicial officer, or to the Commissioner of Motor Vehicles. In *Caceres v. MVAIC*, the court held that where a question exists as to whether an accident report was timely filed pursuant to Ins. Law § 5208(2)(A) "and the issue cannot be resolved without a determination of the credibility of [the claimant]," an evidentiary hearing is appropriate.[58]

In *Rojas v. MVAIC*,[59] the claimant submitted an affidavit, stating that he was injured when struck by a hit-and-run vehicle, in support of his application for leave to sue MVAIC. However, MVAIC submitted an FDNY Ambulance Call Report in which the claimant was reported to have stated that he was injured while defending himself and had punched a man. These conflicting accounts were held to create an issue of fact to be resolved at a hearing.

Yet another requirement for a valid hit-and-run claim is the filing of a statement under oath that the claimant has a cause of action against a person whose identity is unascertainable. In *Eveready Ins. Co. v. Mesic*,[60] the court held that the claimant's failure to file a sworn statement with the insurer after the alleged hit-and-run accident vitiated coverage. The fact that the insurer received some notice of the accident by way of an application for no-fault benefits did not negate the breach of the policy requirement of a sworn statement as to the hit-and-run.[61]

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." Under that endorsement, and whether or not they are covered by a Security Fund, any and all insolvencies give rise to a valid SUM claim.[62] In cases involving mandatory UM coverage, as opposed to SUM coverage, only insolvencies that are not covered by a Security Fund give rise to a valid UM claim.

In *AIG Claims Services, Inc. v. Bobak*,[63] although the offending vehicle's insurer became insolvent, there was evidence that another insurer had issued an excess policy on the offending vehicle and the vehicle owner may have had additional coverage. This led the claimant to file an SUM claim with his own insurer, and thus the arbitration was stayed to determine the issues of insurance coverage.

In *Progressive Ins. Co. v. Elias*,[64] the issue before the court was whether a letter from the New York State Liquidation Bureau advising a claimant that the PMV Fund (Public Motor Vehicle Liability Security Fund) was "financially strained" constitutes a denial of coverage within the meaning of Ins. Law § 3420(f)(1). There was a hearing at which the parties, including the Superintendent of Insurance, relied upon their evidentiary submissions, which included a copy of the Liquidation Bureau's letter, and an affidavit from the Supervisor of the PMV Fund, with copies of the Fund's income and disbursement reports for the pertinent period. At the hearing the parties recited the history of the PMV Fund and the pre- and post-Regulation 35-D case law on the issue of insolvency and UM coverage. Justice Jaime A. Rios noted that insofar as the insured did not purchase SUM coverage, but only mandatory, basic UM coverage and the tortfeasor's insolvent insurer paid into the PMV Fund, the claimant was required to seek payment from the Fund rather than his or her own insurer, unless the insured could establish that the Fund "[was] denying them coverage based upon its inability to pay any allowed claims."[65]

The court went on to hold that

> notwithstanding the "financial strain" language in the letter of June 27, 2005, the letter from the Liquidation Bureau/PMV Fund without more, does not demonstrate an inability of the PMV Fund to pay allowed claims. To the contrary, the letter confirms that the claim is a covered claim and advises the Reliance insured . . . of a certain set of procedures to follow in the event a claim is pursued against him.[66]

Indeed, the court noted that the Fund supervisor's affidavit "sets forth that all allowed claims applied for payment out of the PMV Fund by the New York State Supreme Court are processed and paid by the Liquidation Bureau in order of receipt." In addition, based upon that affidavit, the court held, "[I]t appears that as of December 31, 2006, the PMV fund had a balance of $113,352.82, unpaid

claim obligations of $3,464,353.34, and the claims next in line to be paid by the PMV fund were received by the Bureau on February 1, 2006."[67]

The court further noted, "Pursuant to Insurance Law § 7606, insurers issuing insurance policies or surety bonds described in VTL § 370 shall continue to make payments of three percent of all net direct written premiums of such policies to the PMV fund on a quarterly basis until the net value of the PMV fund equals fifteen percent of the outstanding claim reserves of all authorized insurers contributing to the PMV fund." The court clearly stated that the PMV Fund did not have sufficient funds to pay all pending claims at once. However, the Fund supervisor's affidavit and annexed financial documents demonstrated that "despite some delay, allowed claims are being paid." Thus, since the evidence failed to demonstrate that the claimants had been denied compensation from the PMV Fund due to its inability to pay, they were "unable to establish that the [tortfeasor's] vehicle was an uninsured motor vehicle pursuant to Insurance Law § 3420(f)(1) and, thus, are precluded from seeking UM arbitration from Progressive."[68]

Actions Against MVAIC

Insurance Law § 5218 provides as follows:

> (c) In any action in which the plaintiff is a qualified person, for the death of, or bodily injury to, any person arising out of the ownership, maintenance or use of a motor vehicle in this state and judgment is rendered for the defendant on the sole ground that the death or personal injury was occasioned by a motor vehicle: (i) the identity of which, and of the owner and operator of which, has not been established, or (ii) which was in the possession of some person other than the owner or his agent without the consent of the owner and the identity of the operator has not been established, that ground shall be stated in the judgment. The plaintiff, upon complying with paragraph one of subsection (a) of section five thousand two hundred eight of this article, may within three months from the date of the entry of the judgment make application to bring an action upon the cause against the corporation in the manner provided in this section.
>
> (d) In any action commenced in respect of the death or injury of any person arising out of the ownership, maintenance or use of a motor vehicle in this state the plaintiff shall be entitled to make the corporation a party defendant if the court has entered the order provided for in subsection (a) of this section.

In *Steele v. MVAIC*,[69] the court held that the three-month extension provided in Ins. Law § 5218(c) is not a limitations period but, rather, a savings clause. This clause is intended to provide qualified persons, who were unsuccessful in litigation in establishing that the putative owner or operator of a hit-and-run vehicle were actually involved in the accident, additional time to sue MVAIC in the event the applicable statute of limitations (*i.e.*, three years for personal injury actions (CPLR 214)) has run in the interim. In so holding, the court expressly disagreed with two decisions of the Second Department, which interpreted the three-month provision of § 5218(c) as a strict limitations period that supplants the applicable statute of limitations.[70]

The personal injury action in *Steele* was terminated by a stipulation of discontinuance rather than a judgment. Moreover, the court held that the claimant's application for leave to sue MVAIC, brought within three years after her reaching majority, and only after she had made all reasonable efforts to ascertain the identity of the owner and operator of the offending vehicle, was timely and properly made.

Underinsured Motorist Issues: Trigger of Coverage

In *GEICO v. Young*,[71] the court held that the tortfeasor's vehicle was not underinsured where the limits of the tortfeasor's bodily injury coverage and the limits of the claimant's bodily injury coverage were identical. The court reached this conclusion despite the fact that payments were made under the tortfeasor's policy to more than one claimant.

In *Allstate Ins. Co. v. Dawkins*,[72] the court relied on the Regulation 35-D SUM endorsement, which provides that an uninsured motor vehicle includes a vehicle for which there is bodily injury liability insurance coverage applicable at the time of the accident. However, in *Dawkins* the amount of the insurance coverage was reduced by payments to other persons injured in the accident, to an amount less than the bodily injury liability limits of the insured's policy. In this case, the court held that although the bodily injury limits of the tortfeasor's policy and the claimant's policy were the same, *i.e.*, $25,000/$50,000, and since only $12,500 in coverage remained under the tortfeasor's policy after paying claims of two other individuals, the offending vehicle qualified as "uninsured." Thus, the claimant had a valid SUM claim subject to the offset provisions of the policy.

Offset Provision

In *GEICO v. Young*, the court held that the offset or reduction in coverage provision of Condition 6 to the Regulation 35-D SUM endorsement was "not ambiguous and misleading." The court then held that GEICO properly offset the full $50,000 received by the claimants from the tortfeasor's insurer against the SUM limits under the GEICO policy, thereby precluding any recovery under the SUM endorsement. In *Hament v. State Farm Mutual Automobile Ins. Co.*,[73] the court held that payments received from both the underinsured driver and the vicariously liable owner of that vehicle were to be aggregated for purposes of reducing the SUM limits

under the "Maximum SUM Payments" provision of the policy.

Settlement Without Consent

In *New York City Transit Authority v. Williams*,[74] the court granted the Petition to Stay Arbitration on the basis of a release signed by the claimant. This was presumably accomplished without the consent of the Transit Authority, a self-insured party. ■

1. 15 Misc. 3d 897, 838 N.Y.S.2d 375 (Sup. Ct., Queens Co. 2007).
2. 31 N.Y.2d 121, 335 N.Y.S.2d 64 (1972).
3. 15 Misc. 3d 1123(A), 841 N.Y.S.2d 219 (Sup. Ct., Queens Co. 2007).
4. *Id.*
5. *See* N.Y. Insurance Law § 3420(f) ("Ins. Law").
6. *See* Ins. Law §§ 5201–5225.
7. 44 A.D.3d 558, 845 N.Y.S.2d 2 (1st Dep't 2007).
8. *Id.* at 560.
9. 40 A.D.3d 423, 836 N.Y.S.2d 155 (1st Dep't 2007), *rev'd on other grounds*, 2008 WL1899978 (2008).
10. 15 Misc. 3d 1112(A), 839 N.Y.S.2d 436 (Sup. Ct., Richmond Co. 2007).
11. *Id.* (citations omitted).
12. 37 A.D.3d 607, 830 N.Y.S.2d 287 (2d Dep't 2007).
13. 38 A.D.3d 544, 545, 831 N.Y.S.2d 475 (2d Dep't 2007) (citations omitted).
14. 40 A.D.3d 967, 838 N.Y.S.2d 571 (2d Dep't 2007).
15. 37 A.D.3d 436, 827 N.Y.S.2d 880 (2d Dep't 2007).
16. 40 A.D.3d 957, 836 N.Y.S.2d 682 (2d Dep't 2007).
17. *Id.* at 957–58 (citations omitted); *see also Wood v. Nationwide Mut. Ins. Co.*, 45 A.D.3d 1285, 845 N.Y.S.2d 641 (4th Dep't 2007).
18. 43 A.D.3d 1150, 842 N.Y.S.2d 528 (2d Dep't 2007).
19. *Id.* at 1152 (citations omitted).
20. 46 A.D.3d 620, 847 N.Y.S.2d 628 (2d Dep't 2007).
21. 41 A.D.3d 12, 835 N.Y.S.2d 32 (1st Dep't 2007).
22. 46 A.D.3d 1296, 850 N.Y.S.2d 653 (3d Dep't 2007).
23. *See also Temple Constr. Corp. v. Sirius Am. Ins. Co.*, 40 A.D.3d 1109, 837 N.Y.S.2d 689 (2d Dep't 2007) (8-day delay not untimely; 47-day delay unreasonable where record is silent as to when insurer completed its investigation).
24. 36 A.D.3d 499, 828 N.Y.S.2d 342 (1st Dep't 2007).
25. *Thrasher v. U.S. Liability Ins. Co.*, 19 N.Y.2d 159, 278 N.Y.S.2d 793 (1967).
26. 39 A.D.3d 1110, 835 N.Y.S.2d 479 (3d Dep't 2007).
27. *See also Gen. Assurance Co. v. Garcia*, 37 A.D.3d 466, 830 N.Y.S.2d 237 (2d Dep't 2007).
28. 46 A.D.3d 598, 847 N.Y.S.2d 631 (2d Dep't 2007).
29. *Id.* at 600.
30. *Id.* at 601.
31. 44 A.D.3d 921, 844 N.Y.S.2d 363 (2d Dep't 2007).
32. 44 A.D.3d 1059, 845 N.Y.S.2d 88 (2d Dep't 2007).
33. *Id.* at 1059 (citation omitted); *see also N.Y. Cent. Mut. Fire Ins. Co. v. Rafailov*, 41 A.D.3d 603, 840 N.Y.S.2d 358 (2d Dep't 2007).
34. 45 A.D.3d 1285, 1287, 845 N.Y.S.2d 641 (4th Dep't 2007).
35. 39 A.D.3d 822, 823, 835 N.Y.S.2d 335 (2d Dep't 2007).
36. 41 A.D.3d 339, 838 N.Y.S.2d 559 (1st Dep't 2007), *leave to appeal denied*, 9 N.Y.3d 817, 851 N.Y.S.2d 126 (2008).
37. 46 N.Y.2d 862, 414 N.Y.S.2d 512 (1979).
38. *See Carter v. Mount Vernon Fire Ins. Co.*, 188 A.D.2d 430, 591 N.Y.S.2d 1022 (1st Dep't 1992); *Legion Ins. Co. v. Weiss*, 282 A.D.2d 576, 723 N.Y.S.2d 235 (2d Dep't 2001); *Vanegas v. Nationwide Mut. Fire Ins. Co.*, 282 A.D.2d 671, 723 N.Y.S.2d 516 (2d Dep't 2001); *State Farm Mut. Auto Ins. Co. v. Joseph*, 287 A.D.2d 724, 732 N.Y.S.2d 66 (2d Dep't 2001); *State Farm Mut. Auto Ins. Co. v. Cooper*, 303 A.D.2d 414, 756 N.Y.S.2d 87 (2d Dep't 2003); *GEICO v. Jones*, 6 A.D.3d 534, 774 N.Y.S.2d 435 (2d Dep't 2004); *Hereford Ins. Co. v. Mohammod*, 7 A.D.3d 490, 776 N.Y.S.2d 87 (2d Dep't 2004); *Halali v. Evanston Ins. Co.*, 8 A.D.3d 431, 779 N.Y.S.2d 119 (2d Dep't 2004) ; *Pawley Interior Contracting, Inc. v. Harleysville Ins. Co.*, 11 A.D.3d 595, 782 N.Y.S.2d 660 (2d Dep't 2004); *Vacca v. State Farm Ins. Cos.*, 15 A.D.3d 473, 790 N.Y.S.2d 177 (2d Dep't 205); *Shell v. Fireman's Fund Ins. Co.*, 17 A.D.3d 444, 793 N.Y.S.2d 110 (2d Dep't 2005); *Utica Mutual Ins. Co. v. Gath*, 265 A.D.2d 805, 695 N.Y.S.2d 839 (4th Dep't 1999).
39. 41 A.D.3d at 340.
40. *Id.*
41. 36 A.D.3d 908, 830 N.Y.S.2d 215 (2d Dep't 2007).
42. 36 A.D.3d 645, 828 N.Y.S.2d 479 (2d Dep't 2007).
43. *Id.* at 646; *see also Solomon v. USF&G Co.*, 43 AD3d 333, 841 NYS2d 39 (1st Dep't 2007).
44. 36 A.D.3d 840, 829 N.Y.S.2d 195 (2d Dep't 2007).
45. 40 A.D.3d 602, 835 N.Y.S.2d 409 (2d Dep't 2007).
46. 41 A.D.3d 1321, 837 N.Y.S.2d 476 (4th Dep't 2007).
47. 14 Misc. 3d 1220(A), 836 N.Y.S.2d 483 (Sup. Ct., Suffolk Co. 2007).
48. 44 A.D.3d 662, 843 N.Y.S.2d 165 (2d Dep't 2007).
49. 44 A.D.3d 256, 841 N.Y.S.2d 130 (2d Dep't 2007).
50. *See also AIU Ins. Co. v. Rodriguez*, 43 A.D.3d 1042, 842 N.Y.S.2d 502 (2d Dep't 2007).
51. 37 A.D.3d 1000, 830 N.Y.S.2d 387 (3d Dep't 2007).
52. *Id.* at 1001.
53. 46 A.D.3d 333, 850 N.Y.S.2d 1 (1st Dep't 2007).
54. 15 Misc. 3d 1123(A), 841 N.Y.S.2d 219 (Sup. Ct., Queens Co. 2007).
55. 37 A.D.3d 781, 830 N.Y.S.2d 765 (2d Dep't 2007).
56. 16 Misc. 3d 592, 836 N.Y.S.2d 864 (Sup. Ct., Madison Co. 2007).
57. *Id.* at 597 (citing *Allstate Ins. Co. v. Killakey*, 78 N.Y.2d 325, 328, 574 N.Y.S.2d 927 (1991)).
58. 37 A.D.3d 215, 215, 829 N.Y.S.2d 487 (1st Dep't 2007).
59. 37 A.D.3d 216, 830 N.Y.S.2d 65 (1st Dep't 2007).
60. 37 A.D.3d 602, 831 N.Y.S.2d 426 (2d Dep't 2007).
61. *See also Hanover Ins. Co. v. Etienne*, 46 A.D.3d 825, 848 N.Y.S.2d 312 (2d Dep't 2007).
62. *See Am. Mfrs. Mut. Ins. Co. v. Morgan*, 296 A.D.2d 491, 746 N.Y.S.2d 726 (2d Dep't 2002).
63. 39 A.D.3d 1178, 835 N.Y.S.2d 925 (4th Dep't 2007).
64. 15 Misc. 3d 1113(A), 839 N.Y.S.2d 436 (Sup. Ct., Queens Co. 2007).
65. *Id.*
66. *Id.*
67. *Id.*
68. *Id.*; *see also to same effect, Integon Nat'l Ins. Co. v. Cittadino*, Queens Co. Sup., Index No. 15836/04 (Rios, J.), decided March 28, 2007 (as of August 24, 2006, the PMV Fund had a balance of $2,361,054.07, unpaid claim obligations of $6,246,404.40, and the claims next in line to be paid from the PMV Fund were received by the Bureau on July 11, 2005); *Mejia v. Santos*, N.O.R., N.Y.L.J., Mar. 16, 2007, p. 24, col. 1 (Sup. Ct., Bronx Co. 2007) (notice stating that claim is covered by PMV Fund is neither a denial or disclaimer; the PMV Fund may ultimately be a source of recovery; current balance of $126,103.82 as of June 12, 2006, measured against claim obligations of $5,619,576.20, demonstrates Fund's financial strain, but Fund is a revolving fund, continually replenished; delay in payment does not equate with uncollectibility). *See* Norman H. Dachs & Jonathan A. Dachs, *The "Top 10" Insolvency and the PMV Fund*, N.Y.L.J., May 8, 2007, p. 3, col. 1.
69. 39 A.D.3d 78, 829 N.Y.S.2d 467 (1st Dep't 2007).
70. *See Gittens v. MVAIC*, 7 A.D.3d 528, 775 N.Y.S.2d 571 (2d Dep't 2004); *Kearse v. MVAIC*, 28 A.D.2d 703, 280 N.Y.S.2d 917 (2d Dep't 1967).
71. 39 A.D.3d 751, 835 N.Y.S.2d 283 (2d Dep't 2007).
72. 17 Misc. 3d 1117(A), 851 N.Y.S.2d 62 (Sup. Ct., Queens Co. 2007).
73. 2007 WL 143036 (S.D.N.Y. 2007).
74. 36 A.D.3d 706, 826 N.Y.S.2d 580 (2d Dep't 2007).