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2008 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 uninsured, underinsured, and supplementary uninsured motorist law (UM/UIM/SUM) coverage and claims. In addition, this article will focus upon certain issues that are specific to each particular type of coverage.

Petitions to Stay Arbitration

Statute of Limitations

In *Bloom v. St. Paul Travelers Ins. Co.*,[1] the court held that because the action was based on a dispute arising under a contract of insurance, and sought both the reformation of the policy and the payment of SUM benefits under the reformed policy, the applicable statute of limitations was the six-year period set forth in Civil Practice Law & Rules 213(2).

Burden of Proof

In *Hartford Fire Ins. Co. v. Fell*,[2] the court affirmed the denial of the petitioner's application to stay arbitration on the basis of the respondent's failure to abide by certain provisions of its policy (other than late notice) because the respondent was not the policyholder and there was no evidence in the record that the respondent was ever provided with a copy of the policy or was aware of its terms. "Under these circumstances, petitioner cannot rely on respondent's failure to satisfy [the] terms of an insurance contract that he did not possess and the terms of which he was not aware to obtain a stay of arbitration."[3]

Venue of Arbitration

In *Erie Ins. Co. v. Malcolm*,[4] the court held that the American Arbitration Association (AAA) rules provide that the arbitrator is to select the venue of the arbitration, but that such arbitrations are required to be held not more than 100 miles from an insured's residence.

Arbitration Awards

Scope of Review

In *Mangano v. U.S. Fire Ins. Co.*,[5] the court noted that

> [s]ince a claim by an insured against an insurance carrier under the uninsured motorists' endorsement is subject to compulsory arbitration, the arbitrator's award is subject to "closer judicial scrutiny" under CPLR 7511(b) than it would receive had the arbitration been conducted pursuant to a voluntary agreement between the parties. "To be upheld, an award in a compulsory arbitration proceeding must have evidentiary support and cannot be arbitrary and capricious."

In *Long Island Ins. Co. v. MVAIC*,[6] the court observed: "Judicial review of an arbitrator's award is extremely limited, and a reviewing court may not second-guess the fact-findings of the arbitrator."

The court, in *Aviles v. Allstate Ins. Co.*,[7] rejected the petitioner's challenge to an arbitration award on the grounds of alleged "partiality and misconduct" of the arbitrator, noting that the petitioner failed to carry his burden of establishing bias and that the award itself disclosed no

bias, and "the conclusory claim of the petitioner's counsel to the contrary is unavailing."[8]

In *Progressive Northeastern Ins. Co. v. Gigi*,[9] the court held that the arbitrator's offer to grant the claimant's request for an adjournment, conditioned upon her counsel's payment of the appearance fee of her adversary's expert, was reasonable and did not establish by clear and convincing evidence that the arbitrator committed misconduct within the meaning of CPLR 7511(b)(1)(i).

In *Lowe v. Erie Ins. Co.*,[10] a case involving a challenge to a No-Fault Master Arbitration award, the court addressed the "straightforward but apparent issue of first impression in an appellate court in New York" – in other words, whether the 90-day statute of limitations set forth in CPLR 7511(a), governing applications to vacate arbitration awards, begins to run on the date on which the arbitrator's decision was mailed or on the date when it was received by the petitioner or his or her agent. After reviewing caselaw involving other types of arbitration proceedings, the court concluded that the operative measuring date is the date of receipt. Thus, where the petition to vacate was filed 91 days after the award was mailed, but only 86 days after it was received by the petitioner's attorney, the proceeding was timely commenced. (The question was a close one in the No-Fault context because an Insurance Department Regulation, N.Y. Comp. Codes R. & Regs. title 11, § 65-4.10(e)(3), provides that "[t]he parties shall accept as delivery of the award the placing of the award or a true copy thereof in the mail, addressed to the parties or their designated representatives at their last known address, or by any other form of service permitted by law." The court found that this Regulation governing Master Arbitration proceedings did not apply to CPLR Article 75 proceedings.)

Uninsured Motorist Issues

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 *Tex Development Co., LLC v. Greenwich Ins. Co.*,[11] the court observed that

> Insurance Law § 3420(d) requires an insurer to provide a written disclaimer of coverage "as soon as is reasonably possible." An insurer's failure to provide notice of disclaimer as soon as is reasonably possible precludes effective disclaimer, even where the insured's own notice of the incident is untimely. 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.[12]

In *Preserver Ins. Co. v. Ryba*,[13] the Court of Appeals noted that N.Y. Insurance Law § 3420(d) ("Ins. Law") provides that when a liability policy is "'*delivered or issued for delivery in this state*, [if] an insurer shall disclaim liability or deny coverage for death or bodily injury . . . it shall give written notice as soon as is reasonably possible.'" "A policy is 'issued for delivery' in New York if it covers both insureds and risks located in this state."[14] Where, as in that case, the policy is neither actually "delivered" nor "issued for delivery" in New York, an insurer is not required by Ins. Law § 3420(d) to make a timely disclaimer of coverage. The court further noted that the duty to disclaim in a prompt manner imposed by § 3420(d) only applies to denials of coverage "for death or bodily injury."[15]

A vehicle is considered "uninsured" where it is, in fact, covered by an insurance policy but the insurer subsequently disclaimed or denied coverage.

The Second Department, in *Sirius American Ins. Co. v. Vigo Construction Co.*,[16] held that an unexplained delay of 34 days from the time the insurer knew or should have known of the basis for denying coverage was unreasonable as a matter of law and rendered the purported disclaimer ineffective.

In *Morath v. New York Central Mutual Fire Ins. Co.*,[17] the court held that the insurer's delay of 36 days in disclaiming, based upon the claimant's failure to obtain its prior written consent to settle with the tortfeasor, was unreasonable as a matter of law.

In *Wausau Business Ins. Co. v. 3280 Broadway Realty Co. LLC*,[18] the insured misrepresented when he had first learned of the accident, and the insurer relied upon that misrepresentation in initially agreeing to defend and indemnify the insured in an underlying action. When the insurer learned, two years later, that the insured actually knew of the underlying accident several years earlier, it disclaimed coverage 24 days later, after consulting with both in-house and outside counsel. Under these circumstances, the court held that the disclaimer was timely.

Effective January 17, 2009, the Insurance Law was amended to create a new § 3420(a)(6), which allows, with respect to wrongful death and personal injury claims (only), that if the insurer denies or disclaims liability on the ground of late notice, and the insurer or the insured has not commenced a declaratory judgment action naming the injured person or other claimant or parties within

60 days after the denial/disclaimer, the injured person or other claimant may maintain an action directly against the insurer, in which the sole question will be the validity of the insurer's late notice denial or disclaimer.

In *Braun v. One Beacon Ins. Co.*,[19] the plaintiff allegedly struck and injured a pedestrian on May 28, 2004, while driving her vehicle, which was insured by American Home Ins. Co. One Beacon had issued a policy covering a different vehicle owned by the plaintiff's husband. On July 7, 2004, the injured party's attorney notified One Beacon of his representation in connection with a claim for personal injuries on behalf of the injured party, and requested coverage information.

One Beacon responded to this letter on July 12, 2004, by disclaiming coverage on the basis that its insured, the plaintiff's husband, was not involved in the accident. The disclaimer letter also advised that the applicable coverage was with American Home. American Home tendered its policy limits to the injured party, which were rejected. In August 2004, One Beacon was notified that the injured party was seeking excess coverage from it. One Beacon, by letter dated September 16, 2004, again disclaimed coverage, on the ground that the vehicle involved in the accident was not a "covered auto" under its policy. On the basis of these facts, the court concluded that One Beacon's first disclaimer letter (July 12, 2004) was a timely and effective disclaimer of coverage, and the second disclaimer letter (September 16, 2004), based on the same policy provisions, while perhaps late, did not invalidate the first disclaimer. Thus, the court upheld One Beacon's disclaimer and held that it owed no duty to defend or indemnify the plaintiff in the underlying action.

In *Adames v. Nationwide Mutual Fire Ins. Co.*,[20] the court reiterated the well-established rule that

> [a] notice of disclaimer "must promptly apprise the claimant with a high degree of specificity of the ground or grounds on which the disclaimer is predicated" and "[a]n insurer's justification for denying coverage is strictly limited to the ground stated in the notice of disclaimer." Thus, an insurer waives any ground for denying coverage that is not specifically asserted in its notice of disclaimer, even if that ground would otherwise have merit.[21]

In this case, Nationwide relied in its disclaimer upon the homeowners policy's definition of "insured location." This was not a valid basis for denying coverage since the plaintiff's accident triggered the policy's liability coverage, which was not limited to any particular location, not its property coverage. Nationwide further relied upon definitions and exclusions contained in its umbrella policy, which were not relevant since the judgment sought to be enforced by the plaintiff did not exceed the basic policy's limits. The disclaimer failed to mention the homeowners policy's exclusions relating to business pursuits and rental property, and, thus, those exclusions were held to have been waived.

The Fourth Department, in *Erie Ins. Co. v. Calandra*,[22] held that the petitioner did not waive its right to deny coverage based upon the absence of "physical contact" in a hit-and-run case by delaying to do so because "[p]hysical contact goes to coverage, rather than exclusion . . . [and n]o coverage exists in the absence of the required contact. . . . Inasmuch as there is no coverage here, it cannot be said that petitioner waived the right to deny coverage."

Noncooperation

It is well-established that an 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 insurer's cooperation; and that the attitude of the insured, after his [or her] cooperation was sought, was one of "willful and avowed obstruction."[23]

In *Continental Casualty Co. v. Stradford*,[24] 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 him that he risked a disclaimer of coverage if he continued to breach the cooperation clause of his policy were returned "unclaimed." In two other claims, the insurer 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 (in a 3-2 decision) held that the insurer met its burden to establish that it acted diligently in seeking to bring about the insured's cooperation, and that its efforts were reasonably calculated to obtain the insured's cooperation, and that the attitude of the insured, after his cooperation was sought was one of "willful and avowed obstruction." (However, the court further held that the insurer's disclaimer for lack of cooperation was untimely insofar as the lapse of 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, without explanation, was not 'as soon as is reasonably possible' within the contemplation of Ins. Law § 3420(d).[25] 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.)

The Court of Appeals, dealing solely with the issue of timeliness of disclaimer for lack of cooperation, noted that "[e]ven if an insurer possesses a valid basis to disclaim for noncooperation, it must still issue its disclaimer within a reasonable time."[26] The Court also noted, "Fixing the time from which an insurer's obligation to disclaim runs is difficult . . . unlike cases involving late notice of claims or other clearly applicable coverage exclusions, an insured's noncooperative attitude is often not readily apparent," as it "can be obscured by repeated pledges to cooperate and actual cooperation."[27]

Further, the Court observed that

> [t]o further this State's policy in favor of providing full compensation to injured victims, who are unable to control the actions of an uncooperative insured, insurers must be encouraged to disclaim for noncooperation only after it is clear that further reasonable attempts to elicit their insured's cooperation will be futile.[28]

Insofar as the Court found that a question of fact existed as to the amount of time required for the insurer to complete its investigation of the insured's conduct, it modified the order below by holding that the reasonableness of the two-month delay "to analyze the pattern of obstructive conduct that permeated the insurer's relationship with its insured for almost six years" presented a question of fact sufficient to defeat summary judgment in the insured's favor.[29]

One category of an "uninsured" motor vehicle is where the policy of insurance for the vehicle had been canceled prior to the accident.

In *Allstate Ins. Co. v. Gardaner*,[30] the court held that the insurer was justified in disclaiming for the insured's failure to cooperate in the defense of the action against him where there was no cooperation by the insured, the insured could not be located after a diligent search, and the insured made misrepresentations when he applied for insurance.

On the other hand, in *Country-Wide Ins. Co. v. Henderson*,[31] the affidavit of the insurer's investigator, who had no personal knowledge of the efforts made to locate the insured and which merely recited apparent efforts of an unnamed investigator and attached copies of letters to the insured from a claims representative, was held to be based on hearsay and insufficient to establish that the insurer's efforts were reasonably calculated to bring about the insured's cooperation or that the insured ever received notice of the disclaimer. "[M]ere efforts by the insurer and mere inaction on the part of the insured, without more, are insufficient to establish non-cooperation as 'the inference of non-cooperation must be practically compelling.'"[32]

In *St. Paul Travelers Ins. Co. v. Kreibich-D'Angelo*,[33] a disclaimer based on failure to cooperate was held to be invalid, without evidence that the insured knew that the insurer was seeking his cooperation and that he willfully refused to cooperate.[34]

In *Nationwide Mutual Ins. Co. v. Posa*,[35] the court noted that "failure to make fair and truthful disclosures in reporting the [accident] constitutes a breach of the cooperation clause [and the fraud and misrepresentation clauses] of the insurance policy as a matter of law." (Here, the insured falsely claimed that he damaged his pickup truck by driving into it with his garden tractor, when, in fact, as confirmed by his scorned girlfriend, he was involved in an accident with another motor vehicle.)

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 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 whether the policy was paid for under a premium financing contract.[36]

In *General Assurance Co. v. Rahmanov*,[37] the court applied the rule that there is no retroactive cancellation of automobile insurance policies in New York as against third parties on the basis of fraud in the absence of evidence that the claimant was a participant in the fraud.[38]

In *GEICO Ins. Co. v. Battaglia*,[39] on the other hand, the court upheld the insurer's attempt to void its policy *ab initio* based upon a material misrepresentation with respect to the status of its insured, who was actually deceased. It appears, however, that this decision is incorrect in the absence of any evidence that the claimant, the victim of an accident with a vehicle registered to the deceased insured, was involved in any way in this misrepresentation. The general rule is, and has been for years, that automobile policies cannot be rescinded retroactively for fraud and/or misrepresentation.[40] It does not appear that this line of cases was ever raised by the parties.

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 offend-

ing vehicle could not be ascertained, and that the insured's efforts to ascertain such identity were reasonable."[41]

In *American Transit Ins. Co. v. Wason*,[42] the evidence at the framed issue hearing established that the taxi in which the claimant was a passenger was involved in an accident with a dark green, four-door vehicle, which fled the scene. Upon exiting the taxi, the claimant and the taxi driver discovered a bumper with a license plate attached to it. They placed the bumper in the trunk of the taxi and transported it to a nearby policy precinct, but it was subsequently left in the possession of the taxi driver. Approximately one week later, the taxi driver delivered the license plate, detached from the bumper, to the claimant, who provided it to her attorney. The plate was registered to an individual, Palache, who acknowledged owning a dark green, four-door vehicle, but denied involvement in the accident. On the basis of this evidence, the Special Referee held that Palache's vehicle was involved in the accident, and the Appellate Division upheld that determination. As stated by the court, "[i]t was within the province of the Special Referee to reject the claim of custody arguments proffered by additional respondents and conclude that the license plate discovered at the scene of the accident was the same one produced at the hearing."[43]

On the other hand, in *Phoenix Ins. Co. v. Golanek*,[44] the police accident report set forth a license plate number for the alleged hit-and-run vehicle, and noted that this number had been observed by an eyewitness. This plate number was found to correspond to a vehicle that matched the description of the offending vehicle, but the owner of that vehicle denied involvement in the accident. At the framed issue hearing on the issue of involvement, the eyewitness testified that after the accident, she and her mother followed the offending vehicle and she wrote down its plate number. On her way back to the scene of the accident, the eyewitness encountered a police officer and gave him the plate number, and watched as he recorded it in his memo book. There was no evidence that the officer to whom the plate number was reported was one of the two officers who responded to the scene of the accident or whether he was involved in preparing the police accident report. Neither the papers on which the eyewitness wrote the plate number nor the police officer's memo book was offered into evidence and neither of the responding officers testified at the hearing. At the conclusion of the hearing, the petitioner sought to introduce the police accident report into evidence. The referee ruled this document to be admissible pursuant to the present sense impression exception to the hearsay rule, and then determined that the identified truck was involved in the accident. Thus, he granted the petition and permanently stayed the arbitration.

On appeal, the Second Department reversed. The court held that the police accident report was inadmissible under the present sense impression exception because the report made by the eyewitness to the officer she encountered was not based on any present sense she had of the offending vehicle's plate number. As the court explained,

> [a]fter she wrote that number on a piece of paper, she was no longer relying upon a present sense of the number, but was relying entirely on the contents of her own writing. Thus, the officer's memo book, and certainly the police accident report generated sometime later, did not "reflect[ ] a *present* sense impression rather than a recalled or recast description of events that were observed in the recent past."[45]

Furthermore, "the evidence at the hearing in this case did not establish how much time elapsed between the eyewitness's observation of the license plate and her statement to the police officer, or how much additional time elapsed between that statement and the preparation of the police accident report."[46]

Another requirement for a "hit-and-run" claim is a report of the accident within 24 hours or as soon as reasonably possible.

The court also rejected the petitioner's alternative contention that the police accident report was admissible pursuant to the past recollection recorded exception to the hearsay rule since the eyewitness did not give, and could not have given, testimony to the effect that the police accident report correctly represented her knowledge and recollection when made since she was not present when that report was prepared. Based upon the conclusion that the police accident report was improperly admitted into evidence, and the fact that there was "no other competent evidence" that the identified vehicle was involved in the subject accident, the court concluded that the Petition to Stay Arbitration should have been denied.

In *Erie Ins. Co. v. Calandra*,[47] the court rejected the claimant's contention that there should be coverage even in the absence of physical contact because she was able to establish through the affidavits of two disinterested eyewitnesses that an unidentified vehicle forced her to take evasive action to avoid the collision, thereby causing her to sustain injuries.

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 officer or judicial officer, or to the Commissioner of Motor Vehicles.

In *Sitbon v. Unitrin Preferred Ins. Co.*,[48] the court held that the defendant insurer made a prima facie showing of its entitlement to summary judgment dismissing the complaint for uninsured motorist benefits by demonstrating that timely notice was not provided to either the police or the Commissioner of Motor Vehicles. Moreover, the plaintiff failed to raise a triable issue of fact as to whether

he, or anyone else on his behalf, provided timely notice, or any notice, to the police or the Commissioner. The plaintiff failed to oppose the motion with an affidavit or affirmation from the individual who prepared the original of the unsigned, partially completed, MV-104 form attesting to the filing of the report with the Commissioner and when it was filed. Indeed, the Commissioner's form report of a motor vehicle accident specifically provides that an accident report is not considered complete and filed unless it is signed. Accordingly, the court granted the defendant's motion for summary judgment dismissing the complaint.

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, any and all insolvencies, whether or not covered by a Security Fund, give rise to a valid SUM claim.[49] 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.

The Commissioner's form report of an accident specifically provides that an accident report is not considered complete and filed unless it is signed.

In *Lancer Ins. Co. v. Lackraj*,[50] the court held that the offending vehicle, a bus, did not meet the definition of an "uninsured motor vehicle" within the meaning of Ins. Law § 3420(f)(1), notwithstanding the fact that the policy insuring the vehicle had a large ($250,000) deductible and the owner became insolvent.

Underinsured Motorist Issues – Trigger of Coverage

In *Clarendon National Ins. Co. v. Nunez*,[51] where the tortfeasor's insurer paid out the sums of $5,000 to one claimant and $15,000 each to three other claimants, totaling the full $50,000 limits of coverage for the tortfeasor, the court rejected the underinsured motorist claims of each of the claimants under a 25/50 UM/SUM policy, noting, "since the tortfeasor's policy limits for bodily injury liability were identical to the petitioner's policy for bodily injury liability, the tortfeasor's vehicle was not underinsured." The court went on to add that "[c]ontrary to the respondent's contention, 11 N.Y.C.R.R. 60-2.3(f)(c)(3)(ii) [does] not render the tortfeasor's vehicle 'underinsured' for purposes of triggering the SUM endorsement because of the payments the tortfeasor's insurer already made to them."[52] This conclusion was based upon the court's determination that the section of the Regulation 35-D SUM endorsement that defines an "uninsured motor vehicle" as one for which "(3) there is a bodily injury liability insurance coverage or bond applicable to such motor vehicle at the time of the accident, but . . . (ii) the amount of such insurance coverage or bond has been reduced by payments to other persons injured in the accident, to an amount less than the third-party bodily injury liability limit of this policy," requires such reduction for payments made "to other persons" and *not* for payments made to the claimants.[53]

In *Allstate Ins. Co. v. Dawkins*,[54] the court, relying upon the reduction for payments to other persons injured in the accident provision in the Regulation 35-D SUM endorsement, 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, because only $12,500 in coverage remained under the tortfeasor's policy after paying claims of two other individuals, the offending vehicle qualified as "uninsured," and, thus, the claimant had a valid SUM claim, subject to the offset provisions of the policy.

The Second Department declined Allstate's invitation, made for the first time on appeal, "to reconsider our case law in this area and hold that the Superintendent of Insurance exceeded his authority" in promulgating the "reduction by payments to other persons injured in the accident" provision of Regulation 35-D.[55]

In *Automobile Ins. Co. of Hartford v. Ray*,[56] the court compared the tortfeasor's 100/300 policy limits with the claimant's $300,000 combined single limit (for bodily injury and property damage), and concluded that "the SUM endorsement would not be triggered. Since the petitioner's $300,000 combined policy limit includes property damage, the bodily injury liability limits of the tortfeasor's policy were not less than the bodily injury liability limits of the petitioner's policy."[57]

Offset Provision

In *Clarendon National Ins. Co. v. Nunez*[58] and *Allstate Ins. Co. v. Rivera*,[59] the Second Department held that the SUM carrier was entitled to offset the full $50,000 received by the respondents from the tortfeasor's insurer against the SUM limits of its policy, effectively allowing for an offset for payments made to the "insureds" (plural) despite the fact that the endorsement provision refers to the "insured" (singular), and precluding any recovery by any of the respondents under the $50,000 SUM policy.

In *GEICO v. Dunbar*,[60] the court applied the offset provision to reduce by the $25,000 received from the tortfeasor the full $25,000 SUM coverage, and, thus, granted the SUM carrier a permanent stay of arbitration.

Settlement Without Consent

In *Central Mutual Ins. Co. v. Bemiss*,[61] the respondent was injured in a multiple vehicle accident and negotiated a settlement with one of the tortfeasors for the full amount of that party's liability insurance policy. She then gave to her SUM carrier written notice of her intent to enter into this settlement, but the carrier did not respond to her request for permission to settle. Subsequently, she agreed to settle with a second tortfeasor for less than that party's liability limits without first giving any notice to, or obtaining the consent of, the SUM carrier. The respondent ultimately signed releases for both tortfeasors, which made no provision for protecting the SUM carrier's subrogation rights. When the respondent then made a claim for SUM benefits, the SUM carrier denied coverage based upon the failure to protect its subrogation rights. When the respondent demanded arbitration, the carrier moved for a permanent stay, which the Supreme Court granted.

On appeal, the Third Department majority agreed with the respondent that the settlement with the first tortfeasor was proper insofar as "the terms of the policy permitted her to settle with the first tortfeasor without preserving [the SUM carrier's] subrogation rights."[62] Because a request for consent to settle was made and 30 days passed without a response, under Condition 10 of the SUM endorsement, the insured was permitted to issue a release.

However, the court reached a different conclusion regarding the settlement with the second tortfeasor, concluding that such settlement, even for an amount less than the policy limits, destroyed the insurer's subrogation rights against that tortfeasor. As stated by the court,

> [w]hile paragraph 9 of the policy makes clear that respondent was obligated to fully exhaust the policy of only one of the tortfeasors involved in her accident, that same provision does not excuse a failure to comply with paragraph 10 upon settling with another tortfeasor. Unlike the settlement with the first tortfeasor, paragraph 10's first sentence is not applicable to respondent's settlement with the second tortfeasor because the latter was not for the full policy amount. As a result, only the last sentence of paragraph 10 applies here. That sentence provides: "An insured shall not otherwise settle with a negligent party, without our written consent, such that our [subrogation] rights would be impaired." We do not view this sentence to be limited to where a party seeks in the first instance to settle for the full available policy limits of one tortfeasor. Rather, its function is to make clear that the method described in the first sentence of paragraph 10 is the one and only way to enter a settlement with "any negligent party" which impairs petitioner's rights without its consent. There is no dispute that respondent failed to obtain petitioner's consent or reserve petitioner's subrogation rights against the second tortfeasor here.[63]

Thus, the court affirmed the grant of the petition on the basis of the respondent's failure to comply with the terms of her policy.

A strong dissenting opinion suggested that the majority's requirement of preservation of subrogation rights when less than the policy limits are being paid will make it impossible for a victim even to settle a case where there are multiple tortfeasors.[64]

In *Hertz Claim Management Corp. v. Kulakowich*,[65] the court held that the SUM carrier's failure to respond to a letter notifying it of an offer to settle for the policy limits of the owner of the offending vehicle, and affording it the opportunity to consent to or reject such offer, "may be deemed an acquiescence to the offer to settle."

Exhaustion of Underlying Limits

In *Hertz Claim Management Corp.*, the court held that where the claimant exhausted, through settlement, the bodily injury limits of the policy of the owner of the offending vehicle, which were less than the liability coverage provided under the claimant's own policy, he was not required to exhaust the liability coverage limits under a separate policy of the operator of the offending vehicle prior to providing an underinsured motorist claim.[66] ■

1. 57 A.D.3d 819, 870 N.Y.S.2d 400 (2d Dep't 2008).
2. 53 A.D.3d 760, 860 N.Y.S.2d 691 (3d Dep't 2008).
3. *Id.* at 761 (citations omitted).
4. 50 A.D.3d 1459, 857 N.Y.S.2d 393 (4th Dep't 2008).
5. 55 A.D.3d 916, 917, 866 N.Y.S.2d 348 (2d Dep't 2008) (citations omitted).
6. 57 A.D.3d 670, 671, 869 N.Y.S.2d 195 (2d Dep't 2008) (citations omitted).
7. 47 A.D.3d 710, 711, 848 N.Y.S.2d 897 (2d Dep't 2008).
8. *Id.* at 711; *see also Balis v. Chubb Group of Ins. Cos.*, 50 A.D.3d 682, 855 N.Y.S.2d 192 (2d Dep't 2008).
9. 47 A.D.3d 822, 849 N.Y.S.2d 176 (2d Dep't 2008).
10. 56 A.D.3d 130, 131, 865 N.Y.S.2d 465 (4th Dep't 2008).
11. 51 A.D.3d 775, 858 N.Y.S.2d 682 (2d Dep't 2008).
12. *Id.* at 778 (citations omitted); *see also Continental Cas. Co. v. Stradford*, 11 N.Y.3d 443, 871 N.Y.S.2d 607 (2008); *Fireman's Fund Ins. Co. v. Farrell*, 57 A.D.3d 721, 869 N.Y.S.2d 597 (2d Dep't 2008).
13. 10 N.Y.3d 635, 642, 862 N.Y.S.2d 820 (2008).
14. *Id.* (emphasis added; citations omitted).
15. *Id.*; *see also Doyle v. Siddo*, 54 A.D.3d 988, 865 N.Y.S.2d 126 (2d Dep't 2008) (Ins. Law § 3420(d) not applicable to title dispute).
16. 48 A.D.3d 450, 852 N.Y.S.2d 176 (2d Dep't 2008).
17. 49 A.D.3d 1245, 853 N.Y.S.2d 757 (4th Dep't 2008).
18. 47 A.D.3d 549, 850 N.Y.S.2d 84 (1st Dep't 2008).
19. 49 A.D.3d 480, 854 N.Y.S.2d 146 (2d Dep't 2008).
20. 55 A.D.3d 513, 866 N.Y.S.2d 210 (2d Dep't 2008).
21. *Id.* at 515 (citations omitted); *see Gen. Accident Ins. Group v. Cirucci*, 46 N.Y.2d 862, 864, 414 N.Y.S.2d 512 (1979); *see also* Ins. Law § 3420(d).
22. 49 A.D.3d 1237, 1239, 856 N.Y.S.2d 325 (4th Dep't), *lv. to appeal denied*, 11 N.Y.3d 705, 866 N.Y.S.2d 609 (2008).
23. *Thrasher v. U.S. Liab. Ins. Co.*, 19 N.Y.2d 159, 168, 278 N.Y.S.2d 793 (1967) (citations omitted).
24. 46 A.D.3d 598, 847 N.Y.S.2d 631 (2d Dep't 2007), *modified*, 11 N.Y.3d 443, 871 N.Y.S.2d 607 (2008).
25. *Id.* at 599, 601.
26. *Stradford*, 11 N.Y.3d at 449.

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