2016 Review of UM/SUM Law and Practice

By Jonathan A. Dachs

It is my honor and pleasure to present this annual survey of recent developments in the area of uninsured motorist (UM), and supplementary uninsured/underinsured motorist (SUM) law and practice. As always, the period reviewed – here, the calendar year 2016 – was marked by much significant activity in this highly litigated, ever-changing, and complex area of insurance law.

I. GENERAL ISSUES

A. Purpose of SUM Coverage

In *Nafash v. Allstate Ins. Co.*,[1] the court stated that "When a policyholder purchases SUM coverage in New York, he or she is insuring against the risk that a tortfeasor (1) may have no insurance whatsoever; or (2) even if insured, is only insured for third-party bodily injury at relatively low liability limits, in comparison to the policyholder's own liability limits for bodily injury sustained by third parties."

B. Residents

The definition of an "insured" under the UM and SUM endorsements includes a resident relative of the named insured or spouse.

In *Progressive Northern Ins. Co. v. Pedone*,[2] the court observed that "While a person can have more than one residence for purposes of insurance coverage [citations omitted], a person's status as a resident of an insured's household 'requires something more than temporary or physical presence and requires at least some degree of permanence and intention to remain' [citations omitted]."

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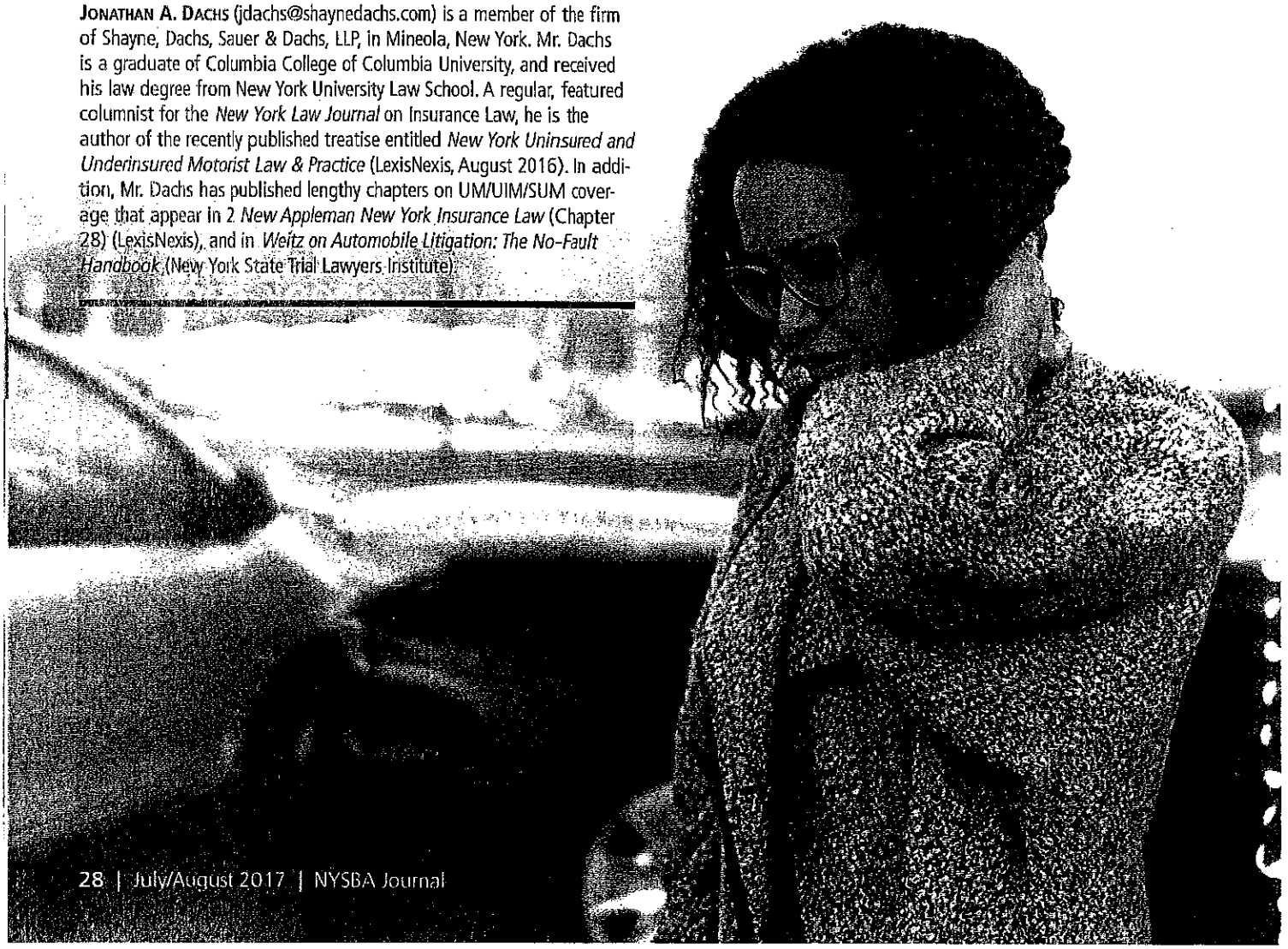

Generally speaking, the issue of residency is a question of fact to be determined at a hearing.

In *Pedone*, the court found that the evidence at the framed-issue hearing supported the Supreme Court's determination that the claimant, an "itinerant musician," resided in his parents' household in Staten Island at the time of the subject accident. The proof in the record included the presence of the claimant's personal belongings and professional equipment at his parents' house, numerous official documents that listed his parents' address as his residence, and testimony adduced at the framed-issue hearing – all of which sufficed to establish residency in his parents' household within the meaning of the insurance policy.

C. "Motor Vehicle"

In *Guevara v. Ortega*,[3] the court held that a New York City Police Department vehicle being driven by a car wash attendant was a "police vehicle" even though it was not being operated by the police department at the time of the accident. Therefore, it was not required to have UM or SUM coverage.[4]

D. Occupancy

Among the definitions of an "insured" under the UM and SUM endorsements is a person "occupying" a motor vehicle covered by those endorsements. The term "occupying" is defined as "in, upon, entering into, or exiting from a motor vehicle."

In *Government Employees Ins. Co. v. Nakhla*,[5] the claimant was driving a taxicab insured by American Transit when it was struck in the rear by another vehicle. When he exited the taxicab to look for damage, the offending vehicle drove away and struck him while he was standing outside the cab. The claimant filed a claim for uninsured motorist benefits with GEICO, the insurer for his own personal vehicle, as a result of injuries he sustained from the second impact, contending that he was a pedestrian, rather than an occupant of the cab, at that time.

As noted by the court, GEICO's policy defined "occupying" as "in, upon, entering into or exiting from a motor vehicle" – a definition taken from Insurance Law § 3420(f)(3), which similarly defines that term. The essential question was whether "a departure from a vehicle is occasioned by or is incident to some temporary interruption of the journey and the occupant remains in the immediate vicinity of the vehicle and, upon completion of the objective occasioned by the brief interruption, he intends to resume his place in the vehicle (*Rice v. Allstate Ins. Co.*, 32 N.Y.2d 6, 10–11)." The court held that GEICO established that the claimant was an occupant of the taxicab at the time of the second impact (on the authority of several earlier decisions[6]).

In *J. Lawrence Construction Corp. v. Republic Franklin Ins. Co.*,[7] the plaintiff parked the insured vehicle, which was leased by his employer, across the street from his office, exited the vehicle and locked it. He then went into his office, retrieved documents from his desk, and proceeded back to the vehicle. As he crossed the street, he remotely unlocked the vehicle with his key fob when he was "half a step" away from the vehicle, and while reaching for the door handle of the passenger door, he was struck by a vehicle. The policy covering the leased vehicle contained an SUM endorsement, which provided coverage to any person who was "occupying" the insured vehicle, and defined "occupying" as "in, upon, entering into, or exiting from a motor vehicle." The insurer denied the plaintiff's claim on the basis that the plaintiff was a pedestrian and not an occupant of the vehicle at the time of the accident.

The court noted that under the law,

> A person remains an occupant of a vehicle even if that person is not in physical contact with the vehicle, "provided there has been no severance of connection with it, his [or her] departure is brief and he [or she] is still vehicle-oriented with the same vehicle" [citations omitted].[8] A connection to a vehicle will be severed "upon alighting therefrom to perform a chore which was not vehicle oriented" [citation omitted].[9] Moreover, there has to be "[m]ore than a mere intent to occupy a vehicle . . . to alter the status of pedestrian to one of 'occupying' it" [citations omitted].[10] "[O]ne is [not] considered to be occupying a car if he is merely approaching it with intent to enter."[11]

Based upon the evidence in this case, the court concluded that the plaintiff leaving the vehicle "was not a temporary break in his journey such that he remained in the immediate vicinity of the insured vehicle." Moreover, the plaintiff had only "a mere intent to enter the insured vehicle and was not an occupant of the insured vehicle at the time of the accident." Accordingly, the court granted the insurer's motion for summary judgment declaring that it had no duty to provide SUM benefits to the plaintiff.

E. Accidents v. Intentional Collisions

In *Progressive Advanced Ins. Co. v. McAdam*,[12] an action for a judgment declaring that the plaintiff insurer was not obligated to pay certain no-fault claims submitted by the defendants, the insurer sought to deny coverage based on its contention that the "accidents" were "intentionally staged and fraudulent." Although the court observed that "[A]n intentional and staged collision caused in furtherance of an insurance fraud scheme is not a covered accident under a policy of insurance [citations omitted]," it went on to find that the insurer failed to meet its *prima facie* burden on the motion because the uncertified police accident reports it submitted were not admissible, and the affidavit of the insurer's medical representative was based largely upon inadmissible evidence and not upon personal knowledge of the facts surrounding the two collisions.

F. Use or Operation

The court held in *Guevara v. Ortega*[13] that a New York City Police Department traffic van being driven by a car wash attendant was a police vehicle even though it was not being driven by the police department at the time of the accident, interpreting the word "operated" as broader than "to cause to function" or "to drive" and to include the meaning "to exact power or influence."

G. Claimant/Insured's Duty to Provide Timely Notice of Claim

In *Kraemer Building Corp. v. Scottsdale Ins. Co.*,[14] the court noted that the insurer's receipt of prompt notice of an occurrence is "a condition precedent to its liability under the policy," and "a failure to give that notice 'may allow an insurer to disclaim its duty to provide coverage' [citations omitted]."

In *Slocum v. Progressive Northwestern Ins. Co.*,[15] the court observed that where a policy requires that notice be given to the insurer "as soon as practicable," it means, in the SUM context, that "the insured must give notice with reasonable promptness after the insured knew or should reasonably have known that the tortfeasor was underinsured." Here, the plaintiff became aware of the limits of the tortfeasor's policy in September 2012, and learned the extent of her injuries by at least June 2013, when she underwent fusion surgery. Under those circumstances, the court concluded that it was unreasonable for the plaintiff to wait until August 2014 to notify the insurer of her SUM claim.

However, the *Slocum* court went on to hold that plaintiff was nevertheless entitled to coverage based on Insurance Law § 3420(a)(5), pursuant to which an insurer may not deny coverage based on untimely notice "unless the failure to provide timely notice has prejudiced the insurer," and that prejudice is not established "unless the failure to timely provide notice materially impairs the ability of the insurer to investigate or defend the claim."[16] Because the plaintiff provided notice of the accident within two years of learning the limits of the tortfeasor's coverage, the burden of proving prejudice rested with the insurer, and prejudice to the insurer was not presumed.[17] The insurer failed to meet its burden of demonstrating that its ability to investigate or defend the claim was "materially impaired."

The court refused, in *Castillo v. Prince Plaza, LLC*,[18] to apply an irrebuttable presumption of prejudice resulting from late notice of the occurrence and the lawsuit, pursuant to Ins. L. §3420(c)(2)(B), where such notice was not given until after a default had already been entered against the insured, because the default had been vacated a year before the insurer raised the statute as a ground for its disclaimer of coverage.

In *Freeway Company, LLC v. Technology Ins. Co.*[19] and *Aspen Ins. UK Limited v. Nieto*,[20] the courts reminded that the amendment to the "no prejudice" rule for late notice may not be applied to cases involving policies issued before January 17, 2009; in such cases, the old common law rules apply.

In *Kraemer Building Corp. v. Scottsdale Ins. Co., supra*, a case that arose prior to the statutory amendment pertaining to the "no prejudice" rule, the court rejected the plaintiff's contention that the prejudice rule then applicable to uninsured and underinsured motorist claims, pursuant to *In re Brandon [Nationwide Mut. Ins. Co.]*,[21] and *Rekemeyer v. State Farm Mut. Auto. Ins. Co.*,[22] should be applied in the context of a liability policy as well.

Under the particular, and compelling, facts of this case, the court applied the doctrine of equitable estoppel to preclude the insurer from denying SUM coverage, rejecting the notion that the doctrine of equitable estoppel may never be employed to create coverage not provided for in an insurance policy.

As noted by the court, in the UM/UIM context, the no-prejudice rule had less potency "because an insurer was able to protect its interests due to its receipt of the separate No-Fault claim," while, in contrast, "'[t]he rationale of the no-prejudice rule is clearly applicable to a late notice of lawsuit under a liability insurance policy,' as a liability insurer is unlikely to obtain pertinent information through other means, impairing its ability 'to take an active, early role in the litigation process and in any settlement discussions and to set reserves' [actions omitted]."

In *Pollack v. Scottsdale Ins. Co.*[23] and *Castillo v. Prince Plaza, LLC*,[24] the courts noted that because an injured party is allowed by law to provide notice to an insurance company,[25] he or she is generally held to any prompt notice condition precedent of the policy, but such an injured party can overcome an insurance company's failure to receive timely notice – which would otherwise vitiate coverage – by a demonstration that he or she did not know the insurer's identity despite his or her reasonably diligent efforts to obtain such information.[26]

As further explained by the court in *Mt. Hawley Ins. Co. v. Seville Electronics Trading Corp.*,[27]

> Insurance Law §3420(a)(3) requires the injured party

> to demonstrate that he or she acted diligently in attempting to ascertain the identity of the insurer and thereafter expeditiously notified the insurer [citation omitted]. "In determining the reasonableness of an injured party's notice, the notice required is measured less rigidly than that required of the insured[ ]" [citations omitted]. "The injured person's rights must be judged by the prospects for giving notice that were afforded him, not by those available to the insured [citation omitted]." "What is reasonably possible for the insured may not be reasonably possible for the person he has injured. The passage of time does not of itself make delay unreasonable" [citation omitted].

The court stated in *Pollack v. Scottsdale Ins. Co.*[28] that "notice of an occurrence by the injured party constitutes *prima facie* compliance with the notice requirements of the policy, and, if unchallenged, relieves the insured of its contractual duty to provide proper notice."

In *Martin Associates, Inc. v. Illinois National Ins. Co.*,[29] the court held, *inter alia*, that notice to an insurer provided by other insureds under the policy was not sufficient to meet the plaintiff's own notice obligation, since its interests were at all times adverse to those of the other insureds.

The Second Department noted in *Osorio v. Bowne Realty Assoc., LLC*[30] that "circumstances may exist that will excuse or explain the insured's delay in giving notice, such as lack of knowledge that an accident has occurred [citations omitted]. It is the insured's burden to show the reasonableness of such excuse [citations omitted]." In this case, although the insured did not provide notice of the accident until three years after it occurred, it raised a triable issue of fact as to whether that delay was reasonable via the affidavits of its manager and director of operations, both of whom stated that they did not know about the accident until they received the summons and complaint.

In *Karl v. North County Ins. Co.*,[31] a pre-"prejudice rule" case, the insurance policy required notice of the occurrence to be given to the carrier "as soon as practicable," and required legal papers to be forwarded "promptly." Although the plaintiff commenced the underlying action against the defendant's insurer in February 2008, and was aware at that time of the identity of the insurer, it was not until June 27, 2008 that the insurer was notified for the first time of the lawsuit, when it received a copy of the summons and complaint from the plaintiff's counsel. The insurer disclaimed coverage six days later based upon the plaintiff's failure to provide timely notice of the occurrence and of the lawsuit. On the basis of the record before it, the court held that the insurer's disclaimer was timely and proper based upon the plaintiff's failure to promptly forward the underlying pleadings.

In *EAN Holdings, LLC v. Joseph*,[32] the court rejected the respondent's contention that despite the fact that notice of his UM claim based upon an alleged hit-and-run accident was not provided until almost six years after the accident, it should be deemed timely because the claim was asserted within the applicable statute of limitations. The court specifically held "that the six (6) year Statute of Limitations had not yet run is insufficient to explain the failure to have given the Petitioner notice within a reasonable time from the date of the accident," and noted that "it has been held that a delay of more than one year is unreasonable as a matter of law [citation omitted]."[33]

H. Proceedings to Stay Arbitration

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."

1. Filing and Service of Petition to Stay

In *Allstate Ins. Co. v. Cappadonia*,[34] the court held that the petition to stay arbitration was time-barred because it was not filed within 20 days of receipt of the formal arbitration demand,[35] rejecting the petitioner's contention that the 20-day rule did not apply since the policy did, in fact, contain an arbitration agreement between the parties.

The Second Department held in *Progressive Cas. Ins. Co. v. Garcia*[36] that Progressive's contention that arbitration should be stayed on the ground that the claimants' accident did not involve an adverse "motor vehicle," but, rather, an all-terrain vehicle,[37] does not relate to whether the parties had an agreement to arbitrate. Rather, that issue relates to whether certain conditions of the insurance contract were complied with so as to entitle the claimants to uninsured motorist benefits, and, therefore, had to be asserted within the 20-day time limit set forth in CPLR 7503(c).

The court also observed that Progressive failed to establish that the claimants' notices on intention to arbitrate were deceptive and intended to prevent it from timely commencing the proceeding. The notices of intention to arbitrate complied with the requirements of CPLR 7503(c), and the insurer failed to proffer an affidavit by someone with personal knowledge to support its contention that the claimants' service of the notices upon a certain post office address used by Progressive to process no-fault claims prevented it from timely contesting the issue of arbitrability. Indeed, the record included a letter from Progressive's own claims representative to the insurer's counsel acknowledging receipt of the notices of intention well within the 20-day period.

2. Burden of Proof

In *Allstate Ins. Co. v. Martinez*[38] and *Hertz Vehicles, LLC v. Monroe*,[39] the courts noted that "'[t]he party seeking a stay of arbitration has the burden of showing the existence of sufficient evidentiary facts to establish a preliminary

issue which would justify the stay' [citations omitted]. Thereafter, the burden shifts to the party opposing the stay to rebut the *prima facie* showing [citations omitted]."

The Second Department in *Wynn v. Motor Veh. Acc. Indem. Corp.*[40] held that it was error to admit into evidence a police report without redacting the police officer's diagram of the accident. As stated by the court:

> Information in a police accident report is "admissible as a business record so long as the report is made based upon the officer's personal observations and while carrying out police duties" [citations omitted]. Conversely, information in a police accident report is inadmissible where the information came from witnesses not engaged in the police business in the course of which the memorandum was made, and the information does not qualify under some other hearsay exception [citations omitted].

Thus, insofar as the diagram contained in the police accident report was not derived from the personal observations of the police officer, who did not witness the accident, and there was insufficient evidence as to the source of the information used to prepare the diagram, whether that person was under a duty to supply it, or whether some other hearsay exception would render the diagram admissible, the court held that the diagram should not have been admitted, and its admission into evidence constituted harmful error.

In *Hertz Vehicles, LLC v. Monroe, supra*, the host driver testified at a framed issue hearing that, at the scene of the accident, the driver of the alleged offending vehicle gave him the telephone number for his insurance carrier. The host driver wrote that information, as well as other information relating to the identity of the offending vehicle, on a piece of paper. The next day, he called the number he had been given and spoke with an insurance agent, who provided the vehicle's insurance information, which he then also wrote on a separate piece of paper. Ten days after the accident, the host driver used the information he had previously recorded to prepare an MV-104 motor vehicle accident report. That report included the name and address of the driver of the alleged offending vehicle, but did not include any identifying information about the vehicle itself, such as its license plate number, state of registration, make, model, or year. Although the report indicated that the alleged offending vehicle was insured by Esurance, the policy number shown correlated to an Infinity policy. Over Infinity's objection, the court admitted an uncertified and unsworn copy of the MV-104 report into evidence for "limited purposes because some information is hearsay."

On the SUM carrier's appeal from the denial of its petition to stay arbitration, the court held that the carrier

> failed to make an evidentiary showing that the MV-104 accident report was admissible as a memorandum of a past recollection because the host driver did not have personal knowledge of the insurance information in the first instance, and the information on the report relating to the alleged offending vehicle and its insurance was derived from pieces of paper that were not produced at the hearing."
>
> '[A] memorandum not in its nature original evidence of the facts recorded, and not verified by the party who made the report and knew the facts, would open the door to mistake, uncertainty and fraud' [citations omitted].

Thus, the court held that since the MV-104 report did not meet the criteria for admissibility as a memorandum of the accident, the burden never shifted to the purported insurer of that vehicle to establish non-insurance or cancellation prior to the accident.

3. Arbitration Awards

a. Scope of Review

In *GEICO Indemnity Ins. Co. v. Global Liberty Ins. Co. of NY*,[41] a case involving an arbitration award in a UM matter, the court observed that

> [j]udicial review of an arbitrator's award is extremely limited [citation omitted]. Generally, an arbitration award can be vacated by a court only upon the narrow grounds set forth in CPLR 7511(b). While decisional law imposes closer judicial scrutiny of an arbitrator's determination in a compulsory arbitration proceeding [citation omitted], where, as here, the arbitration was consensual, a more deferential standard of review applies.

The court went on to add that "[a]n arbitration award may be vacated pursuant to CPLR 7511 (b)(1)(iii) where an arbitrator 'exceeded his [or her] power, which has been interpreted as including only three narrow grounds: if the award is clearly violative of a strong public policy; if it is totally or completely irrational; or if it clearly exceeds a specifically enumerated limitation on the arbitrator's power' [citations omitted]."

Insofar as the party seeking to vacate the award failed to establish that the arbitrator's award violated public policy, was completely irrational, or exceeded a specifically enumerated limitation of the arbitrator's power, the court upheld the confirmation of the award.[42]

In *Civil Service Employees Assoc., A.F.S.C.M.E. Local 1000, A.F.L.-C.I.O. v. County of Nassau*,[43] the court stated that "[u]pon timely application, an arbitration award should be confirmed, unless the award is vacated or modified upon a ground specified in CPLR 7511 (*see* CPLR 7510). 'An arbitration award may not be vacated unless it violates a strong public policy, is irrational, or clearly exceeds a specifically enumerated limitation on the arbitrator's power' [citations omitted]."

> [Moreover,] judicial intervention on public policy grounds constitutes a narrow exception to the otherwise broad power of parties to agree to arbitrate all of the disputes arising out of their juridical relationships, and the correlative, expansive power of arbitrators to

fashion fair determinations of the parties' rights and remedies [citations omitted]. The public policy exception applies only in "'cases in which public policy considerations, embodied in statute or decisional law, prohibit, in an absolute sense, particular matters being decided or certain relief being granted by an arbitrator'" [citations omitted].

In *GEICO Indemnity Ins. Co. v. Global Liberty Ins. Co. of NY, supra*, the court noted that evidence that was not submitted at the arbitration hearing may not be considered upon a motion to vacate (or confirm) the arbitration award.

I. Collateral Estoppel

The Second Department in *Tower Ins. Co. of New York v. Einhorn*[44] held, in pertinent part, that "while a defendant who has defaulted in an action admits all traversable allegations set forth in the complaint, including the basic allegation of liability," in this case, where the insured moved for leave to enter a default judgment only against its insured (Einhorn), "any resulting judgment would bind only her, and may not be given preclusive effect to deprive the nondefaulting defendants of their right to litigate the issues pertaining to coverage as permitted by law in the appropriate forum [citations omitted]."

In *Liberty Mutual Ins. Co. v. Robles*,[45] the petitioner sought a permanent stay of arbitration of a hit-and-run claim. The proposed additional respondents were the insurer and owners of the vehicle that allegedly fled the scene of the accident. In a prior property damage arbitration, the arbitrator determined that the proposed additional respondent's vehicle was the vehicle that fled the scene. Although the petitioner did not raise the issue of collateral estoppel in support of its petition, the Supreme Court granted the petition based upon the doctrine of collateral estoppel. In reversing, the First Department noted, *inter alia*, that although the issue involved was addressed in the claimant/respondent's opposition papers and the petitioner's reply, "those papers were served after the due date of the proposed additional respondent's opposition." Accordingly, the proposed additional respondents had no obligation or opportunity to address the issue.

J. Equitable Estoppel

In *U.S. Specialty Ins. Co. v. Beale*,[46] the court held that even though the subject policy, which was issued to the town of Poughkeepsie, did not include SUM coverage for the town's police vehicles, the insurer was equitably stopped from denying coverage where:

- it knew, as a result of inspecting and photographing the police car operated by the claimant shortly after the accident, that a police vehicle was involved and that the claimant was making a claim for SUM benefits for damages she sustained while operating a police vehicle;
- its claims adjuster engaged in numerous telephone and written communications regarding the claimant's SUM claim, assigned a claim number for use in the SUM claim process, inquired about the underlying lawsuit and advised that there was $1 million in applicable SUM coverage;
- its attorney sent the claimant's attorneys a letter acknowledging the SUM claim and demanding compliance by the claimant with the discovery provisions of the SUM endorsement and requiring the claimant to obtain its consent to any settlement with the tortfeasor;
- it provided written consent to the claimant's settlement with the tortfeasor for the tortfeasor's minimal ($25,000) bodily injury coverage and the issuance of a general release and stipulation of discontinuance;
- it proceeded with discovery for the SUM claim, including obtaining and processing medical authorizations and participating in an examination under oath and a physical examination of the claimant;
- it participated in a mediation of the SUM claim;
- it made an (unsuccessful) offer to settle the SUM claim; and
- it participated in a pre-arbitration telephone conference call with the SUM arbitrator assigned to the matter, before filing a petition seeking a declaration that there was no SUM coverage under the policy.

An arbitration award may not be vacated unless it violates a strong public policy, is irrational, or clearly exceeds a specifically enumerated limitation on the arbitrator's power.

As summarized by the court, the insurer in this case "acted in all respects since 2011 through the commencement of this proceeding as if [the claimant] had SUM coverage for her police vehicle as of the date of the 2011 accident." In reliance upon affirmative representations as to SUM coverage, and after having obtained the insurer's consent, she settled her negligence action against the tortfeasor for $25,000 and released the tortfeasor in order to pursue her SUM claim. As a result, she is now foreclosed from pursuing claims against the tortfeasor for damages she believed were available through SUM coverage. Under the particular, and compelling, facts of this case, the court applied the doctrine of equitable estoppel to preclude the insurer from denying SUM coverage, rejecting the notion (asserted by the insurer) that the doctrine of equitable estoppel may

never be employed to create coverage not provided for in an insurance policy.

K. Bad Faith

In *Gutierrez v. Government Employees Ins. Co.*,[47] the plaintiff brought an action against his SUM carrier for breach of the terms of the insurance policy and breach of the implied covenant of good faith and fair dealing, based upon the insurer's refusal to pay his claim after he exhausted the coverage of the tortfeasor. The first cause of action, sounding in breach of contract, demanded payment of the SUM benefits. The second cause of action sought damages in part for GEICO's alleged breach of "its duty to act in good faith" by unreasonably withholding payment of SUM benefits. The third cause of action alleged that GEICO "breached its contract and/or policy, and absolute duties and obligations to the plaintiff and its insureds."

GEICO moved pursuant to CPLR 3211(a)(7) to dismiss the second and third causes of action on the basis that if they sounded in breach of the implied covenant of good faith and fair dealing, "that covenant was implicit in every contract, and therefore those causes of action were duplicative of the cause of action sounding in breach of contract."

The court found that the second cause of action alleged a failure to act in good faith, and noted that "[i]mplicit in every contract is an implied covenant of good faith and fair dealing [citation omitted]," – i.e., "a pledge that neither party to the contract shall do anything which will have the effect of destroying or impinging the right of the other party to receive the fruit of the contract, even if the terms of the contract do not explicitly prohibit such conduct [citations omitted]." Nevertheless, the court held that such a cause of action "is not necessarily duplicative of a cause of action alleging breach of contract." The court did, however, hold that the third cause of action sounded in breach of contract, and, thus, was duplicative of the first.

The court noted that

> An insurance carrier has a duty to "investigate in good faith and pay covered claims" (*Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of N.Y.*, 10 N.Y.3d 187, 195). Damages for breach of that duty include both the value of the claim, and consequential damages, which may exceed the limits of the policy, for failure to pay the claim within a reasonable time (*see Panasia Estates v. Hudson Ins. Co.*, 10 N.Y.3d 200, 203; *Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of N.Y.*, 10 N.Y.3d at 195). Such a cause of action is not duplicative of a cause of action sounding in breach of contract to recover the amount of the claim [citations omitted]. Such consequential damages may include loss of earnings not directly caused by the covered loss, but caused, instead, by the breach of the implied covenant of good faith and fair dealing [citations omitted]. The second cause of action states a claim for consequential damages for breach of the implied covenant of good faith and fair dealing.

II. UNINSURED MOTORIST ISSUES

A. Insurer's Duty to Provide Prompt Written Notice of Denial or Disclaimer

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

An insurance company has an affirmative obligation to provide written notice of a disclaimer of coverage as soon as is reasonably possible, even where the policyholder's own notice of claim to the insurer is untimely

Insurance Law § 3420(d)(2) provides that if "an insurer shall disclaim liability or deny coverage for death or bodily injury . . . it shall give written notice as soon as reasonably possible of such disclaimer or liability or denial of coverage to the insured and the injured person or any other claimant."

As the Court of Appeals observed in *Keyspan Gas East Corp. v. Munich Reinsurance America, Inc.*,[48]

> [t]he Legislature enacted section 3420(d)(2) to "aid injured parties" by encouraging the expeditious resolution of liability claims [citations omitted]. To effect this goal, the statute "establishe[s] an absolute rule that unduly delayed disclaimer of liability or denial of coverage violates the rights of the insured [or] the injured party" [citation omitted]. Compared to traditional common-law waiver and estoppel defenses, section 3420(d)(2) creates a heightened standard for disclaimer that "depends merely on the passage of time rather than on the insurer's manifested intention to release a right as in waiver, or on prejudice to the insured as in estoppel [citations omitted]."

In *Provencal, LLC v. Tower Ins. Co. of New York*,[49] the court noted that where the underlying insurance claim does not arise out of an accident involving bodily injury or death, Ins. L. § 3420(d)(2) and its heightened requirements do not apply.[50]

The court held, in pertinent part, in *Estee Lauder Inc. v. One Beacon Ins. Group, LLC*[51] that in a matter involving property damage claims, the court rules on the common

law for the proposition that "[a] ground not raised in the letter of disclaimer may not later be asserted as an affirmative defense."

In *Carlson v. American International Group, Inc.*,[52] the court noted that the provisions of Ins. L. § 3420 apply only to policies "issued or delivered in this state," and that the phrase "issued or delivered" is not to be conflated with the phrase "issued for delivery," which formerly appeared in the statute. Thus, where the policy involved was issued in New Jersey and delivered in Seattle, Washington, and then in Florida, it was not issued or delivered in New York, and, therefore, the statute (there, § 3420[a][2], governing direct actions against the insurer to recover on a judgment against its insured) was inapplicable.[53]

In *Pollack v. Scottsdale Ins. Co.*,[54] the court observed that "Where the required notice of [denial or disclaimer] is not provided by the insured, but rather by the injured party, the insurer's notice of disclaimer must address with specificity the grounds for disclaiming coverage applicable to the injured party as well as the insured."

In *Batista v. Global Liberty Ins. Co.*,[55] the court observed that "An insurance company has an affirmative obligation to provide written notice of a disclaimer of coverage as soon as is reasonably possible, even where the policyholder's own notice of claim to the insurer is untimely" and that "Where there is a delay in providing the written notice of disclaimer, the burden rests on the insurance company to explain the delay."

In *Imperium Ins. Co. v. Utica First Ins. Co.*,[56] the court held that the insurer sufficiently demonstrated that its delay in issuing its disclaimer "was reasonably related to a prompt, diligent, and necessary investigation to determine the relationship of the parties in the underlying action and whether an employee exclusion in the relevant insurance policy excluded coverage," and that the insurer's three-day delay in sending its notice of disclaimer after the completion of its investigation was not unreasonable.

In *Martin Associates, Inc. v. Illinois Mutual Ins. Co.*,[57] the court held, *inter alia*, that a disclaimer for late notice issued by the insurer 26 days after it received notice was timely as a matter of law.

In *Black Bull Contracting, LLC v. Indian Harbor Ins. Co.*,[58] the court held that the insurer's disclaimers, "had they been subject to the timeliness requirement of Insurance Law §3420(d)(2)," would have been untimely as a matter of law because they were issued 79 days and 85 days after the insurer received notice of the claim, and the basis for the disclaimer was apparent from the face of the notice of claim and accompanying correspondence.

However, the court went on to note that whether the untimeliness of the disclaimer under Ins. L. § 3420(d)(2) precluded the insurer from denying coverage depended on whether there was "a lack of coverage in the first instance" or "a lack of coverage based on an exclusion." As the Court of Appeals elaborated in *Worcester Ins. Co. v. Bettenhauser*,[59] "Disclaimer pursuant to section 3420[d] [now §3420(d)(2)] is unnecessary when a claim falls outside the scope of the policy's coverage. Under those circumstances, the insurance policy does not contemplate coverage in the first instance, and requiring payment of a claim upon failure to timely disclaim would create coverage where it never existed. By contrast, disclaimer pursuant to section 3420(d) is necessary when denial of coverage is based upon a policy exclusion without which the claim would be covered."[60]

B. Hit-and-Run

UM/SUM coverage is available to victims of accidents involving a "hit-and-run," i.e., an unidentified vehicle that leaves the scene of the accident.

In *Government Employees Ins. Co. v. Huang*,[61] the court reminded that when there is a genuine triable issue of fact with respect to whether a claimant's vehicle had any physical contact with an alleged hit-and-run vehicle, the appropriate procedure is to stay arbitration pending a framed-issue hearing on that issue.

In *American Transit Ins. Co. v. Caba*,[62] the court stated that in reviewing a determination made after a hearing, the power [of the appellate court] is "as broad as that of the hearing court," and it "may render the judgment it finds warranted by the facts, bearing in mind that in a close case, the hearing court had the advantage of seeing the witnesses and hearing the testimony [citations omitted]."

In some instances, a claim is made that the subject vehicle was identified by the claimant/insured, but was not, in fact, involved in the subject accident. Such cases often result in framed issue hearings to determine the issue of involvement, with results dependent upon the specific facts of each case.

For example, in *American Transit Ins. Co. v. Caba, supra*, the claimant was able to record the license plate number of the vehicle that hit his vehicle as it drove away from the scene, and he provided it to the police. Upon claimant's presentation of his claim to the purported insurer for the offending vehicle, that insurer denied that its insured vehicle was involved in the accident. Claimant then presented an uninsured motorist claim to his own insurer. After a framed issue hearing, the court granted the SUM carrier's Petition to Stay Arbitration on the ground that the alleged offending vehicle was insured at the time of the accident.

On appeal, the court upheld the Supreme Court's determination that the claimant's vehicle was struck by the identified vehicle, which was insured, on the basis that such determination was supported by the record, which included the Police Accident Report, a New York registration search document, and testimony by the claimant as to the involvement of the subject vehicle in the accident, which was "credible and unrebutted."

In *EAN Holdings, LLC v. Joseph*,[63] the Supreme Court reminded that physical contact from an unidentified

vehicle is a condition precedent to an arbitration based upon a hit-and-run accident, and that in *Allstate Ins. Co. v. Killakey*,[64] the Court of Appeals ruled that "physical contact occurs within the meaning of the statute, when the accident originates in a collision with an unidentified vehicle, or an integral part of an unidentified vehicle."

III. UNDERINSURED/SUPPLEMENTARY UNINSURED MOTORIST ISSUES

A. Trigger of SUM Coverage

In *Nafash v. Allstate Ins. Co*,.[65] the court reaffirmed that the appropriate comparison for determining whether SUM coverage is triggered is between the bodly injury liability limits of the tortfeasor and the bodily injury liability limits of the claimant.

B. Offset/Reduction in Coverage

In *Ameriprise Auto & Home Ins. Co. v. Savio*,[66] where the Claimant's policy provided bodily injury liability coverage of $100,000/$300,000, but only $50,000/$100,000 in SUM coverage, the court held that insofar as the $50,000 recovered by the claimant from the tortfeasor (the applicable limits for death) were the same as the maximum SUM limit provided for by her policy, and, thus, the difference between the SUM policy limit for one person ($50,000) and the amount paid by the tortfeasor's insurer ($50,000) was zero, the Claimant had no possibility of an additional recovery, and, thus, her SUM claim was rendered academic. Accordingly, the order granting a permanent stay of arbitration was affirmed.

In *Redeye v. Progressive Ins. Co*,.[67] the plaintiff, a pedestrian injured when a vehicle operated by a drunk driver collided with a parked car, which was propelled into him, recovered damages in a settlement from the driver of the vehicle, as well as a fire company that allegedly sold the driver alcoholic beverages prior to the accident. He then made a claim for SUM benefits from his own motor vehicle insurer, which the insurer denied on the ground that the SUM coverage was exhausted by the recoveries the plaintiff already received. Although the plaintiff conceded that the amount of his SUM coverage was properly reduced by the amount he received from the driver's insurer, he argued that it was improper to reduce the SUM coverage by the amount he received from the fire company under its general liability insurance policy. The Fourth Department rejected that contention and granted the insurer's Petition to Stay Arbitration, finding that the payment from the fire company's insurer was for bodily injury damages, and, thus, constituted a proper reduction pursuant to the Non-Duplication provision of the SUM Endorsement.

However, in *Government Employees Ins. Co. v. Sherlock*,[68] the Second Department, effectively overruling its earlier decision in *Weiss v. Tri-State Consumer Ins. Co*,[69] held that GEICO's insured, who maintained a policy with $25,000 in SUM coverage, and who settled her action against the automobile tortfeasor for the $50,000 limit of his policy, and then, after an arbitration, settled with the municipal (non-motor vehicle) defendants, i.e., town and town police department, for an additional $425,000, was entitled to proceed to SUM arbitration against GEICO for the total sum of $200,000, representing the $250,000 SUM limits reduced by the motor vehicle tortfeasor's $50,000 coverage, only. Essential to this decision was the court's finding, in agreement with the claimant, that the "Non-Duplication" provision of the SUM Endorsement (Condition 11) does not serve to reduce the SUM limits for recovery for non-motor vehicle defendants except to the extent that such recovery could be deemed duplicative of the SUM benefits claimed. As stated by the court, "The key to a proper understanding of Condition 11 is the recognition that 'shall not duplicate' is not aimed at preventing an insured from seeking full compensation by combining partial recoveries from several tortfeasors, but at preventing double recoveries for their bodily injuries." The claimant in this case alleged in her arbitration request that the bodily injury damages "are in the millions of dollars." The court thus noted that, presumably, if the motor vehicle policy contained the same $250,000 liability limit that the GEICO policy provided, the claimant would have been able to obtain $250,000 from the motor vehicle defendant's insurer, as well as the $425,000 from the municipality defendants' insurer. Insofar as the claimant seeks only, through her claim under the SUM endorsement, for which she paid a premium, to be in the same position she would have been in had the motor vehicle defendants not been underinsured relative to her, "[to] the extent that *Weiss* can be interpreted to require that the amount of SUM coverage be reduced without regard to the actual amount of bodily injury damages suffered, it should no longer be followed."

Thus, there is now a dispute between the Fourth and Second Departments on this issue.[70]

C. Priority of Coverage

In *Government Employees Ins. Co. v. Nakhla*,[71] the court took note of the fact that the SUM policy at issue provided that if the claimant was entitled to uninsured motorist or SUM benefits under more than one policy, "the maximum amount such insured may recover shall not exceed the highest limit of such coverage for any one vehicle under any one policy," and that the policy covering the vehicle "occupied by the insured person" would be applied first. In this case, GEICO, the insurer for the claimant's personal auto, successfully argued that the claimant, who was struck by a vehicle as he was standing outside of the taxicab he had been driving, while he was looking for damage by a hit in the rear to the taxicab, was an occupant of the taxicab at the time he was struck, and, thus, that the policy on the taxicab was primary to its policy. The only issue that remained was whether GEICO's policy limits

exceeded the taxicab's policy limits – an issue as to which the court remanded the matter for determination. ■

1. 137 A.D.3d 1088 (2d Dep't 2016).
2. 139 A.D.3d 958 (2d Dep't 2016).
3. 136 A.D.3d 508 (1st Dep't 2016).
4. *See State Farm Mut. Auto. Ins. Co. v. Fitzgerald*, 25 N.Y.3d 799 (2015).
5. 140 A.D.3d 762 (2d Dep't 2016).
6. *See In re Nassau Ins. Co. [Maylou]*, 103 A.D.2d 978 (2d Dep't 1984); *Estate of Cepeda v. USF&G*, 37 A.D.2d 454, 455 (1st Dep't 1971); *and State-Wide Ins. Co. v. Murdock*, 31 A.D.2d 978 (2d Dep't 1969), *aff'd*, 25 N.Y.2d 674 (1969).
7. 145 A.D.3d 761 (2d Dep't 2016).
8. *Rice v. Allstate Ins. Co.*, 32 N.Y.2d 6, 11–12 (1973); *see Coregis Ins. Co. v. McQuade*, 7 A.D.3d 794, 795 (2d Dep't 2004); *Travelers Ins. Co. v. Wright*, 202 A.D.2d 680 (2d Dep't 1984).
9. *Saunderson v. Motor Veh. Acc. Indem. Corp.*, 54 A.D.2d 936 (2d Dep't 1976).
10. *Rice v. Allstate Ins. Co.*, 32 N.Y.2d at 11 (1973); *see State Farm Auto. Ins. Co. v. Antunovich*, 160 A.D.2d 1009, 1010 (2d Dep't 2010); *Saunderson v. Motor Veh. Acc. Indem. Corp.*, 54 A.D.2d at 936 (2d Dep't 1976).
11. *Rice v. Allstate Ins. Co., supra*, 32 N.Y.2d at 11.
12. 139 A.D.3d 691 (2d Dep't 2016).
13. 136 A.D.3d 508 (1st Dep't 2016).
14. 136 A.D.3d 1205 (3d Dep't 2016), *motion for lv. to appeal denied*, 27 N.Y.3d 908 (2016).
15. 137 A.D.3d 1634 (4th Dep't 2016).
16. 16 Ins. L. § 3420(c)(2)(C).
17. 17 Ins. L. § 3420(c)(2)(A).
18. 142 A.D.3d 1127 (2d Dep't 2016).
19. 138 A.D.3d 623 (1st Dep't 2016).
20. 137 A.D.3d 720 (2d Dep't 2016).
21. 97 N.Y.2d 491 (2002).
22. 4 N.Y.3d 468 (2005).
23. 143 A.D.3d 794 (2d Dep't 2016).
24. 142 A.D.3d 1127 (2d Dep't 2016).
25. 25 See Ins. L. § 3420[a][3].
26. See also, *Aspen Ins. UK Ltd. v. Nieto*, 137 A.D.3d 720 (2d Dep't 2016).
27. 139 A.D.3d 921 (2d Dep't 2016).
28. 143 A.D.3d 794 (2d Dep't 2016).
29. 137 A.D.3d 503 (1st Dep't 2016), *motion for lv. to appeal denied*, 27 N.Y.3d 910 (2016).
30. 140 A.D.3d 1136 (2d Dep't 2016).
31. 137 A.D.3d 865 (2d Dep't 2016).
32. 52 Misc. 3d 1220 (A) (Sup. Ct., Nassau Co. 2016).
33. *See Rekemeyer v. State Farm Mut. Auto. Ins. Co.*, 4 N.Y.3d 468 (2005). Although the court did not specifically address the issue of prejudice, it is readily apparent that the respondent did not, and could not, present evidence to rebut or overcome the statutory presumption of prejudice caused by such a delay (Ins. L. § 3420[c][2][A]).
34. 143 A.D.3d 1266 (4th Dep't 2016).
35. 35 CPLR 7503[c].
36. 140 A.D.3d 886 (2d Dep't 2016).
37. *See Progressive Ne. Ins. Co. v. Scalamandre*, 51 A.D.3d 932, 933 (2d Dep't 2008).
38. 140 A.D.3d 743 (2d Dep't 2016).
39. 138 A.D.3d 847 (2d Dep't 2016).
40. 137 A.D.3d 779 (2d Dep't 2016).
41. 51 Misc.3d 138 (A) (App. Term, 2d Dept., 2d, 11th & 13th Jud. Dists. 2016).
42. *See also Hanover Ins. Co. v. Vasquez*, 143 A.D.3d 612 (1st Dep't 2016) (award upheld as rationally supported by the record).
43. 142 A.D.3d 1167 (2d Dep't 2016).
44. 133 A.D.3d 841 (2d Dep't 2016).
45. 139 A.D.3d 496 (1st Dep't 2016).
46. 54 Misc.3d 880 (Sup. Ct., Dutchess Co. 2016).
47. 136 A.D.3d 975 (2d Dep't 2016).
48. 23 N.Y.3d 583 (2014).
49. 138 A.D.3d 732 (2d Dep't 2016).
50. *See* Dachs, Jonathan A., *The Applicability (Inapplicability) of New York's Disclaimer Statute, Continued*, N.Y.L.J., March 15, 2017, p.3, col. 1.
51. 130 A.D.3d 497 (1st Dept. 2015), *rev'd.*, 28 N.Y.3d 960 (2016).
52. 130 A.D.3d 1477 (4th Dep't 2015), *lv. to appeal granted*, 26 N.Y.3d 918 (2016).
53. *See* Dachs, Jonathan A., *The Applicability (Inapplicability) of New York's Disclaimer Statute*, N.Y.L.J., Feb. 1, 2017, p.3, col. 1.
54. 143 A.D.3d 794 (2d Dep't 2016).
55. 135 A.D.3d 797 (2d Dep't 2016).
56. 130 A.D.3d 574 (2d Dep't 2015), *motion for lv. to appeal denied*, 26 N.Y.3d 918 (2016).
57. 137 A.D.3d 503 (1st Dep't 2016), *motion for lv. to appeal denied*, 27 N.Y.3d 910 (2016).
58. 135 A.D.3d 401 (1st Dep't 2016).
59. 95 N.Y.2d 185, 188–89 (2000).
60. See also *State Farm & Cas. Co. v. Guzman*, 138 A.D.3d 503 (1st Dep't 2016) ("Since the policy never provided coverage for those circumstances in the first place, the untimeliness of Plaintiff's disclaimer is irrelevant"); *United Services Auto. Ass'n v. Iannuzzi*, 138 A.D.3d 638 (1st Dep't 2016) ("Since the acts at issue were outside the scope of coverage, timely disclaimer pursuant to Insurance Law §3420(d) was unnecessary").
61. 139 A.D.3d 950 (2d Dep't 2016).
62. 137 A.D.3d 1018 (2d Dep't 2016).
63. 52 Misc.3d 1220(A) (Sup. Ct., Nassau Co. 2016).
64. 78 N.Y.2d 325 (1991).
65. 137 A.D.3d 1088 (2d Dep't 2016).
66. 137 A.D.3d 1272 (2d Dep't 2016).
67. 133 A.D.3d 1261 (4th Dep't 2015), *motion for lv. to appeal denied*, 26 N.Y.3d 918 (2016).
68. 140 A.D.3d 872 (2d Dep't 2016).
69. 98 A.D.3d 1107 (2d Dep't 2012).
70. See Dachs, J., *SUM Offsets: A Rare Reversal of 'Settled' Law*, N.Y.L.J., July 20, 2016, p. 3, col. 1.
71. 140 A.D.3d 762 (2d Dep't 2016).