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2008 Insurance Law Update

Uninsured, Underinsured and Supplementary Uninsured Motorist Law – Part I

By Jonathan A. Dachs

It is once again my distinct pleasure to report on developments in the area of uninsured motorist (UM), underinsured motorist (UIM), and supplementary uninsured motorist (SUM) law from the prior calendar year. As usual, 2008 was a busy and significant year in this ever-changing, highly complex area of the law.

This article, which is the first of two parts, will address several general issues pertaining to UM/UIM/SUM coverage and claims. Part II, which will appear in a forthcoming issue of the *Journal*, will address several additional general issues, as well as other issues that are specific to each particular type of coverage.

Insured Persons

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

Relatives

In *Government General Employees Ins. Co. (GEICO) v. Constantino*,[1] the claimant, who was struck by a hit-and-run driver while he was riding a bicycle, sought SUM benefits under a policy issued to his fiancée. The insurer sought to stay arbitration on the ground that the claimant was not a "resident relative" under the policy and, therefore, not entitled to benefits thereunder. The claimant argued that he was entitled to SUM benefits because when his fiancée purchased the policy from GEICO, she specifically sought coverage for him that was equal to her own, and because a page of GEICO's Web site listed him as a "driver[ ] covered" and an "individual covered" under the policy. The court affirmed the grant of the Petition to Stay on the basis that the claimant was neither married to nor related to the insured and was, therefore, not a "relative." The court further rejected the claimant's contention based upon the Web site entry because the policy provided that its "terms and provisions . . . cannot be . . . changed, except by an endorsement issued to form a part of this policy," and the Web page did not constitute such an endorsement.[2] Moreover, insofar as the language of the policy was not in any way ambiguous, "resort may not be had to the extrinsic web page which is not a part of the policy."[3]

Residents

In *Korson v. Preferred Mutual Ins. Co.*,[4] the court explained that

> [t]he term "household" as used in insurance policies, has been characterized as ambiguous and devoid of any fixed meaning. Its interpretation requires an inquiry into the intent of the parties. The interpretation must reflect the reasonable expectation of the ordinary business person and the circumstances particular to each case must be considered.[5]

Thus, in this case, where evidence revealed that the subject house was a single family home, with a single mailbox, and one electric meter, one gas bill, unrestricted access between the areas of the home in which the co-owners lived, and the policy indicated that both co-owners were named insureds with respect to a single address, the court held, "There is no indication in that document that their reasonable expectation was to insure anything other than one household."[6] Thus, the action brought against one co-owner by the other co-owner's step-daughter to recover for injuries sustained by her daughter as a result of exposure to lead paint while living with the second co-owner fell within the exclusion in the homeowner's policy for bodily injury to "residents of your household," even though they lived on separate floors in the residence.

Occupants

In *Continental Casualty Co. v. Lecei*,[7] the court observed that where the claimant was not a named insured under the policy issued to his employer, for purposes of SUM coverage he could be deemed an insured entitled to coverage only if at the time of the accident he was "occupying" the employer's truck within the meaning of the policy. Insofar as the parties offered radically different versions of the facts relating to the claimant's actions at the time of the accident, a hearing was required to determine whether he was an "occupant" of the truck and, therefore, entitled to coverage.

In *Faragon v. American Home Assurance Co.*,[8] the claimant, a truck driver, was struck by a hit-and-run vehicle while standing on the street after off-loading a 44,000-pound, 50-to-55-foot-long boom lift from a 70-foot tractor-trailer. This procedure involved many steps, including setting out safety cones, unchaining the boom lift, folding out and inserting pins in the jib, inspecting the basket, lowering the trailer, backing the machine off the trailer, and securing and extending axle lifts. He had completed these steps, and had been training the worker who was going to operate the equipment for 10 to 15 minutes when the accident took place. After observing that the term "occupying" has long received a liberal interpretation in New York and thus, "the status of passenger is not lost even though [an individual] 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,"[9] the court held that the claimant "was no longer vehicle-oriented." As the court explained, "[h]is absence from the vehicle was not intended to be brief and, at the time of the accident, he was engaged in instructing the lessee about the operations of the delivered equipment. Under such circumstances, he was no longer 'occupying' his employer's vehicle."[10]

"Motor Vehicles"

In *Progressive Northeastern Ins. Co. v. Scalamandre*,[11] the court held that a four-wheeled ATV did not constitute a "motor vehicle" for purposes of invoking a UM endorsement. The court further explained that "although UM coverage extends to all 'motor vehicles,' as defined by Vehicle and Traffic Law § 125, ATVs are specifically excluded from the definition of motor vehicles set forth therein."[12] Finally, the court distinguished this case from *Nationwide Mutual Ins. Co. v. Riccadulli*,[13] wherein a three-wheeled ATV was considered a motorcycle, thereby rendering UM benefits available. In *Scalamandre*, however, the ATV at issue was a four-wheeled vehicle, which "[did] not fit the statutory definition of a motorcycle, which is limited to [vehicles] with no more than 'three wheels in contact with the ground.'"[14]

"Accidents"

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

In *Emanvilova v. Pallotta*,[15] the court stated that "[e]ven innocent victims are not entitled to coverage if their injuries were not caused by an 'accident' within the meaning of the applicable insurance policy."

In *State Farm Mutual Automobile Ins. Co. v. Langan*,[16] the claimant's decedent was struck and killed by a motor vehicle driven by Ronald Popadich, who pleaded guilty to murder in the second degree, after admitting that he intentionally caused the death by striking the decedent with his automobile. The court upheld the decedent's insurer's disclaimer of uninsured motorist benefits on the ground that the death was the result of an intentional act, and not an accident.[17]

In an interesting concurring and dissenting opinion, Justice Mastro noted that "the overwhelming national trend" has been to permit uninsured motorist coverage in situations like this by interpreting the term "accident" from the perspective of the injured party rather than the tortfeasor. Accordingly, Justice Mastro called for "a reexamination of the governing principles in this area by our state's highest court."[18]

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

UM, UIM and SUM endorsements require the claimant, as a condition precedent to the right to apply for benefits, to give timely notice to the insurer of an intention to make a claim. Although the mandatory UM endorsement requires such notice to be given "within ninety days or as soon as practicable," Regulation 35-D's SUM endorsement requires simply that notice be given "as soon as practicable." A failure to satisfy the notice requirement vitiates the policy.[19]

In *American Transit Ins. Co. v. Rechev of Brooklyn*,[20] the First Department appears to have held that an insurer must demonstrate prejudice from an untimely notice of a lawsuit in order to sustain a notice of disclaimer on that ground. Specifically, the court noted that although the injured party had provided the insurer with information regarding the accident shortly after it occurred, she failed to give the insurer notice of her lawsuit against its insured until 14 months after the suit was commenced and after she had obtained a default judgment against the insured. In upholding the insurer's late notice disclaimer, the court specifically observed that the insurer had lost its right to appear to interpose an answer, *i.e.*, that it had suffered prejudice as a result of the late notice – citing its previous decision (reported on last year) in *American Transit Ins. Co. v. B.O. Astra Management Corp.*[21]

In upholding the insurer's late notice disclaimer, the court specifically observed that the insurer had lost its right to appear to interpose an answer, *i.e.*, that it had suffered prejudice as a result of the late notice.

In a lengthy concurring opinion, Justice McGuire agreed with the majority's "implicit conclusion" that the insurer was required to show that it was prejudiced by the failure of the injured party to provide timely notice of the underlying action, but explained this conclusion by saying

> this appeal is controlled by our decision in *American Transit Ins. Co. v. B.O. Astra Mgmt. Corp.* Consistent with the emphasis of the Court of Appeals placed in *Argo* [*Corp. v. Greater N.Y. Mut. Ins. Co.*, 4 N.Y.3d 332, 340, 794 N.Y.S.2d 704 (2005)] on the fact that the carrier had not received timely notice of claim, this Court held that "[h]aving received timely notice of claim, plaintiff insurer was not entitled to disclaim coverage based on untimely notice of the claimant's commencement of litigation unless it was prejudiced by the late notice" (*id.* at 432). This case is *a fortiori* to *B.O. Astra*, because ATIC received both timely notice of the accident and timely notice of [the injured party's] claim.[22]

Specifically addressing the issue of prejudice, Justice McGuire found that a liability insurer that receives notice of a lawsuit *after* a default judgment has already been taken against its insured demonstrates prejudice, and should not be required to move to vacate the default. Indeed, it would be prejudicial to the insurer's right "to require it to shoulder the burden of moving to vacate the default."

Effective January 17, 2009, the N.Y. Insurance Law ("Ins. Law") has been amended in relation to timing for the giving of notice of claim under insurance contracts – specifically, the effective elimination of the "no-prejudice" rule. Chapter 388 of the 2008 Laws of New York, signed into law on July 21, 2008, effective 180 days thereafter and applicable to policies issued or delivered in New York on or after that date and to any action maintained under such a policy, added a new subdivision, Ins. Law § 3420(a)(5). This subdivision requires every policy or contract insuring against liability for injury to a person issued or delivered by the state to contain a provision that "failure to give any notice required to be given by such policy within the time period prescribed therein shall not invalidate any claim made by the insured, injured person or any other claimant, unless the failure to provide timely notice has prejudiced the insurer" (with exceptions for "claims made" policies). A new § 3420(c)(2)(C) provides that "[t]he insurer's rights shall not be deemed prejudiced unless the failure to timely provide notice materially impairs the ability of the insurer to investigate or defend the claim." A new § 3420(c)(2)(A) creates a shifting burden of proof on the issue of "prejudice," as follows:

> In any action in which an insurer alleges that it was prejudiced as a result of a failure to provide timely notice, the burden of proof shall be on: (i) the insurer to prove that it has been prejudiced, if the notice was provided within two years of the time required under the policy; or (ii) the insured, injured person or other claimant to prove that the insurer has not been prejudiced, if the notice was provided more than two years after the time required under the policy.

Moreover, pursuant to a new § 3420(c)(2)(B), there will be an irrebuttable presumption of "prejudice" if, "prior to notice, the insured's liability has been determined by a court of competent jurisdiction or by binding arbitration; or if the insured has resolved the claim or suit by settlement or other compromise."[23]

The interpretation of the phrase "as soon as practicable" continued, as always, to be a hot topic.

In *Progressive Northern Ins. Co. v. Sachs*,[24] the court held that the claimant had adequately demonstrated that he was unaware of the seriousness of his injuries until early in 2007 – almost five years after the accident – and, thus, sufficiently established, as a matter of law, the existence of a valid excuse for his delay in providing notice of his SUM claim. Notably, the court did not rely upon the absence of prejudice to the SUM insurer ground relied upon by the lower court but, instead, affirmed the order below on this distinct ground.[25]

On the other hand, in *J.C. Contracting of Woodside Corp. v. Ins. Corp. of New York*,[26] the court held that notice of claim given to the insurer approximately five months

after the plaintiff was served with the summons and complaint in the underlying action, and while a motion for a default judgment was pending, was untimely as a matter of law.

In *Allstate Ins. Co. v. Berger*,[27] the court held that the insureds did not breach their obligation to timely notify their insured of the lawsuit brought against them by the injured party where there was no evidence that either of them was properly served with the summons and complaint in that action. Accordingly, the court held that the insurer's disclaimer based upon late notice was invalid, concluded that coverage was available under the tortfeasor's policy, and granted the UM carrier's Petition to Stay Arbitration.

However, in *Briggs Avenue LLC v. Ins. Corporation of Hannover*,[28] the Court of Appeals held that a liability insurer was entitled to disclaim coverage when the insured, because of its own error in failing to update the address it had listed with the Secretary of State, did not comply with a policy condition requiring timely notice of a lawsuit. As observed by the Court, "[i]t was unquestionably practical for Briggs to keep its address current with the Secretary of State, and thus to assure that it would receive, and be able to give, timely notice of the lawsuit. Brigg's failure to do so was simply an oversight."[29]

In *Young Israel Co-op City v. Guideone Mutual Ins. Co.*,[30] the court held that the plaintiffs' *40-day delay* in notifying the insurer of a motor vehicle accident was unreasonable as a matter of law. Given that the plaintiffs were allegedly negligent in the rear-end collision and that the underlying claimant was taken away from the scene of the accident by ambulance, the insured failed to raise an issue of fact as to whether the delay was reasonably founded upon a good faith belief of nonliability.

Discovery

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

In *Interboro Ins. Co. v. Rienzo*,[31] the court held that the branch of the petition that sought to require the claimant to submit to an EUO and a physical examination, and to furnish pertinent medical documentation or authorizations, should have been granted – especially since it was not opposed by the claimant.

In *Progressive Casualty Ins. Co. v. Jackson*,[32] on the other hand, the court held that it was a provident exercise of the lower court's discretion to deny that branch of the petition which sought pre-arbitration discovery.

Pursuant to 2008 New York Laws, chapter 388, effective January 17, 2009, a new § 3420(d)(1) was created. This provides, with respect to liability policies that afford coverage for bodily injury or wrongful death claims where the policy is a personal lines policy other than an excess or umbrella policy, that within 60 days of receipt of a written request by an injured party or other claimant who has filed a claim, an insurer must confirm in writing whether the insured had a liability insurance policy in effect with that insurer on the date of the occurrence, and specify the limits of coverage provided under that policy. If the injured person or other claimant fails to provide sufficient identifying information to allow the insurer, in the exercise of reasonable diligence, to identify a liability policy that may be relevant to the claim, the insurer has 45 days from the initial request to ask for more information, and then another 45 days after such information is provided to furnish the requested insurance information. Pursuant to an amendment to Ins. Law § 2601(a) ("Unfair Claim Settlement Practices"), the failure to comply with these disclaimer requirements may result in departmental sanctions, including financial penalties.

Petitions to Stay Arbitration: Filing and Service

New York Civil Practice Law and Rules 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." The 20-day time limit is jurisdictional and, absent special circumstances, courts have no jurisdiction to consider an untimely application.[33]

In *Fiveco, Inc. v. Haber*,[34] the Court of Appeals held "it is well settled that '[a] party to an agreement may not be compelled to arbitrate its dispute with another unless the evidence establishes the parties' "clear, explicit and unequivocal" agreement to arbitrate.'" Because the contract in this case contained an arbitration provision, "it cannot be said that 'the parties never agreed to arbitrate' or that 'no agreement to arbitrate has ever been made,'" regardless of the present viability of the contract containing the agreement to arbitrate.[35] Where, however, the policy does contain an agreement to arbitrate, albeit one that is subject to a condition precedent, and the insurer's contention is that the condition was not satisfied, it must move to stay within 20 days or be precluded from raising the breach of the condition precedent as a defense.[36]

In *Travelers Indemnity Co. v. Fernandez*,[37] after the insured's initial petition to stay arbitration was denied as untimely, the claimant failed to pursue arbitration for several months, and the American Arbitration Association proceeded to close its file. This required the claimant to file and serve a new demand for arbitration, as to which the insurer this time timely moved for a stay. The court affirmed the determination that the untimeliness of the first petition had no bearing on the second petition, and that since the second petition was filed within 20 days

after receipt of the second demand for arbitration, it was timely and properly heard.

In *Interboro Ins. Co. v. Coronel*,[38] the court held that where the SUM carrier was in rehabilitation and, thus, subject to a stay at the time it received the Demand for Arbitration served upon it, the 20-day period for moving to stay arbitration was stayed until the insurer emerged from rehabilitation and the rehabilitation stay was lifted. Thus, the court held that where the insurer petitioned to stay arbitration within 20 days after receipt of a notice from the AAA advising it of a pre-hearing telephone conference, that proceeding was timely commenced in accordance with CPLR 7503(a).

In *State Farm Ins. Co. v. Williams*,[39] although the claimant served Notices of Intention to Arbitration long before the insurer petitioned to stay arbitration, an issue of fact was raised as to whether those Notices were defective because they contained an incorrect policy number, in which case the notices would have been deemed insufficient to trigger the running of the 20-day period. Thus, the matter was remitted for a hearing on the issue of whether the correct policy number was used on the Notices of Intention to Arbitrate.

In *State Farm Ins. Cos. v. DeSarbo*,[40] where the court had previously ruled that the insurer had not timely moved to stay an underinsured motorist arbitration, and, thus, it could not raise certain defenses, the court held that since there was a valid agreement to arbitrate and the 20-day rule applied, the insurer could not circumvent it by commencing a declaratory judgment action seeking the same relief.

In *State Farm Mutual Automobile Ins. Co. v. Scott*,[41] the court held that the timeliness of the proceeding to stay arbitration should not be measured from the service of claimants' attorney's letter notifying the petitioner of their intent to arbitrate their "uninsured motorist claims" because that letter gave no indication whether such claims were being brought based upon a lack of coverage or a hit-and-run. Rather, the court held that timeliness should be measured from the service of the claimants' Demand for Arbitration, which constituted the insurer's first notice that the claims were being brought under the hit-and-run provision, and, thus, when the insurer first learned that it possessed a ground for seeking a stay of arbitration, *i.e.*, one of the claimants' statement that there was no physical contact with the offending vehicle. ■

1. 49 A.D.3d 736, 854 N.Y.S.2d 459 (2d Dep't 2008).
2. *Id.* at 737.
3. *Id.*
4. 55 A.D.3d 879, 866 N.Y.S.2d 338 (2d Dep't 2008).
5. *Id.* at 880–81 (citations omitted).
6. *Id.* at 881.
7. 47 A.D.3d 509, 850 N.Y.S.2d 76 (1st Dep't 2008).
8. 52 A.D.3d 917, 859 N.Y.S.2d 301 (3d Dep't 2008).
9. *Id.* at 918 (citation omitted).
10. *Id.* at 919.
11. 51 A.D.3d 932, 858 N.Y.S.2d 327 (2d Dep't 2008).
12. *Id.* at 933 (citation omitted).
13. 183 A.D.2d 111, 589 N.Y.S.2d 356 (2d Dep't 1992).
14. *Scalamandre*, 51 A.D.3d at 933. *See* N.Y. Vehicle & Traffic Law § 123 (VTL); *see also* VTL § 125-a.
15. 49 A.D.3d 413, 414, 854 N.Y.S.2d 360 (1st Dep't), *lv. to appeal dismissed*, 11 N.Y.3d 826, 868 N.Y.S.2d 594 (2008).
16. 55 A.D.3d 281, 865 N.Y.S.2d 102 (2d Dep't 2008).
17. *See also MetLife Auto & Home v. Kalendarev*, 54 A.D.3d 830, 865 N.Y.S.2d 108 (2d Dep't 2008).
18. *Langan*, 55 A.D.3d at 289 (Mastro, J.P., dissenting).
19. *See N.Y. Cent. Mut. Fire Ins. Co. v. Ljekocevic*, 48 A.D.3d 469, 849 N.Y.S.2d 805 (2d Dep't 2008).
20. 57 A.D.3d 257, 867 N.Y.S.2d 914 (1st Dep't 2008).
21. 39 A.D.3d 432, 835 N.Y.S.2d 106 (1st Dep't), *lv. to appeal denied*, 9 N.Y.3d 802, 840 N.Y.S.2d 762 (2007). *See* Jonathan A. Dachs, *2007 Insurance Law Update: Uninsured, Underinsured and Supplementary Uninsured Motorist Law – Part I*, N.Y. St. B.J. (June 2008), pp. 34, 37.
22. *Am. Transit Ins. Co.*, 57 A.D.3d at 259 (McGuire, J., concurring) (citations omitted).
23. *See* Howard B. Epstein & Theodore A. Keyes, *New Late Notice Law Requires Insurers to Show Prejudice*, N.Y.L.J., Jan. 2, 2009, p. 3, col. 1; Seth B. Schafler & Robyn S. Crosson, *Laws on Late Notice of Insurance Claims Improved*, N.Y.L.J., Aug. 14, 2008, p. 4, col. 4; Norman H. Dachs & Jonathan A. Dachs, *Status of "No Prejudice" and Direct Action Legislation*, N.Y.L.J., July 3, 2008, p. 3, col. 1; Daniel W. Gerber & Nikia A. O'Neal, *Recent Activity in the No-Prejudice Debate*, N.Y.L.J., Mar. 17, 2008, p. 4, col. 4; Norman H. Dachs & Jonathan A. Dachs, *Legislative Initiatives Regarding the 'No-Prejudice Rule,"* N.Y.L.J., Sept. 11, 2007, p. 3, col. 1.
24. 50 A.D.3d 803, 856 N.Y.S.2d 633 (2d Dep't 2008).
25. *See Rekemeyer v. State Farm Mut. Auto Ins. Co.*, 4 N.Y.3d 468, 796 N.Y.S.2d 13 (2005).
26. 48 A.D.3d 422, 850 N.Y.S.2d 643 (2d Dep't 2008).
27. 47 A.D.3d 708, 851 N.Y.S.2d 584 (2d Dep't 2008).
28. 11 N.Y.3d 377 (2008).
29. *Id.* at 381.
30. 52 A.D.3d 245, 859 N.Y.S.2d 171 (1st Dep't 2008).
31. 54 A.D.3d 675, 863 N.Y.S.2d 483 (2d Dep't 2008).
32. 49 A.D.3d 748, 853 N.Y.S.2d 652 (2d Dep't 2008).
33. *See Travelers Indem. Co. v. Fernandez*, 55 A.D.3d 746, 866 N.Y.S.2d 260 (2d Dep't 2008) (the 20-day limitation is treated as a statute of limitations); *State Farm Ins. Cos. v. DeSarbo*, 52 A.D.3d 936, 859 N.Y.S.2d 312 (3d Dep't 2008); *State Farm Ins. Co. v. Williams*, 50 A.D.3d 807, 856 N.Y.S.2d 631 (2d Dep't 2008); *Standard Fire Ins. Co. v. Mouchette*, 47 A.D.3d 636, 849 N.Y.S.2d 592 (2d Dep't 2008).
34. 11 N.Y.3d 140, 144, 863 N.Y.S.2d 391, *reargument denied*, 11 N.Y.3d 801, 868 N.Y.S.2d 580 (2008).
35. *Id.* at 145; *see also Interboro Ins. Co. v. Maragh*, 51 A.D.3d 1024, 858 N.Y.S.2d 391 (2d Dep't 2008) (issue as to whether claimant was a resident of insured's household at time of accident deals with condition precedent to arbitration; if not a resident, not an insured, and, therefore, no agreement to arbitrate and 20-day time limit inapplicable); *Dairyland Ins. Co. v. Figueroa*, 48 A.D.3d 462, 850 N.Y.S.2d 638 (2d Dep't 2008).
36. *See also Nova Cas. Co. v. Martin*, 57 A.D.3d 548, 870 N.Y.S.2d 55 (2d Dep't 2008).
37. 55 A.D.3d 746, 866 N.Y.S.2d 260 (2d Dep't 2008).
38. 54 A.D.3d 342, 863 N.Y.S.2d 448 (2d Dep't 2008).
39. 50 A.D.3d 807, 856 N.Y.S.2d 631 (2d Dep't 2008).
40. 52 A.D.3d 936, 859 N.Y.S.2d 312 (3d Dep't 2008).
41. 49 A.D.3d 465, 854 N.Y.S.2d 132 (1st Dep't 2008).