

*Insurance Coverage
in New York*

A Seminar Memorandum

By: Warren S. Koster, Esq.
Paul F. Callan, Esq.

TABLE OF CONTENTS

<u>I. INTRODUCTION</u>	1
<u>II. DUTY TO DEFEND AND INDEMNIFY</u>	1
A. <u>Defense/Indemnification</u>	1 - 2
B. <u>Determination of Coverage</u>	3 - 4
C. <u>Four Corners Rule</u>	4 - 5
<u>III. NOTICE REQUIREMENT</u>	6
A. <u>Claim v. Occurrence</u>	7
B. <u>Prejudice</u>	8
C. <u>Timely Notice Exceptions</u>	8 - 9
D. <u>Notice from Third Parties</u>	9 -10
E. <u>Written v. Oral Notice</u>	10 -11
F. <u>Notice to Agent/Broker</u>	11 -12
G. <u>Claims-Made Policies</u>	12
<u>IV. DISCLAIMER</u>	12
A. <u>Insurance Law</u>	12 -13
B. <u>Non-coverage</u>	13 -14
C. <u>Timely Disclaimer Where Coverage Exists</u>	14 -16
D. <u>Timely Disclaimer Cases</u>	16 -19
E. <u>Written Notice of Disclaimer</u>	20
F. <u>Lack of Cooperation</u>	21 -22
<u>V. RESERVATION OF RIGHTS/DISCLAIMER LETTER</u>	23 -26
<u>VI. ESTOPPEL AND DECLARATORY JUDGEMENT</u>	26 -29
<u>VII. COURSES OF ACTION IN CLAIM SITUATIONS</u>	29 -31
<u>VIII. CONFLICT OF INTEREST/SELECTION OF COUNSEL</u> .	31 -34
<u>IX. BAD FAITH</u>	34 -39

APPENDIX A

I. INTRODUCTION

Where an insurance policy includes the insurer's promise to defend the insured against specified claims as well as to indemnify for actual liability, the insurer's duty to furnish a defense is broader than its obligation to indemnify. When a claim is reported to an insurance company the first decision that must be made concerns the issue of insurance coverage. Is the claim covered by the policy of insurance issued to the insured? Was timely notice given by the insured to the carrier? Are there any exclusions in the insurance policy that would preclude coverage under the facts of the claim? Is the person or entity seeking coverage an "insured" under the policy of insurance? It is recommended that when a claims adjuster receives a claim, the policy of insurance should be consulted to resolve these issues. If there is coverage, there will be a duty to defend.

II. DUTY TO DEFEND AND INDEMNIFY

A. Defense/Indemnification

The issue as to whether or not there is a duty to defend arises when the insurer receives a copy of the complaint.

There is a distinction between an insurer's duty to defend and its duty to indemnify. It is well settled in New York that a duty to defend is broader than a duty to indemnify, and that a contract of insurance will be strictly construed in favor of the insured (Seaboard Security, Co. v. Gillett Co., 64 N.Y.2d 304). It is equally well settled that the obligation of an insurer to defend does not extend to claims which are not covered by the policy or which are generally excluded from coverage. The duty to defend arises whenever the allegations in a complaint against the insured fall within the scope of the risks undertaken by the insurer, regardless of how false or groundless those allegations might be (Goldberg v. Lumber Mut. Cas. Ins. Co., 297 N.Y.2d 148). The duty to defend in New York is not contingent on the insurer's ultimate duty to indemnify should the insured be found liable, nor is it material that the complaint against the insured might assert additional claims which fall outside the policy's general coverage or within its exclusionary provisions. Rather, the duty of the insurer to defend the insured rests solely on whether the complaint alleges any facts or grounds that bring the action within the protection purchased (Ruder and Finn v. Seaboard Sur. Co., 52 N.Y.2d 663). In other words, if there is at least one cause of action in the complaint or one single allegation that is within the coverage of the policy, then the insurer has the obligation to defend its insured throughout the litigation, even though the result may not warrant indemnification by the insurer for its insured.

These rules provide litigation insurance as part of a liability insurance policy (International Paper Co. v. Continental Cas. Co., 35 N.Y.2d 322). If the claims asserted, however frivolous, are within policy coverage, the insurer must defend irrespective of ultimate liability. A declaration that an insurer is without obligation to defend a pending action can be made "only if it could be concluded as a matter of law that there is no possible factual or legal basis on which the insurer might eventually be held to be obligated to indemnify the insured under any provision of the insurance policy" (Spoor-Lasher Co. v. Aetna Cas. and Sur. Co., 39 N.Y.2d 875).

The duty to indemnify is, however, distinctly different. The duty to defend is measured against the allegations of pleadings, but the duty to pay is determined by the actual basis for the insured's liability to a third person.

B. Determination of Coverage

To determine if coverage exists, the first place to look is the complaint. An insurer's duty to defend its insured arises whenever the allegations in a complaint state a cause of action that gives rise to the reasonable possibility of recovery under the policy (see Technicon Electronics Corp. v. American Home Assurance Co., 74 N.Y.2d 66). This is known as the "four corners of the complaint" rule. It is based on the principle that the duty to defend is broader than the duty to indemnify. As the rule has developed, an insurer may be contractually bound to defend even though it may not ultimately be bound to pay, either because its insured is not factually or legally liable or because the occurrence is later proven to be outside the policy's coverage.

In order to determine if there is coverage, a comparison must be made between the allegations in the complaint and the language of the insurance policy, including the exclusions in the insurance policy. It is important to remember that the issue is not whether the injured party can maintain a cause of action against the insured, but whether the plaintiff can state facts which bring the injury within the coverage (see International Paper Co. v. Continental Casualty Co., 35 N.Y.2d 322). If a comparison between the complaint and the policy reveals that there is no reasonable possibility that the claim is covered by the policy, then no duty to defend is owed. But the analysis depends on the facts that are pleaded, not the conclusory assertions of the parties.

You must examine the facts of the complaint to determine if the legal theory of the plaintiff can be determined. If the theory of liability upon which the injured party is proceeding cannot be determined from the facts pleaded, the insurer must defend because the duty to defend is broader than the duty to indemnify. But where it can be determined from the factual allegations that no basis of recovery exists within the coverage provided by the policy as stated, there is no duty to defend.

C. Four Corners Rule

In making a determination about insurance coverage based upon the “four corners of the complaint” rule, look to the factual allegations and not the legal characterizations of the causes of action. Simply because a cause of action contains the word “negligence” does not mean that the cause of action is, in fact, one which will constitute the tort of negligence.

The issue has arisen in New York as to whether the parties can look past the complaint for evidence supporting coverage. This question was answered in the affirmative by the New York Court of Appeals in Fitzpatrick v. American Honda Motor Co., (78 N.Y.2d 61). The complaint in Fitzpatrick was poorly drafted and if one applied the “four corners of the complaint” rule, there would not have been coverage. However, the insurer conducted its own investigation and determined facts that clearly demonstrated the existence of coverage. The Court of Appeals held that in circumstances where the insurer is attempting to shield itself from the responsibility to defend despite its actual knowledge that the lawsuit involves a covered event, it could not apply the “four corners of the complaint” rule. To do so would render the duty to defend narrower than the duty to indemnify.

For that reason, it was held that an insurer must provide a defense if it has knowledge of facts which potentially bring the claim within the policy’s indemnity coverage. The Court of Appeals reasoned that an insured’s right to a defense should not depend solely on the allegations a third party chooses to put into the complaint. This is particularly so because the drafter of the pleading may be unaware of the true underlying facts that may affect the defendant’s coverage. In light of this decision, insurers must now weigh the advantages of conducting a thorough investigation against the risks of discovering information that would suggest a possibility of coverage.

It is important to note that in the course of this opinion the Court of Appeals affirmed the rule that insurers are not permitted to look beyond the complaint’s allegations to avoid their obligation to defend. It is also important to remember that an insurer obligated to defend a covered claim that has been alleged together with a non-covered claim owes a defense as to the entire complaint. Simply stated, an insurer is generally obligated to provide a defense unless it

can demonstrate that the allegations of the complaint cast the pleading solely and entirely within pertinent policy exclusions or outside the coverage provided by the policy, and further that the allegations *in toto* are subject to no other interpretations (see Home Mutual Insurance Co. v. Lapin, 192 A.D.2d 927). An insurance carrier may terminate its allegation-imposed duty to defend only where it can establish as a matter of law or fact that it owes no duty to indemnify the insured (see International Paper v. Continental, supra.). The burden of establishing that a claim falls within a policy's exclusionary provisions rests with the insurer.

III. NOTICE REQUIREMENT

As important as determining coverage under the policy is the determination of whether the insured provided timely notice of the claim. Insurance policies typically require that the insured give the insurance carrier notice “as soon as reasonably practicable” of any claims, occurrences or losses made against them and of any actual lawsuits initiated by the injured party. Many insurance policies require that this notice be written notice. The purpose of such a requirement is to allow the insurer an opportunity to investigate a claim and determine as much information about the circumstances of a claim as early as possible. Moreover, many policies include a provision that the policyholder must give the insurer notice whenever he or she has information from which one could reasonably deduce that an occurrence or loss has taken place that might involve the insurance contract. In the event of litigation, the burden is on the insured to establish compliance with the notice requirement. If the insured cannot prove that either the insurer was given the notice required by the policy, or that the failure to give timely notice was excusable under the policy and circumstances, the insured may be precluded from recovering for that particular loss or occurrence if it is a first party claim. If it is a third-party claim the insured may not be provided with a defense and indemnification.

In New York, compliance with the notice provisions of an insurance contract is a condition precedent to an insurer’s liability. If an insured fails to provide timely notice as required by the particular policy, then, absent a valid reason for the delay, the insurer is under no obligation to defend or indemnify the insured. The burden is on the insured to show that the delay was reasonable under the circumstances.

A. Claim v. Occurrence

In this regard, the courts in New York distinguish between the terms “claim” and “occurrence,” which appear in many policies. A “claim” is an assertion by a third party that in the opinion of that party, the insured may be liable to it for damages within the risks covered by the policy. It must relate to an assertion of legally cognizable damage and must be a type of demand that can be defended, settled and paid by the insurer. (Evanston Ins. Co. v. GAB

Business Servs., Inc., 132 A.D.2d 180). A claim may be made without the institution of a formal proceeding.

Under New York Law, a notice of occurrence requirement is treated differently from a notice of claim requirement. In the former, the insured's knowledge of events that create only a distinct possibility of a claim may not trigger a notice of occurrence provision so long as the insured has a good faith and reasonable belief that no liability covered by the policy will result. A notice of occurrence provision focuses on the insured's knowledge of events and reasonable conclusions based on that knowledge.

A notice of claim provision, however, focuses on the actions of third-parties and may be triggered by an unreasonable assertion of liability. An assertion of possible liability, no matter how baseless, is therefore all that is needed to trigger a notice of claim provision.

The courts in New York will be more lenient in excusing an insured's failure to provide notice of an occurrence as opposed to an insured's failure to provide notice of claim. As previously stated, a notice of claim does not have to be a formal pleading but can be a letter advising of the injured party's intention to recover damages.

B. Prejudice

New York permits an insurance company to assert the defense of non-compliance without showing that the lack of timely notice prejudiced the insurer in any way. New York has adopted this harsh rule because of the belief that the failure to give timely notice deprives the insurer of an opportunity to play a meaningful role in the investigation and research that is required in litigation, which is the very reason for the notification requirement. An insurer cannot be expected to show precisely what the outcome would have been had timely notice been given. This uncertainty, however, is the result of the failure of the insured to comply with the policy, and it should not be permitted to use that uncertainty as a weapon against the insurer.

C. Timely Notice Exceptions

However, New York also provides relief from this harsh rule of failing to give timely notice if there are extenuating circumstances and there has not been a lack of due diligence on the part of the insured. Cases in New York have demonstrated the following extenuating circumstances excusing a failure to give timely notice:

1. Lack of knowledge by the insured, despite the exercise of due diligence, of the potentially covered loss, act or omission;
2. A reasonable belief by the insured that the incident was so trivial that it would not evolve into a claim;
3. A reasonable belief by the insured that no claim could be asserted that might be covered by the policy;
4. A reasonable belief by the insured that the causal relationship between the occurrence and the insured's actions were such that the plaintiff would not attempt to hold the insured responsible for the demand or injury;
5. A reasonable belief by the insured that the injured party would obtain or had already obtained compensation from a third-party who would not seek reimbursement from the insured;
6. A reasonable belief by the insured that he or she is not liable;
7. The infancy of the insured;
8. Under compelling circumstances, the physical incapacity of the insured;
9. A reasonable belief that notice had or would have been given on the insured's behalf; and
10. An inability, despite due diligence, to obtain a copy of the policy.

D. Notice from Third Parties

There are situations in which the insurer receives notice of the claim or the potential claim from a party other than the insured. New York has a statute that expressly authorizes the injured party to give notice in lieu of the insured. Insurance Law §3420(a)(3) requires all policies issued or delivered in New York to provide that notice given by or on behalf of the insured or written notice by or on behalf of the injured person or any other claimant, to any licensed agent of the insurer in New York, with particulars sufficient to identify the insured, is deemed sufficient notice to the insurer. An injured party is no longer wholly dependent upon the diligence and conscientiousness of an insured that is liable for the injury. Where the insurer has failed to give proper notice, the injured party can itself give notice, thereby preserving its rights to proceed directly against the insurer. Having been statutorily granted an independent right to give notice and recover directly from the insurer, the injured party or other claimant is not charged vicariously with the insured's delay to provide such notice.

Although New York does allow an injured party to give notice to the insurer or its authorized representative of a claim, notice by any other person is not deemed sufficient to satisfy the notice requirement of the policy. The notice must be provided either by the insured or the injured party.

E. Written v. Oral Notice

Insurance policies often require that the notice given must be written notice. If written notice is required then oral notice will not suffice. A case in point is Collins v. Isaksen, 221 A.D.2d 403). The plaintiff was injured on September 28, 1986, while riding a horse owned by the defendant Isaksen. The defendant claims to have orally notified Edgemere Agencies, an agent of Utica Mutual Insurance Company, the following day or shortly thereafter. In January 1989, the plaintiff commenced a lawsuit. On January 27, 1989, Utica received a copy of the summons and complaint from the Isaksens. By letter dated January 30, 1989, Utica disclaimed coverage based on the failure to give written notice of the accident as soon as practicable. The court held that even if the defendant Isaksen gave oral notice, this was not sufficient to meet the written notice requirement of the policy and there was no evidence that the insurer waived the written notice requirement. The court found that the twenty-eight month delay in providing notice was unreasonable. However, as previously stated, the court has an obligation to determine if there was a reasonable excuse for the twenty-eight month delay. An insured's delay may be excused when it is based upon a good faith belief of non-liability if such belief is reasonable under all of the circumstances. The court found there to be issues of fact as to whether or not the defendant believed that the plaintiff would commence an action against him and whether the insured was liable for the plaintiff's injuries. It therefore remanded the case for a further hearing on this issue.

It is important to remember that the length of the delay is not the sole determining issue. That is the first area of inquiry. The second area of inquiry is whether or not there is a valid excuse by the insured for the delay. An extenuating circumstance will excuse the delay.

F. Notice to Agent/Broker

It is clear that written notice provided to an insurance agent of an insurer will be deemed written notice to the insurance carrier. The result may be different if notice is provided to an insurance broker. An insurance broker is the agent of the insured and notice to the ordinary insurance broker is not notice to the liability carrier. However, a broker will be held to have

acted as the insurer's agent where there is evidence of action on the insurer's part, or facts from which a general authority to represent the insurer may be inferred. In the case of U.S. Underwriters Insurance Co. v. Manhattan Demolition Co., Inc., 250 A.D.2d 600, the court found that the procedure of U.S. Underwriters Insurance for obtaining "per job" approval for an already-existing policy created a reasonable belief on the part of the insured, Manhattan Demolition Co., Inc., that it was not dealing with its own broker to obtain insurance but rather was dealing with an agent of U.S. Underwriters Insurance Company. In addition, approximately forty separate certificates of insurance issued to Manhattan Demolition, each of which had been reviewed and approved by the insurer, all indicated that the broker was in fact the authorized representative of the insurer. Therefore, there may be situations in which notice to the insurance broker will be deemed notice to the insurer.

G. Claims-Made Policies

Many liability policies are "claims-made" policies. Under such policies, coverage is provided based on when a claim is made as opposed to when the circumstances giving rise to the claim came into existence. Claims-made policies differ, however, in their definition of when a claim is made. Under the standard claims-made policy, a claim is deemed to have been made when a demand for compensation is made against the insured. Some policies, however, provide that a claim is not made until notice of the claim is actually given to the insurer.

IV. DISCLAIMER

A. Insurance Law

Insurance Law § 3420(d) requires the following:

If under a liability policy delivered or issued for delivery in the State, an insurer shall disclaim liability or deny coverage for death or bodily injury arising out of a motor vehicle accident or any other type of accident occurring within this state, it shall give written notice as soon as reasonably possible of such disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant.

Naturally, litigation concerning denial of coverage centers around the phrase “written notice as soon as reasonably possible.”

Generally, the term “written notice” is given its literal and ordinary meaning, and strict compliance with regard to such notice is required. A disclaimer notice must state the ground or grounds upon which the insured disclaims liability clearly and without ambiguity. Importantly, an insurer is precluded from supporting its basis for disclaimer on grounds not raised in its original disclaimer notice. This situation is most frequently found where an insurer fails to disclaim on the ground of an insured’s lack of cooperation as stated in the policy. Finally, with respect to written notice, the language in the statute (“deny coverage”) refers to a denial of liability predicated upon an exclusion set forth in the policy of insurance that, without the exclusion, would provide coverage for the liability in question. In other words, an insurer’s failure to disclaim does not create coverage that the policy was not written to provide.

B. Non-coverage

In determining whether there is a duty to defend, the insurer must distinguish between a disclaimer for non-coverage and a disclaimer based upon an exclusion within the policy. New York distinguishes between the two and there are different requirements for disclaiming based upon non-coverage as opposed to an exclusion where coverage exists under the policy.

When a liability insurer is notified of the claim, it must timely disclaim coverage in order to avoid its duty to defend and indemnify (Insurance Law § 3420(d)). A timely disclaimer is not required, however, when the policy on which the claim rests does not, by its terms, cover the incident giving rise to liability. A distinction has to be drawn between the denial of a claim based upon an exclusion from coverage as opposed to non-coverage. In the former situation, the policy covers the claim but for the applicability of the exclusion and, therefore, a notice of disclaimer is required. In the latter, the claim is not within the ambit of the policy and, therefore, mandating coverage on the basis of an insurer’s failure to serve a timely notice of disclaimer

would be to create coverage where none previously existed (see Zappone v. Home Ins. Co., 55 N.Y.2d 131,137).

A recent decision in this area is the case of Steinblatt v. Reco, et al., 256 A.D.2d 571. The defendant Reco issued a policy of insurance to All Island Taxi Corporation. This policy was a premises liability policy. A vehicle of All Island Taxi Corporation was involved in a motor vehicle accident. All Island sought coverage from Reco under the policy and claimed that Reco failed to disclaim coverage in a timely manner. The policy at issue clearly did not cover injuries that “arose out of” automobile accidents, but instead was limited to premises liability. Therefore, since the policy did not provide coverage for the underlying event, Reco was not precluded from denying coverage based upon the alleged failure to comply with Article 34 of the Insurance Law.

In substance, the failure to timely disclaim coverage in a non-coverage situation does not stop the insurer from later disclaiming coverage and avoiding a duty to defend and indemnify the insured. A timely disclaimer is not required by law in a non-coverage situation.

C. Timely Disclaimer Where Coverage Exists

If an insurer determines that there is coverage for the claim being made against its insured there still may be an exclusion or exclusions to the policy which would vitiate an insured’s entitlement to a defense and indemnification. It is the obligation of the insurer to make an early determination as to whether or not any of the conditions precedent or exclusions in the insurance policy precludes the application of insurance coverage to the claim.

Insurance Law § 3420(d) requires written notice of a disclaimer to be given “as soon as reasonably possible” after the insurer first learns of the grounds for disclaimer of liability or denial of coverage. An insurer will be estopped from disclaiming coverage with respect to a personal injury claim based on an exclusion in a policy where it has delayed unreasonably in doing so. Not only does the insured have an obligation to provide timely notice of a claim, but an insurer has an obligation to provide timely notice of a disclaimer of coverage where coverage would normally exist but for an exclusion in the policy.

An insurance carrier must give timely notice of the disclaimer “as soon as is reasonably possible” after it first learns of the accident or grounds for disclaimer of liability or denial of coverage. This rule applies even if the insured or the injured party has in the first instance failed to provide the insurance carrier with timely notice of the accident or the claim. It is the insurer’s burden to explain the delay in notifying the insured or injured party of its disclaimer and the reasonableness of any such delay must be determined from the time the insurance carrier was aware of sufficient facts to disclaim coverage. Under these principles, even if an insured fails to give timely notice of a claim, the insurer may be precluded from disclaiming coverage because it did not do so in a timely manner.

Case law addressing the issue of reasonableness is varied and is factually based upon the actions of the parties, the insurer and the insured, with respect to reporting, investigating, and, finally, disclaiming. A variety of these cases are discussed below. The question of unreasonableness depends upon the circumstances of the case that make it reasonable for the insurer to take more or less time to make, complete and act diligently in its investigation of its coverage and breach of conditions of the policy by the insured.

Most litigation in the area of timeliness is concerned with whether the notification to an insured, an injured party, or a claimant was within a reasonable period of time. A review of the case law in New York makes it clear that, naturally, the date when the carrier first learned of the accident is the focal point in determining whether the disclaimer was sent within a reasonable time after the incident. From that date various factors come into play. These might include the cooperation or lack of cooperation of the insured, how long after the date of the accident the carrier learned of the circumstances surrounding the accident, fraudulent representations made by the insured and, of course, the reasons of the carrier for the delay. All of these factors aside, if an insurer makes a determination to disclaim coverage it must document the reason for the delay. It does not matter how long the delay is if there is no reason for the delay provided to the Court there will be a finding that as a matter of law the delay was unreasonable.

D. Timely Disclaimer Cases

In Mt. Vernon Fire Insurance Company v. City of New York, 236 A.D.2d 296, the insured notified its insurance broker of the accident soon after it occurred. The insurer received a first report from its investigator outlining the circumstances surrounding the incident and the fact that notice was given to the insurance broker. Instead of issuing an immediate disclaimer based upon lack of written notice, the insurer waited eighty-three days before issuing such a disclaimer letter. This was found to be unreasonable by the court. By reason of its investigator's report, the insurer knew that its insured had learned of the underlying incident and notified its broker on the day the incident happened, and the insurer knew or should have known that the broker was not its agent. The carrier had all of the reasons necessary to disclaim coverage on the day it received the report from its investigator but chose to wait an additional eighty-three days. Waiting this additional eighty-three day period cost the insurer its disclaimer of coverage. The court found that the insurer was obligated to provide such coverage.

In United States Liability Insurance Co. v. Staten Island Hospital, 162 A.D.2d 445, it was held that a thirteen month delay was, as a matter of law, an unreasonable delay in filing the disclaimer notice. The insurer first learned of the grounds for disclaimer of coverage during the plaintiff's deposition. Yet, the insurer waited an additional thirteen months before issuing the disclaimer letter.

In Hartford Insurance Company v. County of Nassau, 416 N.Y.S.2d 539, the Court of Appeals held that where no explanation is provided for the delay, a two month delay is, as a matter of law, an unreasonable length of time to disclaim coverage. While the outcome may seem harsh, the court emphatically notes that "it is the responsibility of the insurer to explain its delay; it is not the function of the courts to engage in speculation.

However, in North Fork Dedham Mutual Fire Insurance Co. v. Petrizzi, 503 N.Y.S.2d 51, the court held that a two month delay in sending a notice of disclaimer was proper. The carrier was not notified of the accident until almost eleven months following the occurrence. Upon learning of the accident, the insurer attempted to contact its insured but was advised that

she had just given birth to a baby. Several weeks later the insurer finally got a signed statement from its insured concerning the underlying accident. Three weeks later it filed a declaratory judgment with the court seeking an order that it was not obligated to indemnify and defend the insured. The Appellate Division, First Department held that the commencement of a declaratory judgment action by the insurer was sufficient written notice of disclaimer to satisfy Insurance Law § 3420(d) and found that the two month delay was reasonable under the circumstances of this case.

An often cited case is Prudential Property and Casualty Insurance v. Persaud, 256 A.D.2d 502. There, Ricky Persaud shot the injured party, Lisa Brown, on September 28, 1993. At the time, a homeowner's policy issued by Prudential to Persaud was in effect. A health care provider who called the plaintiff on Brown's behalf first notified Prudential of the incident over six months later, on April 6, 1994. Prudential's own records acknowledged receipt of the notice, which included all of the information that was required by the policy to be provided in a written notice. The carrier assigned a claim number to the matter and began an investigation. On or about May 5, 1994, Prudential disclaimed coverage based on Persaud's failure to give timely notice of the claim, without mention of the lack of written notice. A duplicate copy of the disclaimer letter was sent to Lisa Brown. On June 14, 1994, Prudential disclaimed coverage as to Brown based upon her failure to give timely notice.

Brown subsequently commenced a negligence action against Persaud alleging that she was injured when he accidentally discharged a pistol. Prudential then commenced a declaratory judgment action arguing that it was not required to defend or indemnify Persaud in connection with the underlying action.

The court concluded that Prudential waived the written notice requirement and that the oral notification of the claim by the health care provider constituted sufficient notice. However, it found that Lisa Brown's delay of over six months in providing this notice was unreasonable as a matter of law. The court then turned to the issue of whether Prudential issued a timely disclaimer of coverage. It held that the carrier's May 5, 1994 disclaimer, based only on

Persaud's failure to provide timely notice of the incident, was not effective against Lisa Brown. Prudential first disclaimed coverage against Lisa Brown based on her failure to provide timely notice on June 14, 1994. However, Prudential was fully aware of the facts underlying its disclaimer on April 6, 1994 when it received notice of the claim from Lisa Brown. The unexplained delay of over two months in disclaiming coverage as to Lisa Brown based on her untimely notice was deemed unreasonable as a matter of law. Consequently, Prudential was obligated to defend Persaud.

Time is of the essence when an insurer is seeking to disclaim coverage based upon an exclusion in the policy or upon a failure by the insured to satisfy a condition precedent in the policy. Even if the plaintiff did not provide timely notice (condition precedent) or there is an exclusion that is applicable, there will be a finding of coverage and a duty to defend and indemnify unless the insurer issues a timely disclaimer. It is important to remember that no matter how quickly the insurer disclaims coverage it must be prepared to explain its delay. Regardless of the length of the delay, the courts will not accept the delay unless there is an adequate explanation.

E. Written Notice of Disclaimer

Insurance Law § 3420(d) requires that all notices of disclaimer must be written on a separate document. The written notice must apprise the insured of all grounds for disclaimer. It must be specific and the language of the disclaimer must be clear and unambiguous. Those grounds not disclaimed will be waived and cannot be raised in any future judicial proceeding. The written disclaimer must be mailed to the insured and any party making a claim under the policy. While it is not required, all notices should be mailed certified return receipt requested.

In the case of Fabian v. Motor Vehicle Accident Indemnification Corporation, et al., 111 A.D.2d 366, Allstate disclaimed coverage based on a failure to provide written notice. It failed to assert the non-cooperation of its insured, but sought to do so in a declaratory judgment action. The court held that although an insurer may disclaim coverage for a valid reason, the 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. Absent such specific notice, a claimant might have difficulty assessing whether the insurer will be able to disclaim successfully. This uncertainty could prejudice the claimant's ability to ultimately obtain recovery. In addition, the insurer's responsibility to furnish notice of the specific ground on which the disclaimer is based is not unduly burdensome, the insurer being highly experienced and sophisticated in such matters. Therefore, the court denied the disclaimer of coverage.

F. Lack of Cooperation

This is an often-overlooked reason given by insurers to disclaim coverage against insureds. However, it is very common that insureds do not cooperate with the carrier or their designated counsel in defending an action. Even if an insurer does disclaim based on non-cooperation it is very difficult to convince the court of such lack of cooperation.

In order to disclaim coverage on the ground of lack of cooperation, the insurance carrier must demonstrate (1) that it acted diligently in seeking to bring about the insured's cooperation, (2) that the efforts employed by the insurer were reasonably calculated to obtain the insured's cooperation, and (3) that the attitude of the insured, after his cooperation was sought, was one of wilful and avowed obstruction (see Thrasher v. United States Liab. Ins. Co., 19 N.Y.2d 159).

One such successful disclaimer based on non-cooperation occurred in State Farm and Casualty Company v. Imeri, 182 A.D.2d 683. State Farm was able to demonstrate that it undertook diligent efforts to locate the missing insured and secure his cooperation. In addition to numerous telephone calls and personal visits to the insured's last known residence and business addresses, State Farm representatives undertook searches of the records of Department of Motor Vehicles in New York, and its counterpart in Texas, conducted Post Office and prison index inquiries, canvassed several establishments in the area of the insured's former place of business, personally questioned a former employer, and, pursuing a lead that the insured had been issued a traffic ticket in Michigan, contacted Michigan authorities. Furthermore, the evidence demonstrated that the insured willfully obstructed State Farm's defense of the underlying action. By verbal instruction and written correspondence the insured was made fully aware of his contractual obligation to cooperate in defending the litigation. Indeed, the insured's receipt of State Farm's written correspondence was evidenced by a signed, United States Postal Service return receipt, as well as the testimony of a State Farm claim representative who engaged in several post-accident conversations with the insured. The court upheld the disclaimer.

A different decision was reached in Commercial Union Insurance Company v. Burr, 226 A.D.2d 416. The record supports a finding that Commercial Union undertook diligent efforts which were reasonably calculated to bring about the insured's cooperation inasmuch as it attempted to contact the insured, personally and by mail, on numerous occasions over a period of several months, and even retained the services of a private investigation firm for this purpose. However, the investigative report revealed that the insured did in fact timely respond to the final notice sent by Commercial Union, provided an explanation for his previous unavailability, and pledged his full cooperation with the investigation. Given these circumstances, Commercial Union could not disclaim coverage even based upon his failure to respond to all prior inquiries from the carrier.

Non-action by an insured will not amount to lack of cooperation. This was the holding of the court in Statewide Insurance Company v. Ray, 125 A.D.2d 573. Such lack of action does not amount to willful and avowed obstruction as required by the Thrasher case.

V. RESERVATION OF RIGHTS/DISCLAIMER LETTER/CHECK LIST

The following checklist should be utilized to disclaim coverage. Please be advised that this is a general outline. Depending on the various circumstances with regard to a particular reason for disclaimer, portions of these steps will be more important should a claimant challenge the disclaimer.

1. Notification by Claimant – Once the insurer is notified by a claimant, it is on notice, and an investigation of the claim must begin immediately.

2. Investigation – It is important to begin prompt investigation of the allegations. This will include seeking the cooperation of the insured. In this regard, please note that it is not sufficient to disclaim based on lack of cooperation for returned mail. All correspondence should be mailed certified with a return receipt requested. If you are unable to contact the insured, an investigator should be retained immediately to locate the insured and must document the efforts of the investigation. Most importantly, all steps taken to obtain the cooperation of the insured must be documented, as should the non-cooperation of the insured.

3. Written Notice – The disclaimer must be in writing and must be on a separate document that is dedicated to the disclaimer. The written notice must apprise the insured of all grounds for disclaimer. Those grounds not claimed here will be waived and cannot be raised in any future judicial proceeding. A reservation of rights letter will not and does not constitute written notice of disclaimer. Written disclaimer must be mailed to the insured and to any party making a claim under the policy. It is recommended that if the insured has personal counsel that such counsel be notified and sent a copy of the disclaimer. While it is not officially required, all written notices should be mailed certified receipt.

4. Reasonable time – Upon learning of the underlying claim, the insurer must disclaim within a reasonable time. All investigation must be well documented so, if challenged, reasons can be offered explaining any delay in notification to the claimant.

As noted above, strict compliance with the written notice requirement is necessary for denial of coverage to be applied as valid. It is important to remember that a reservation of rights

letter does not constitute a disclaimer in New York. This was one of the issues that existed in the case of Mohawk Minden Insurance Company v. Ferry, 251 A.D.2d 846. On November 7, 1992, nine-year-old Rebecca Ferry was seriously injured while helping her mother feed cows on the family's farm using a forage wagon manufactured by defendant, Gehl Company. Her parents did not report the accident to their insurer, Mohawk Minden, when it occurred. In March 1996, Mary G. Ferry, Rebecca's grandmother and the guardian of her property, commenced an action on behalf of her granddaughter in Federal Court against Gehl Company. Thereafter, Gehl commenced a third-party action against the Ferrys for indemnification and contribution. The Ferrys forwarded the third-party action to their insurer, Mohawk Minden, for defense. The insurer received the pleadings on September 27, 1996. In October 1996, counsel retained by Mohawk Minden to defend the Ferrys served a third-party answer and cross-claim as well as discovery demands.

By letter to the Ferrys dated November 19, 1996, Mohawk Minden reserved its rights to deny coverage based upon the Ferrys' failure to timely report the accident and based upon certain policy exclusions, terms and conditions. On November 20, 1996, Mohawk Minden commenced this action against the Ferrys seeking a judgment declaring that it was not obligated to defend or indemnify the Ferrys.

The appellate court went to the language in Section 3420(d) of the Insurance Law, which places the burden of denying coverage upon an insurer "as soon as is reasonably possible." While generally, the reasonableness of a particular delay is a question of fact requiring consideration of the totality of the circumstances, a lengthy delay, or one for which no adequate explanation is offered, will be found to be unreasonable as a matter of law. Moreover, an insurer who fails to disclaim coverage as soon as reasonably possible cannot justify its failure to do so on the insured's late notice. Applying these principles to the facts herein, the appellate court concluded that the insurer was obligated to defend and indemnify because of an untimely disclaimer. The insurer possessed sufficient information upon which to base a disclaimer on September 27, 1996, when it received the third-party complaint. This document disclosed the

date of the loss, and thus the fact of the Ferrys' lack of earlier notice, the relationship of the parties, the nature of the accident, the extent of the child's injuries, and the fact that the claim was for contribution or indemnification. The November 19, 1996 reservation of rights letter did not constitute an effective disclaimer, nor did Mohawk Minden formally issue such a disclaimer except inferentially by commencement of the declaratory judgment action, notice of which the Ferrys received on December 26, 1996, 90 days after plaintiff received notice of the claim.

It is therefore important to distinguish between a reservation of rights letter and a disclaimer letter. The former will have no effect whatsoever as far as a timely disclaimer is concerned, whereas the latter will have such an effect. In a letter that reserves rights and disclaims simultaneously, it has been held that the disclaimer is valid. This was the holding of the Appellate Division, First Department, in DeSantis Brothers v. Allstate Insurance Company, 244 A.D.2d 183. The court held that the letter was no less a disclaimer letter by virtue of the fact that the letter also offered to defend the insured while reserving the insurer's rights and reaffirming indemnification. The fact that the letter also advised that the insurer was disclaiming coverage at this time served as sufficient notice pursuant to Insurance Law 3420(d).

In summary, it is apparent that what is most important in denying coverage is to act upon a denial as quickly as possible, and if there is delay, an excuse must be proffered. In case after case, it appears as if carriers believe that a reservation of rights letter adequately serves as a proper notice of disclaimer. This is a faulty assumption. A separate written disclaimer notice must be sent stating, in clear and unambiguous terms, all grounds for disclaimer. Those reasons not raised cannot be raised in later judicial proceedings.

VI. ESTOPPEL AND DECLARATORY JUDGEMENT

The doctrine of estoppel is closely associated with Insurance Law § 3420(d) concerning disclaimer of coverage. There have been a number of cases in which courts have applied the doctrine of estoppel to compel insurance carriers to provide insurance coverage to their insureds based upon the conduct of the insurer.

One such case is Dryden Mutual Insurance Company v. Michaud, 115 A.D.2d 150. The insurer brought a declaratory judgment action to relieve it from defending and indemnifying its insured, Michaud, in a lawsuit brought by a Lenore J. Redolphy. Ms. Redolphy went to the premises of the plaintiff to have her hair done. The policy provided by Dryden Mutual Insurance Company to Ms. Michaud contained an exclusion that the policy did not apply to “bodily injury or property damage arising out of business pursuits of any insured except activities therein which are ordinarily incident to non-business pursuits”.

The accident occurred on February 19, 1982. On March 24, 1982, plaintiff’s adjusters obtained a statement from Michaud concerning the facts of the accident, which informed Dryden Mutual, at least constructively, that the accident happened in the course of Michaud’s hair dressing business. It was not until April 21, 1982, that plaintiff’s adjuster informed Michaud and her personal attorney by letter, that in the adjuster’s opinion, the accident was excluded from coverage under the business pursuits exclusion.

In June 1983, Ms. Redolphy began an action in negligence against Michaud. Ms. Michaud’s personal attorney interposed an answer. However, shortly thereafter attorneys retained by Dryden Mutual Insurance Company substituted for the insured’s personal attorney and represented her in the action. This representation continued for seven months before a declaratory judgment action was commenced against the Redolphys and the insured, Michaud.

The Appellate Division, Third Department, held that the representation by Dryden Mutual’s designated counsel for seven months while it possessed or should have possessed knowledge of the facts giving rise to its defense to coverage on this policy, resulted in an estoppel preventing Dryden Mutual from disclaiming coverage. Where an insurance company adjuster has knowledge of the facts governing the exclusion and delays an unreasonable period of time before commencing a declaratory judgment action, estoppel will act to prevent a coverage disclaimer.

Estoppel was also the governing principle in the case of Zurich Insurance Company v. Lumbermen’s Casualty Company, 233 A.D.2d 186. Lumbermen’s Casualty provided insurance

for a tenant. The tenant had a contractual indemnification agreement with the landlord and Lumbermen's was kept apprised of settlement negotiations involving the landlord's insurer over a period of three years. During this period of time, Lumbermen's failed to adopt a "no coverage" position until the middle of settlement negotiations. The landlord's insurer, Zurich Insurance Company, settled the case and then brought an action against Lumbermen's Casualty Company to recover 50% of the settlement. The Appellate Division, First Department, held that the trial court properly determined that Lumbermen's was estopped from disclaiming liability on the contractual indemnification claim given its delay in doing so and its failure to adequately explain the basis of the disclaimer. Lumbermen's acknowledged, in April and June of 1991, its duty to defend in regard to the "contractual allegations", and was kept abreast of developments over the next two years, without making known any intention to disclaim liability. Under the circumstances, the failure to openly adopt a "no coverage" position until the middle of settlement negotiations, three years after agreeing to defend, was unreasonable.

In Lenox Realty Inc. v. Excelsior Insurance Company, 255 A.D.2d 644, the owner of a parking lot sued the insurer for a snow removal contractor seeking additional insured status under the general liability policy issued to the subcontractor. The subcontractor's insurance agent acted without authority to bind coverage naming the owner as an additional insured under the policy. The court held that an insurer may be equitably estopped from denying coverage where the party for whose benefit the insurance was procured reasonably relied upon the provision of an insurance certificate to that party's detriment (See Zurich Ins. Co. v. White, 221 A.D.2d 700). The interesting part of this decision by the Appellate Division, Third Department, is the fact that the insurer, Excelsior, had no knowledge that the landlord was named as an additional insured pursuant to a certificate of insurance. The court said that this lack of knowledge was "insignificant." Regardless of whether Excelsior knew of the request, the fact remains that the landlord was provided with a certificate naming them as an additional insured and permitted the subcontractor to proceed with work under the contract in reliance upon this certificate. It should be noted that the agency agreement between the insurer and the agent provided that the agent

was authorized to bind insurance, including any policy amendments, for Excelsior. This case can be distinguished based upon the fact that the agent had apparent authority to act on behalf of Excelsior in issuing the subject certificate. I believe that the result would have been different if there had been no such agency relationship.

In summary, insurers can be estopped from denying coverage where they have taken action, or where agents on their behalf have taken action, that conveys the impression of insurance coverage. If such an impression is conveyed by acts of the insurer then a court is likely to apply the doctrine of estoppel.

VII. COURSES OF ACTION IN CLAIM SITUATIONS

The following courses of action are available to an insurer once it completes an analysis of the complaint and the insurance policy. There are six courses of action that an insurer can take when confronted with a claim. Which course of action is selected depends on the facts of the claim, the language of the complaint and the terms of the policy of insurance.

1. **Unconditional Defense** – If there is no question concerning coverage issues, the pleading makes out a “covered” cause of action and the person or entity seeking the coverage is defined as an insured in the policy, then an unconditional defense will be tendered by the insurance carrier. An unconditional defense and indemnification is provided when there is no viable coverage defense.

2. **Conditional Defense without a Declaratory Judgment Action** – This situation is rare and will exist where there are valid coverage defenses that will require judicial confirmation to terminate the defense duty and there is a potential advantage to maintain and control the defense or prevent a default. This position should be adopted when a defense is required and there is little potential for declaratory judgment prior to verdict.

3. **Conditional Defense with a Parallel Declaratory Judgment Action** – If a defense is required and there exists the possibility of a judicial determination of coverage defenses, it is in

the best interest of the insurer to provide a conditional defense and commence a declaratory judgment action. The insurer maintains control of the defense and avoids a default.

The method utilized to establish an insurer's rights under the policy is to initiate a declaratory judgment action. The Supreme Court may render a declaratory judgment, having the effect of a final judgment as to the rights and other legal relations of the parties to the controversy (see CPLR Section 3001). If an insurer commences a declaratory judgment action and the insured is successful in defending such action, the insured is entitled to receive attorney's fees and other expenses associated with the litigation.

4. No Defense and No Judicial Intervention – This course of action is a risky one and should be utilized only if the insurer is certain that the claim is not covered by the policy.

5. Declaratory Judgment Action with No Defense Provided – If there is little risk of a default judgment being taken against the insured and there is no advantage to controlling the defense, this is a possible course of action.

6. Settlement – Even if there are possible coverage defenses, the carrier may choose to settle an action if it is in its economic best interest to do so. This generally means settling the case for “nuisance value” in order to conserve litigation expense.

VIII. CONFLICT OF INTEREST/SELECTION OF COUNSEL

As we have seen, the duty to defend an insured in New York is exceedingly broad. An insurance carrier is not only obligated to defend an insured pursuant to policy considerations, but must do so in such a way that will ensure that there will not be a conflict of interest between the insured and the law firm retained by the insurer.

Canon 5 of the New York Code of Professional Responsibility provides that an attorney owes a duty of undivided loyalty to the client. Disciplinary Rule 5-105 prohibits a lawyer from accepting or continuing in employment if the interests of another client may impair the attorney's professional judgment. New York employs two different standards by which courts evaluate disqualification motions because of alleged dual representation; which standard will apply depends on whether the representation of the two clients is simultaneous or successive. When a law firm concurrently represents both parties, courts are to apply a per se prohibition; but if the case involves former clients of the law firm, the court will inquire into whether there is a "substantial relationship" between the two matters.

In cases involving counsel assigned by an insurance carrier, the courts have by extension consolidated the interests of the carrier and the designated law firm. The following situations are typical of the conflict cases decided by the courts:

1. Covered and Non-Covered Causes of Action – The cases hold that when covered and non-covered causes of action are asserted against an insured, the insured may select his or her own counsel at the insurance carrier's expense to defend the entire action. This option avoids the likelihood of a conflict of interest (see Hall v. McNeil, 125 A.D.2d 943, 510 N.Y.S.2d 341).

2. Disclaimer – In cases where there has been a disclaimer and/or reservation of rights by the carrier, the insured is entitled to counsel of his or her own designation. This was the situation in Major Builders Corp. v. Commercial Union, 155 A.D.2d 267, 546 N.Y.S.2d 866. The insured brought a declaratory judgment action seeking to compel Commercial Union to assume its defense. The court found the insurer's disclaimer to be without merit. In view of the fact that the insured, because of the insurer's disclaimer, had an attorney of its own choosing for three years and because of potential conflicts between the insured and insurer on how the case should be pursued, the insured was allowed to designate its own counsel.

3. Previously Represented Defendant – Where there has been a long-term relationship between the insured and the insurer there may be several claims made against an insured. Carriers who limit the use of the number of firms utilized to defend insureds will send the matters to firms that previously may have represented a party adverse to the insured. If the adverse case is still pending, then the prohibition per se rule applies. If the adverse case is no longer still pending, then the “substantial relationship” test is applied. If there is no nexus between the cases there will generally not be a conflict of interest.

4. Counterclaim – If it can be demonstrated that the interests of the plaintiff and the insurance company representing the insured in the counterclaim are adverse the insured is entitled to select counsel. This was the situation in Gorman v. Pattengell, 145 A.D.2d 411. Plaintiff sued defendant, individually and in her capacity as executrix, for the wrongful death of her husband. The accident occurred when the automobile she was driving skidded on ice and swerved into the defendant’s lane of travel. The defendant interposed a counterclaim. The plaintiff forwarded the counterclaim to her insurance company. It appointed a law firm to defend her. The plaintiff sought disqualification of the firm chosen by her insurance company upon the ground that if she were found to be 100% liable for the accident on the counterclaim her insurance company would not be obligated to pay any money.

The court agreed. Since the interests of the plaintiff and those of her insurance company representing her on the counterclaim were adverse to each other, her continued representation on the counterclaim by the carrier’s law firm created a conflict of interest requiring its disqualification. The plaintiff was entitled to retain, at her insurance carrier’s expense, an attorney with no business connection to her insurance carrier and who would defend solely her interests.

In selecting counsel, it is important to remember that the insured is entitled to counsel that will place his or her interests above those of the insurer. The insured is

entitled to this pursuant to the contract of insurance. In choosing counsel, the insurer has the obligation to avoid a conflict of interest or the appearance of a conflict of interest.

IX. BAD FAITH

The leading decision on an insurer's "bad faith" in New York is Pavia v. State Farm Mutual Automobile Insurance Company, 82 N.Y.2d 445. This is a 1993 decision by the Court of Appeals of New York. The case involved a severe injury sustained by Frank Pavia in a motor vehicle accident on April 19, 1985. The accident involved a car operated by a Carmine Rosato, which struck a parked vehicle owned by the defendant, Emiroso. As a result of the accident, Mr. Pavia was rendered a hemiplegic. In October 1985, he commenced a personal injury action against Rosato and Emiroso. State Farm insured Mr. Rosato in the amount of \$100,000. State Farm determined as early as March 1986 that Mr. Rosato, its insured, was 100% responsible for the accident. By August 1986, a State Farm claims representative responsible for handling the case was in receipt of medical records attesting to the severity of the plaintiff's injuries. A physical examination of the plaintiff conducted by State Farm on April 27, 1987, confirmed those findings. Carmine Rosato testified on June 7, 1987 at his deposition that the Emiroso car may have been backing up at the time of the accident and was not double-parked as originally thought. The attorney for State Farm recommended a further inquiry into this issue. On June 26, 1987, counsel for the plaintiff demanded State Farm settle the case for the policy limit of \$100,000 and required acceptance of the offer within 30 days. This time period expired without response from State Farm. State Farm, however, had embarked on a thorough investigation of the potential defenses illuminated by Mr. Rosato's deposition. It hired an investigator to locate witnesses that would corroborate Mr. Rosato's version of the accident. By November of 1987, State Farm's efforts to locate those witnesses were abandoned because the search had proved fruitless. On December 16, 1987, State Farm authorized payment of the policy limit in the case.

Counsel for the plaintiff rejected this. Trial commenced in Kings County in March 1988 and a verdict was returned in amount of \$6,322,000.

Mr. Rosato assigned all causes of action he had against State Farm to the plaintiff by executing an assignment agreement. Mr. Pavia then commenced a bad faith case against State Farm.

At the time of this case, New York had in place a body of law on bad faith/good faith. An insurer may be held liable for the breach of its duty of “good faith” in defending and settling claims over which it exercises exclusive control on behalf of its insured. This duty is implied from the insurance contract. Whenever an insurer is presented with a settlement offer within policy limits, a conflict arises between, on the one hand, the insurer’s interest in minimizing his payments and on the other hand, the insured’s interest in avoiding liability beyond the policy limits. By refusing to settle within the policy limits, an insurer risks being charged with bad faith on the premise that it has advanced its own interests by compromising those of its insured, or even those of an excess insurance carrier who alone may be placed at further risk due to the defendant’s intractable opposition to any settlement of the claim.

Based upon the above principles, a verdict was returned in Pavia’s favor at the trial level. The Appellate Division, Second Department, affirmed the judgment. The case was appealed by State Farm to the New York Court of Appeals.

The Court of Appeals in Pavia affirmed the above principles and held that in order to establish a prima facie case of bad faith, it must be established that the insurer’s conduct constituted a “gross disregard” of the insured’s interests – that is, a deliberate or reckless failure to place on equal footing the interests of its insured with its own interests when considering a settlement offer. In a bad-faith case, a plaintiff must establish that the defendant insurer engaged in a pattern of behavior evincing a conscious or knowing indifference to the probability that an insured would be held personally accountable for a

large judgment if a settlement offer within the policy limits were not accepted. New York now follows the “gross disregard” standard.

The court then continued and stated that evidence that a settlement demand was made and not accepted is not dispositive of the insurer’s bad faith. An insurer cannot be compelled to concede liability and settle a questionable claim simply because an opportunity to do so is presented. Rather, the plaintiff in a bad-faith action must show that the insured lost an actual opportunity to settle the claim at a time when all serious doubts about the insured’s liability were removed. Bad faith is established only where liability is clear and the potential recovery far exceeds the insurance coverage. It does not follow that whenever an injury is severe and the policy limits are significantly lower than a potential recovery, the insurer is obliged to accept a settlement demand within the policy. The bad-faith equation must include consideration of all of the facts and circumstances relating to whether the insurer’s investigatory efforts prevented it from making an informed evaluation of the risks of refusing settlement. In making this determination, courts must assess the plaintiff’s likelihood of success on the liability issue in the underlying action, the potential magnitude of damages and the financial burden to which each party may be exposed as a result of a refusal to settle. Additional considerations include the insurer’s failure to properly investigate the claim and any potential defenses thereto; the information available to the insurer at the time the demand for settlement is made; and any other evidence which tends to establish or negate the insurer’s bad faith in refusing to settle. The insurer’s fault in delaying or ceasing settlement negotiations by misrepresenting the facts also factors into the analysis.

Application of the aforementioned principles led the Court of Appeals to hold that the plaintiff failed to establish a prima facie case of bad faith in the Pavia case. Plaintiff’s allegations of bad faith stemmed principally from State Farm’s failure to abide by a settlement deadline unilaterally established by plaintiff Pavia’s counsel and its delay in ultimately offering the policy limits in settlement.

In Smith v. General Accident Company, 91 N.Y.2d 648, the Court of Appeals added to the obligations of an insurance carrier the duty to keep its insured advised of settlement negotiations. The plaintiff, a 14-year-old child, was injured while attempting to cross the street outside a bagel shop. A delivery truck parked in front of the store blocked his view of oncoming traffic. As Smith stepped into the street, a car driven by a Frank Primiani struck him. A Jay Brody owned the delivery truck. Smith sued both Primiani and Brody, alleging that Brody was negligent in parking the truck with the rear of the vehicle extending into the street thereby blocking his view of oncoming traffic. The trial, in Richmond County, was bifurcated and the jury returned a verdict in the liability phase finding Smith and Brody each 50% at fault. General Accident was Brody's insurer with coverage in the amount of \$500,000. At this point, General Accident did not reach a settlement with Smith. On the damages phase of the trial, the jury returned a verdict of \$1.1 million. Brody thereafter assigned any cause of action that he might have had against General Accident to Smith and the plaintiffs commenced this action claiming bad faith.

The thrust of the bad faith case against General Accident was that once the jury returned a finding of 50% liability against Brody, Smith's injuries were so extensive that it was highly likely that a jury would return a verdict in the damages phase of the trial in excess of the policy limits. After the jury returned its verdict in the liability phase of the trial, the most that General Accident offered to settle the claim was \$300,000. General Accident never advised its insured of settlement negotiations with the plaintiff. The trial judge in the bad faith case instructed the jury that they could consider this fact as evidence of bad faith. The jury returned a finding against General Accident. The Appellate Division, Second Department, reversed the trial court and held that the jury instruction on settlement negotiation was improper. The Court of Appeals reversed the Appellate Division.

It ruled that the failure of General Accident to advise an insured of settlement demands and negotiations is “other evidence,” as referred to in the Pavia case, which must be considered by a court in determining whether the insurer’s conduct amounted to bad faith.

A recent decision that you should be aware of is the case of Redcross v. Aetna Casualty and Surety Company, 688 N.Y.S.2d 817. This is a 1999 appellate court decision. The issue in this case was whether or not an insurer acted in bad faith by refusing to settle for more than the per person limits of the policy. The facts of this case showed that one plaintiff’s injuries exceeded the policy limits while the other claimant’s injuries did not. The court held that an insurer confronted with multiple claims arising out of the same accident is not required, in order to forestall a bad-faith settlement claim, to accept a “package deal” within the overall policy limits if, in doing so, it will be overpaying on some of the claims in order that in the other claims, as to which the insurer is ready to pay the full policy limit, the insured not be exposed to liability that exceeds the policy limit. Of course, in practice, insurers commonly consider and offer the overall per occurrence policy limits in such circumstances to achieve an equitable settlement and avoid protracted litigation, and nothing precludes them from so doing. The case holds that if an insured does not wish to take this course of action, such a decision is not one of bad faith.

In summary, New York adheres to the “gross disregard” of the interests of the insured as the standard for a bad faith claim. Failure to keep the insured advised of settlement negotiations is a factor to be considered in any bad faith determination. An insurer is well advised to keep its insured abreast of settlement negotiations in a case where potential damages approach or exceed the limits of the policy.