I. Regulatory Limits on Claims Handling

A. Timing for Responses and Determinations

Article 26 of New York’s Insurance Law governs what would be considered “unfair” claim settlement practices. Under § 2601, a practice is considered unfair if an insurer fails “to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies.” Insurance Law § 2601 (emphasis added). Insurance companies must have “reasonable standards” by which to promptly investigate claims. Id. (emphasis added). Where liability has become reasonably clear, an insurance company must be “prompt, fair and equitable” in effectuating settlements. Id.

The timeframe is further explained in the New York Code of Rules and Regulations (“NYCRR”) at 11 NYCRR 216.0, et seq. 11 NYCRR 216.4 provides:

(a) Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice. Such acknowledgment may be in writing. If an acknowledgment is made by other means, an appropriate notation shall be made in the claim file of the insurer.

In addition, 11 NYCRR 216.5 provides:

(a) Every insurer shall establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant’s authorized representative, within 15 business days of receipt of notice of claim. An insurer shall furnish to every claimant, or claimant’s authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be
required of the claimant, within 15 business days of receiving notice of the claim.


Also applicable in this context is New York Insurance Law §3420(d)(2), under which:

If under a liability policy delivered or issued for delivery in this 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 is reasonably possible of such disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant.

An insurer’s failure to disclaim in a timely manner will constitute a waiver of the insurer’s right to disclaim with respect to policy conditions and exclusions. In New York, the requirement of a timely disclaimer of coverage has been interpreted as “an unconditional rule.” Allstate Ins. Co. v. Gross, 27 N.Y.2d 263, 317 N.Y.S.2d 309 (1970). The timely disclaimer statute only applies to cases involving bodily injury claims arising out of a New York accident. KeySpan Gas East Corp. v. Munich Reins. Am., Inc. 23 N.Y.3d 583, 992 N.Y.S.2d 185 (2014). The New York courts have generally held that relatively short delays in disclaiming are untimely as a matter of law, and the insurer is estopped to deny coverage. See West 16th St. Tenant Corp. v. Public Serv. Mut. Ins. Co., 290 A.D.2d 278, 736 N.Y.S.2d 34 (1st Dept. 2002) (30-day delay held untimely); AIU Ins. Co. v. Veras, 94 A.D.3d 642, 942 N.Y.S.2d532 (1st Dept. 2012) (29-days untimely); Erie Painting and Maintenance, Inc. v. Illinois Union Ins. Co, 876 F.Supp. 2d 222 (W.D.N.Y. 2012) (29-day delay held issue of fact). The test is not the number of days that have elapsed, but rather whether the insurer’s explanation for the delay is reasonable. See Vecchiarelli v. Continental Ins. Co., 277 A.D.2d 992, 716 N.Y.S.2d 524 (4th Dept. 2000); Stables v. Aetna Life Ins. Co., 226 A.D.2d 138, 639 N.Y.S.2d 824 (1st Dept. 1996). The insurer has the burden of justifying any delay in issuing a disclaimer, and the reasonableness of the delay is to be determined from the time at which the insurer is aware of sufficient facts upon which to base a disclaimer. See Campos v. Sarro, 309 A.D.2d 888, 767 N.Y.S.2d 442 (2nd Dept. 2003); Mohawk Minden Ins. Co. v. Ferry; 251 A.D.2d 846, 674 N.Y.S.2d 512 (3rd Dept. 1998). The statute does not permit an insurer to delay issuing a disclaimer on a ground that the insurer believes to be valid, while

While violation of the statute bars reliance on policy exclusions or conditions, the statute does not apply where a claim does not fall within the coverage of a policy in the first instance. See York Restoration Corp. v. Solty’s Const., Inc., 79 A.D.3d 861, 914 N.Y.S.2d 178 (2nd Dept. 2010). The statute does not apply to requests for contribution or indemnity as between insurance companies. See JT Magen v. Hartford Fire Ins. Co., 64 A.D.3d 266, 879 N.Y.S.2d 100 (1st Dept. 2009); Bovis Lend Lease LMB, Inc. v. Royal Suplus Lines Ins. Co., 27 A.D.3d 84, 806 N.Y.S.2d 53 (1st Dept. 2005).

B. Standards for Determination and Settlements

There is no specific set of standards for settlements in New York, although as noted above, New York does have protections against unfair claim settlement practices under §2601.

The requirements of New York Insurance Law §2601 are further detailed by 11 NYCRR 216.0, et. seq. In its preamble, 11 NYCRR 216.0(e) prescribes certain claims handling procedures to be followed by insurers, including the following:

1. Have as your basic goal the prompt and fair settlement of all claims.
2. Assist the claimant in the processing of a claim.
3. Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible.
4. Clearly inform the claimant of the insurer’s position regarding any disputed matter.
5. Respond promptly, when response is indicated, to all communications from insureds, claimants, attorneys and any other interested persons.
6. Every insurer shall distribute copies of this regulation to every person directly responsible for the supervision, handling and settlement of claims subject to this regulation, and every insurer shall satisfy itself that all such personnel are thoroughly conversant with, and are complying with, this regulation.

F.2d 47 (2nd Cir. 1992), certified question withdrawn, 984 F.2d 69 (2nd Cir. 1993).


C. Privacy Protections (including Fed. Gramm-Leach-Bliley Act)

Under New York Insurance Law §321, entitled “Medical information exchange centers,” an insurance company cannot disclose medical information concerning insurance applicants unless it complies with the requirements of Insurance Law §321(a), which provides:

Whenever any insurance company (which is a member of a medical information exchange center or which otherwise may transmit medical information in whatever manner to any other similar facility including but not limited to an electronic data facility used by two or more insurance companies to determine or aid in determining the insurability of applicants) requests medical information from any applicant for personal insurance, it shall not transmit, nor be considered to have obtained the applicant's informed consent to transmit, the information to any such facility unless such company furnishes such applicant with a clear and conspicuous notice disclosing:

1. a description of such facility and its operations, including its name, address and telephone number where it may be contacted to request disclosure of any medical information transmitted to it;

2. the circumstances under which such facility may release such medical information to other persons; and

3. such applicant's rights to request such facility to arrange disclosure of the nature and substance of any information in its files pertaining to him, and to seek correction of any inaccuracies or incompleteness of such information.

Pursuant to Insurance Law §321(b), the requisite notice must be tendered upon completion of any application for personal insurance.

II. General Rules of Insurance Policy Construction

Where the terms of an insurance policy are clear and unambiguous, interpretation of such terms is a question of law for the court. See Town of

A policy should be read as a whole to give full meaning and effect to all of the applicable policy provisions. See Excess Ins. Co., Ltd. V. Factory Mut. Ins., 3 N.Y.3d 577, 789 N.Y.S.2d 461 (2004). An insurance contract should not be read so that some provisions are rendered meaningless. County of Columbia v. Continental Ins. Co., 83 N.Y.2d 618, 612 N.Y.S.2d 345 (1994). In construing an endorsement to an insurance policy, “the endorsement and the policy should be read together, and the words of the policy remain in full force and effect except as altered by the words of the endorsement.” Id.; Richner Communications, Inc. v. Tower Ins. Co. of New York, 72 A.D.3d 670, 898 N.Y.S.2d 615 (2d Dept. 2010).

The test for ambiguity is whether there is a “reasonable basis for a difference of opinion” as to the meaning of the policy. Federal Ins. Co. v. International Business Machines Corp., 18 N.Y.3d 642, 942 N.Y.S.2d 432 (2012). That is, is the policy, read as a whole, susceptible of two reasonable interpretations. See Meyers & Sons Corp. v. Zurich American Ins. Corp., 74 N.Y. 298, 546 N.Y.S.2d 818 (1989). The focus of the test “is on the reasonable expectations of the average insured upon reading the policy.” Mostow v. State Farm Ins. Companies, 88 N.Y.2d 321, 645 N.Y.S.2d 421 (1996); MIC Property & Cas. Corp. v. Avila, 65 A.D.2d 1303, 886 N.Y.S.2d 186 (2d Dept. 2009). An insurance policy is not ambiguous merely because the parties interpret the language differently. See Commercial Union Ins. Co. v. Liberty Mut. Ins. Co., 36 A.D.3d 645, 828 N.Y.S.2d 479 (2d Dept. 2007). Nor should the court find an ambiguity on the basis of an interpretation which “would strain the contract beyond its reasonable and ordinary meaning.” See Federal Ins. Co. v. American Home Assur. Co., 639 F.3d 557 (2d Cir. 2011). If the language of the policy is deemed to be ambiguous, the policy is interpreted against the insurer and in favor of the insured. See Federal Ins. Co. v. International Business Machine Corp., 18 N.Y.3d 642, 942 N.Y.S.2d 432 (2012). It is the insurer’s burden to prove that the interpretation it advances is not only reasonable, but also that it is the only fair one. See Massa v.

An insurance company asserting an exclusion has the burden of establishing that the exclusion contains “clear and unmistakable language,” that the exclusion applies in the particular case, and that it is subject to no other reasonable interpretation. See Pioneer Tower Owners Ass’n v. State Farm Fire & Cas. Co., 12 N.Y.3d 302, 880 N.Y.S.2d 885 (2009). Exclusions are “not to be extended by interpretation or implication.” Id. “Policy exclusions are given strict and narrow construction.” Belt Painting Corp. v. TIG Ins. Co., 100 N.Y.2d 377, 763 N.Y.S.2d 790 (2003). Where the existence of coverage depends upon an exception to an exclusion, the insured has the burden of demonstrating that the exception has been satisfied. See Redding-Hunter Inc. v. Aetna Cas. and Sur. Co., 206 A.D.2d 805, 615 N.Y.S.2d 133 (3rd Dept. 1994). “Exclusions in policies of insurance must be read seriatim, not cumulatively, and if any one exclusion applied there can be no coverage since no one exclusion can be regarded as inconsistent with another.” See 385 Third Ave. Associates, L.P. v. Metropolitan Metals Corp., 81 A.D.3d 475, 916 N.Y.S.2d 95 (1st Dept. 2011).

III. Choice of Law

For contract disputes, the New York courts apply “the law of the place which has the most significant contacts with the matter in dispute.” See Maryland Cas. Co. v. Continental Cas. Co., 332 F.3d 145 (2d Cir. 2003). Under this “grouping of contacts” inquiry, the courts look to the following factors identified in § 188 of the Restatement (Second) of Conflict of Law: The place of contracting, the places of negotiation and performance of the contract, the location of the subject matter, and the domicile or place of business of the contracting parties. See Zurich Ins. Co. v. Shearson Lehman Hutton, Inc., 84 N.Y.2d 309, 618 N.Y.S.2d 609 (1994); Olin Corp. v. Ins. Co. of North America, 929 F.2d 62 (2d Cir. 1991). Where liability insurance is concerned, the most important factor is “the local law of the state which the parties understood to be the principal location of the insured risk...unless with respect to the particular issue, some other state has a more signification relationship...to the transaction and the parties.” Zurich Ins. Co. v. Shearson Lehman Hutton, Inc., supra., Federal Ins. Co. v. Safenet, Inc., 817 F.Supp.2d 290 (S.D.N.Y. 2011).

Where a liability insurance policy covers risks in multiple states, “the state of the insured’s domicile should be regarded as a proxy for the principal location of the insured’s risk.” See In Re Liquidation of Midland Ins. Co., 16 N.Y.3d 536, 923 N.Y.S.2d 396 (2011). This approach “promotes certainty, predictability and uniformity of result.” Id. The courts look to the state of the insured’s principal place of business at the time the policy was issued as a “controlling factor” in determining the applicable law. See Certain Underwriters at Lloyd’s, London v. Foster Wheeler Corp., 36 A.D.3d 17, 822 N.Y.S.2d 30 (1st Dept. 2006), aff’d, 9 N.Y.3d 928, 844 N.Y.S.2d 773 (2007); FC Bruckner Associates, L.P. v. Fireman’s Fund Ins. Co., 95 A.D.3d 556, 944 N.Y.S.2d 84 (1st Dept. 2012) (look to first named insured’s

For an automobile liability policy, the principal location of the insured risk is the place where the vehicle is principally garaged and registered. See State Farm Mut. Auto. Ins. Co. v. Thomas, 75 A.D.3d 644, 906 N.Y.S.2d 291 (2d Dept. 2010); Eagle Ins. Co. v. Singletary, 279 A.D.2d 56, 717 N.Y.S.2d 351 (2d Dept. 2000).

IV. Duties Imposed by State Law
A. Duties to Defend

1. Standard for determining duty to defend


Where a policy represents that it will provide the insured with a defense, courts have said that it actually constitutes “litigation insurance” in addition to liability coverage. See BP Air Conditioning Corp. v. One Beacon Insurance Group, 8 N.Y.3d 708, 714, 840 N.Y.S.2d 302, 301 (2007) (“An Insured’s right to representation and the insurer’s correlative duty to defend suits, however groundless, false or fraudulent are in a sense ‘litigation insurance’ expressly provided by the insurance contract”) (internal quotation marks and citations omitted). Litigation insurance is regarded as an integral part of the insured’s bargain, even where an eventual judgment against the insured may not be within the scope of coverage. See BP Air, 8 N.Y.3d at 714, 840 N.Y.S.2d at 306 (“an insurer may be required to defend under the contract even though it may not be required to pay once the litigation has run its course).

An insurer can avoid its defense obligation only where it can demonstrate as a matter of law that there is no possible factual or legal basis on which it will be obligated to indemnify the insured. Servidone Constr. Corp. v. Security Insurance Co., 64 N.Y.2d 419, 488 N.Y.S.2d 139 (1985); Hotel des Artistes, Inc. v. General Acc. Ins. Co. of America, 9 A.D.3d 181, 775 N.Y.S.2d 262 (1st Dept. 2004). Insurers must provide a defense to the entire complaint if any one of the causes of action may fall within the scope of the coverage, even if other causes of action fall outside the coverage. Seaboard Surety Co. v. Gillette Co., 64 N.Y.2d 304, 486 N.Y.S.2d 873 (1984); New York City Housing Authority v. Commercial Union Ins. Co., 289 A.D.2d 311, 734 N.Y.S.2d 590 (2nd Dept. 2001); Bravo Realty Corp. v. Mt.
Hawley Ins. Co., 823 N.Y.S.2d 360 (1st Dept. 2006). A defense must be provided even if the insured is ultimately found not to be liable. See City of New York v. Consolidated Edison Co. of N.Y., Inc., 238 A.D.2d 119, 655 N.Y.S.2d 496 (1st Dept. 1997).

The four-corners-of-the-complaint rule has been broadened only to support a duty to defend. An insurer is required to provide a defense when it has actual knowledge of facts establishing a reasonable possibility of coverage. Fitzpatrick v. American Honda Motor Co., Inc., 78 N.Y.2d 61, 571 N.Y.S.2d 672 (1991); Firemen's Insurance Co. of Washington, D.C. v. 860 West Tower, Inc., 246 A.D.2d 401, 667 N.Y.S.2d 718 (1st Dept. 1998). The insurer cannot ignore credible extrinsic information provided by the insured that would create a duty to defend. Almar, Inc. v. Utica Mut. Ins. Co., 280 A.D.2d 624, 721 N.Y.S.2d 693 (2nd Dept. 2001). On the other hand, the insurer may not use extrinsic facts to show that there is no coverage under the policy. Fitzpatrick v. American Honda Motor Co., Inc., supra; Petr-Al Petroleum Corp. v. Firemen's Insurance Co. of Newark, NJ, 188 A.D.2d 139, 593 N.Y.S.2d 693 (4th Dept. 1993).

When the insurer seeks to rely upon a policy exclusion to deny coverage, it bears the burden of demonstrating that the allegations cast the pleading solely and entirely within the policy exclusion and that allegations are subject to no other interpretation. Automobile Ins. Co. of Hartford v. Cook, 7 N.Y.3d 131, 818 N.Y.S.2d 176 (2006); Labate v. Liberty Mut. Fire Ins. Co., 19 A.D.3d 652, 799 N.Y.S.2d 71 (2nd Dept. 2005).

Once the duty to defend attaches, an insurer cannot withdraw from the defense absent a judicial declaration that there is no coverage. See Dillon v. Otis Elevator Co., 22 A.D.3d 1, 800 N.Y.S.2d 385 (1st Dept. 2005); Flans v. Martini, 136 A.D.2d 498, 523 N.Y.S.2d 819 (1st Dept. 1988); Monaghan v. Meade, 91 A.D.2d 1014, 4579, N.Y.S.2d 886 (2nd Dept. 1983). Policies providing umbrella or excess coverage are not required to defend where the primary carrier is required to defend. See Labatt Brewing Co., Ltd. v. Zurich Ins. Co., 281 A.D.2d 363, 723 N.Y.S.2d 17 (1st Dept. 2001). Where the insured's potential liability could reach into the excess insurer's layer, a declaratory judgment action is the appropriate means of establishing the excess insurer's coverage obligations. See Long Island Lighting Co. v. Allianz Underwriters Ins. Co., 826 N.Y.S.2d 55 (1st Dept. 2006).

2. Issues with reserving rights


Generally, if the insurer elects to defend under a reservation of rights, there is a potential for conflict of interest and the insured is entitled to counsel of its choice. Federated Dept. Stores, Inc. v. Twin City Fire Ins. Co., 28 A.D.3d 32, 807 N.Y.S.2d 62 (1st Dept. 2006). A conflict of interest generally exists where coverage for one or more causes of action...
depends upon how the facts develop or are presented by defense counsel. See U.S. Underwriters Ins. Co. v. TNP Trucking, Inc., 44 F. Supp. 2d 489 (E.D.N.Y. 1999). Once an insurer has decided to defend an insured, the case should be evaluated for any potential conflicts of interest. Ordinarily, an insurance company has the right to control the litigation and to select the defense counsel that it wants to handle the insured’s defense. However, where a conflict arises, the insured has the right to select independent counsel at the insurer’s expense. See Ottaviano v. Genex Co-op., Inc., 15 A.D.3d 924, 790 N.Y.S.2d 791 (4th Dept. 2005); 69th Street and 2nd Ave. Garage Associates, L.P. v. Ticar Title Guaranty Co., 207 A.D.2d 225, 622 N.Y.S.2d 13 (1st Dept. 1995).

A conflict of interest may exist where, among other things:

(a) Defense attorney’s duty to the insured is to defeat all potential bases of coverage but the duty to the insurer requires that he or she defeat only those bases that would invoke coverage. Public Service Mut. Ins. Co. v. Goldfarb, 53 N.Y.2d 392, 442 N.Y.S.2d 522 (1981).

(b) An insurer provides coverage to two or more insureds in the same case whose positions may be conflicting or adverse. Rimar v. Continental Cas. Co., 50 A.D.2d 169, 376 N.Y.S.2d 309 (4th Dept. 1975).

Where a conflict exists, the Appellate Division, Third Department, views a carrier’s failure to advise an insured of its right to select independent counsel as potentially giving rise to a deceptive business practice. See Elacqua v. Physicians’ Reciprocal Insurers, 52 A.D.3d 886, 888, 860 N.Y.S.2d 229 (3rd Dept. 2008) (holding that physicians and physicians’ medical partnership were harmed as result of medical malpractice insurer failing to inform them that, once conflict arose, they had a right to select independent counsel of their choosing at insurer’s expense, as would support claim for deceptive business practices). But see Tower Ins. Co. of N.Y. v. Sanita Constr. Co., Inc., 129 A.D.3d 430, 11 N.Y.S.3d 122 (1st Dept. 2015) (no duty to affirmatively advise the insured of the right to independent counsel); Sumo Container Station, Inc. v. Evans, Orr, Pacelli, Norton & Laffan, P.C., 278 A.D.2d 169, 719 N.Y.S.2d 223 (1st Dept. 2000).

Not every reservation of rights requires the appointment of independent counsel. See Public Service Mut. Ins. Co. v. Goldfarb, supra. If, for example, the covered and uncovered theories of liability are distinct (such as uncovered property damage and covered bodily injury), defense counsel could not possibly steer the case in favor of the insurance company. See Prudential Property & Cas. Ins. Co. v. Godfrey, 169 A.D.2d 1035, 1036, 565 N.Y.S.2d 315, 316 (3rd Dept. 1991) (“Inasmuch as plaintiff’s interest in disproving negligent entrustment of the ATV does not conflict with defendants’ interest in defeating both the negligence and negligent entrustment claims, there is no need for independent counsel”).

V. Extra Contractual Claims Against Insurers: Elements And Remedies

A. Bad Faith
1. First-party actions

In New York, there is no private cause of action for bad faith in a first-party claim. See US Alliance Fed. Credit Union v. CUMIS Ins. Soc., Inc., 346 F.Supp.2d 468 (S.D.N.Y. 2004); see also, New York University v. Continental Ins. Co., 87 N.Y.2d 308, 639 N.Y.S.2d 283, 662 N.E.2d 763 (1995); Sichel v. Unum Provident Corp., 230 F.Supp.2d 325 (S.D.N.Y. 2002). However, in Acquista v. New York Life Ins. Co., 285 A.D.2d 73, 730 N.Y.S.2d 272 (1st Dept. 2001), the plaintiff doctor sued his disability insurance providers after they rejected his claims for benefits, alleging, inter alia, breach of contract, bad faith, unfair practices, and fraud. The bad faith claim was predicated on the insurance company’s repeated and willful delays in processing the claim. Acquista, 285 A.D.2d at 77, 730 N.Y.S.2d at 275. The appellate court reversed the trial court’s dismissal of plaintiff’s bad faith claim and held that where “the insurer’s denial of the claim was deliberately made in bad faith, with knowledge of the lack of a reasonable basis for the denial,” consequential damages may be awarded. See id.

However, as explained by Sichel v. UNUM Provident Corp., 230 F. Supp.2d 325 (S.D.N.Y. 2002), Acquista holds only that a plaintiff may be awarded consequential damages for losses stemming from a deliberate delay in processing claims. New York’s Court of Appeals held in 2008 that a plaintiff can recover consequential damages arising from a breach of the covenant of good faith and fair dealing as long as plaintiff can show that such consequential damages were contemplated by the parties as a probable result of that breach. PanAsia Estates v. Hudson Insurance Co., 10 N.Y.3d 200, 856 N.Y.S.2d 513, 886 N.E.2d 135 (2008); Bi-Economy Market Inc. v. Harleysville Insurance Company of New York, 10 N.Y.3d 187, 194, 886 N.E.2d 127, 856 N.Y.S.2d 505 (2008); see also, Goldmark Inc. v. Catlin Syndicate Ltd., 2011 W.L. 743568 (E.D.N.Y. February 24, 2011). Additionally, such consequential damages would not be limited to the policy limits. Id. The attorney’s fees incurred by the insured to seek affirmative recovery from the insurer are not recoverable. See Santoro v. Geico, 117 A.D.3d 1026, 986 N.Y.S. 2d 572 (2d Dept. 2014).

In New York, an insured may sue for bad faith and obtain punitive damages where necessary to vindicate a public right. See New York Univ. v. Continental Ins. Co., 87 N.Y.2d 308, 639 N.Y.S.2d 283 (1995); see also Rocanova v. Equitable Life Assur. Soc. of U.S., 83 N.Y.2d 603, 612 N.Y.S.2d 339 (1994) (private party seeking to recover punitive damages must not only demonstrate egregious tortious conduct by which he or she was aggrieved, but also that such conduct was part of pattern of similar conduct directed at public generally); Alexander v. Geico Ins. Co., 35 A.D.3d 989, 826 N.Y.S.2d 777 (3rd Dept. 2006) (insured could not recover punitive damages from automobile insurer for failure to provide continued no-fault benefits following accident when there was no showing that insurer, in dealing with general public, “engaged in egregious or fraudulent conduct evincing such wanton dishonesty as to imply criminal indifference to civil obligations”).

2. Third-party actions

The rule that a private cause of action for bad faith in a first-party claim will not lie has been extended to situations where a third party is bringing a claim against the insurer. In Cosmopolitan Mut. Ins. Co. v. Nassau Ins. Co., 99 Misc.2d 1018, 417 N.Y.S.2d 835 (N.Y. Sup. 1979) the defendant insurer was being sued by other insurers who were the subrogees of
the insurer’s claimants. The court noted that the statutory scheme empowers the Superintendent of Insurance to punish, including through an award of punitive damages, insurers for engaging in unfair claims settlement practices and, therefore, obviated the need to permit private third-party causes of action under these circumstances. Cosmopolitan Mut. Ins., 99 Misc.2d at 1019, 417 N.Y.S.2d at 835-36; see also Roldan v. Allstate Ins. Co., 149 A.D.2d 20, 43, 544 N.Y.S.2d 359, 374 (2nd Dept. 1989) (“The availability of punitive damages in private lawsuits premised on unfair claim practices has been preempted by the administrative remedies available to the Superintendent of Insurance pursuant to Insurance Law §2601. Accordingly, the plaintiff's demand for punitive damages in the present case is stricken.”).

“Because an insurance company has exclusive control over a claim against its insured once it assumes defense of the suit, it has a duty under New York law to act in 'good faith' when deciding whether to settle such a claim, and it may be held liable for breach of that duty.” Pinto v. Allstate Ins. Co., 221 F. 3d 394, 398 (2nd Cir. 2000). Among the factors to be considered in determining whether an insurer has failed to settle a claim in bad faith are: whether liability is clear, whether the potential damages far exceed the limits of the primary coverage, whether the claim was properly investigated, the financial burden to which each party may be exposed, the information available to the insurer when the demand for settlement was made, and any other evidence which tends to establish or negate the insurer’s bad faith in refusing to settle. Redcross v. Aetna Cas. & Sur. Co., 260 A.D.2d 908, 688 N.Y.S.2d 817 (3rd Dept. 1999); Pinto v. Allstate Ins. Co., supra.

The plaintiff in a bad faith action must demonstrate a causal connection between the primary insurer’s acts or omissions and the damages sustained by the insured/excess insurer. The plaintiff must show that “the insured lost an actual opportunity to settle the claim.” Pavia, supra.

Where coverage is denied, bad faith cannot be established as long as the insurer has an arguable basis for denying coverage. See Bennion v. Allstate Ins. Co., 284 A.D.2d 924, 727 N.Y.S.2d 222 (4th Dept. 2001); Redcross, supra.

B. Fraud

In New York, the elements of actual fraud are (1) that the defendant made a representation, (2) as to a material fact, (3) which was false, (4) and known to be false by the defendant, (5) that the representation was made for the purpose of inducing the other party to rely upon it, (6) that the other party rightfully did so rely, (7) in ignorance of its falsity (8) to his injury. Brown v. Lockwood, 76 A.D.2d 721, 432 N.Y.S.2d 186 (2nd Dept. 1980); National Union Fire Ins. Co. of Pittsburgh, Pa. v. Robert Christopher Associates, 257 A.D.2d 1, 691 N.Y.S.2d 35 (1st Dept. 1999).


One court has noted that there could be a “tort cause of action against an insurer who unjustifiably denies a valid claim” and that “[s]uch a tort claim should be available regardless of whether the plaintiff can successfully demonstrate the elements of fraud.” Batas v. Prudential Ins. Co. of America, 281 A.D.2d 260, 275, 724 N.Y.S.2d 3 (1st Dept. 2001); See also Kraatz v. USAA Cas. Inc. Co., 2017 W.L.876187 (W.D.N.Y.2017) (allegation that Insurer fraudulently dissuaded insured from filing a claim).

To plead a constructive fraud, a plaintiff must demonstrate “a breach of a duty which, irrespective of moral guilt and intent, the law declares fraudulent because of its tendency to deceive, to violate a confidence or to injure public or private interests which the law deems worthy of special protection.” Brown, supra, 76 A.D.2d at 730-31, 432 N.Y.S.2d at 193. The only difference between actual and constructive fraud, therefore, is that, in the latter, scienter upon the part of the defendant is replaced by a requirement that the plaintiff prove the “existence of a fiduciary or confidential relationship warranting the trusting party to repose his confidence in the defendant and therefore to relax the care and vigilance he would ordinarily exercise in the circumstances.” Id.

C. Intentional Infliction of Emotional Distress

There are four elements to the tort of intentional infliction of emotional distress in New York as adopted from the Restatement Second of Torts: (1) extreme conduct, (2) intent to cause or disregard the probability of causing severe emotional distress, (3) causal connection between the conduct and injury and (4) severe emotional distress. Howard v. New York Post Company, Inc., 81 N.Y.2d 115, 596 N.Y.S.2d 350 (1993); Mitchell v. Giambruno, 35 A.D.3d 1040, 826 N.Y.S.2d 788 (3rd Dept. 2006).

Since most suits against insurers are based on breach of contract, the insurer’s conduct rarely meets the outrageousness required to substantiate a claim for intentional infliction of emotional distress. See Cunningham v. Security Mut. Ins. Co., 260 A.D.2d 983, 689 N.Y.S.2d 290 (3rd Dept. 1999) (insured's allegations that her property insurer failed to timely compensate her for a house fire, leaving her homeless and without adequate possessions or funds for living expenses for over a year, and accused her of committing arson and submitting false statements under oath did not constitute the prima facie tort of intentional infliction of emotional distress); see also McGee v. Paul Revere Life Insurance Co., 954 F. Supp. 582 (E.D.N.Y. 1997); Trachman v. Empire Blue Cross and Blue Shield, 251 A.D.2d 322, 673 N.Y.S.2d 726 (2nd Dept. 1998).

D. State Consumer Protection Laws, Rules and Regulations

New York’s Consumer Protection Act is grounded in General Business Law §349. This law prohibits deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any services in this state. General Business Law §349 declares as unlawful “[d]eceptive acts and practices in the conduct of any business, trade or commerce or in the
furnishing of any service in this state." (See NY Gen. Bus. L. §349[a]). "Deceptive practices" are acts which are dishonest or misleading in a material respect," and "deceptive acts" are defined objectively as acts likely to mislead a reasonable consumer acting reasonably under the circumstances." See Spagnola v. Chubb Corp., 574 F.3d 64, 774 (2nd Cir. 2009). To state a prima facie case under §349, plaintiff must show: "first, that the challenged act or practice was consumer-oriented; second, that it was misleading in a material way; and third, that the plaintiff suffered injury as a result of the deceptive act." See Vitolo v. Mentor H/S, Inc., 426 F. Supp.2d 28 (E.D.N.Y 2006), citing Stutman v. Chemical Bank, 95 N.Y.2d 24, 731 N.E.2d 608 (2000). Private contract disputes regarding insurance policy coverage, and the processing of a claim that is unique to the parties, do not fall within the ambit of provision of General Business Law. See Cooper v. New York Cert. Mut. Fire Ins. Co., 72 A.D.3d 1556, 900 N.Y.S.2d 545 (4th Dept. 2010); Fekete v. GA Ins. Co. of New York, 279 A.D.2d 300, 719 N.Y.S.2d 52 (1st Dept. 2001). An insurer's general practices which have a "broad impact on consumers at large" may state a cause of action under Section 349. Wilner v. Allstate Ins. Co., 71 A.D.3d 155, 893 N.Y.S.2d 208 (2d Dept. 2010); see Ural v. Encompass Ins. Co. of America, 97 A.D.3d 562, 948 N.Y.S.2d 621 (2d Dept. 2012).


Plaintiff must also show that defendant is engaging in an act or practice that is deceptive or misleading in a material way and that plaintiff has been injured by reason thereof. Batas, 281 A.D.2d 260 (holding that insureds' allegations that health insurer did not conduct utilization review procedures promised in contract stated cause of action for breach of contract, fraud, and violations of deceptive trade practices law and false advertising law; although insureds sustained no out-of-pocket costs, insureds sufficiently alleged actual injury as nonreceipt of promised health care for which restitution of premiums paid could be an appropriate remedy).

The court may award treble damages up to $1,000 (General Business Law §349 [h]). The court has discretion to award attorney’s fees. Wilner v. Allstate Ins. Co., 71 A.D.3d 155, 893 N.Y.S.2d 208 (2nd Dept. 2010).

A plaintiff seeking compensatory damages must show that defendant engaged in a materially deceptive act or practice that caused actual, although not necessarily pecuniary, harm. See Newman v. RCN Telecom Services, Inc., 238 F.R.D 57 (S.D.N.Y. 2006).

VI. Discovery Issues in Actions Against Insurers

A. Discoverability of Claim Files
As a general rule, material prepared for litigation in a case other than the one in which disclosure is sought is not immunized. See Firemen's Ins. Co. of Newark, N. J. v. Gray, 41 A.D.2d 863, 342 N.Y.S.2d 501 (3rd Dept. 1973). The documents compiled in a claim file used to defend an insured against legal action are not prepared for legal action as against the insurer itself, and hence underwriting and claim files of defendant insurers are subject to discovery in a declaratory judgment action seeking to determine whether defendant insurers were entitled to disclaim coverage and thereby require another insurer to provide coverage. See Firemen’s Ins., supra.


An insurer waives the claim that writings in the file prepared after commencement of the action had been prepared in anticipation of litigation where insurer's representative reviewed entire file before testifying at deposition. Stern v. Aetna Cas. & Sur. Co., 159 A.D.2d 1013, 552 N.Y.S.2d 730 (4th Dept. 1990).


**B. Discoverability of Reserves**

Depending on the reason for the creation of a “reserve”, it may be discoverable in New York. In Bovis Lend Lease, LMB, Inc. v. Seasons Contracting Corp., 2002 WL 31729693 (S.D.N.Y., Dec. 5, 2002), a declaratory action brought against a demolition contractor by an insurer seeking contribution for defense and settlement of underlying action, a letter from insurer to insured's insurance broker summarizing amount of indemnity reserves, with assessments as to whether such reserves were adequate for claims against insured arising out of construction project was not subject to attorney-client or work-product privilege under New York law because the document was created at the request of a broker, who, as matter of routine, asked for status reports on all claims. See also National Union Fire Ins. Co. of Pittsburgh, PA v. H&R Block, Inc., 2014 WL 4377845 (S.D.N.Y. 2014) (permitting discovery of reserve information in bad faith action). But see 40 Rector Holdings, LLC v. Travelers Indemnity Co., 40 A.D.3d 482, 836 N.Y.S.2d 173 (1st Dept. 2007) (denying discovery of reserve information); Mt. McKinley Ins. Co. v. Corning, 2010 WL 6334283 (Sup.Ct.N.Y.Ct. 2010) (denying discovery of reserve information absent bad faith allegations).

In J.R. Stevenson Corp. v. Dormitory Authority of State of N.Y., 112 A.D.2d 113, 492 N.Y.S.2d 385 (1st Dept. 1985), an action involving a construction contract, one party sought accounting reports prepared for an
insurer as a review of operations and expenditures of the corporation for which the insurer acted as a surety. Id. Their purpose in seeking this discovery was to determine whether the insurer had adequate reserves pursuant to the insurance law's requirements and to verify the corporation's figures and establish the propriety of the corporation's expenditures. Id. The court held that these were independent verifications by the insurer of the obligor's claims and thus were prepared in the ordinary course of business and were not protected from discovery as material prepared for litigation under McKinney's CPLR 3101(d), nor did they qualify as attorney's work product. Id.

C. Discoverability of Existence of Reinsurance

The New York courts are split on whether the existence of reinsurance is discoverable in New York. In Anderson v. House of Good Samaritan Hosp., 767 N.Y.S.2d 330, 331 (4th Dept. 2003), the court held that the Supreme Court erred in denying that part of plaintiff's motion with respect to defendants' insurance and reinsurance policies. The court found that CPLR 3101(f), entitled, "Contents of insurance agreement," provides that a "party may obtain discovery of the existence and contents of any insurance agreement under which any person carrying on an insurance business may be liable to satisfy part or all of a judgment which may be entered in the action or to indemnify or reimburse for payments made to satisfy the judgment." Id., citing CPLR 3101(f). See also Suffolk Federal Credit Union v. Cumis Ins. Society, Inc., 270 F.R.D. 141 (E.D.N.Y. 2010), but see Karta Indus., Inc. v. Ins. Co. of Pa., 256 A.D.2d 375, 685 N.Y.S.2d 685 (1st Dept. 1999).

D. Communications between Insurer and Reinsurer: No information Found; Attorney-Client Communications

1. Issues relating to tripartite relationship

Where an attorney acts for two different parties having common interest, communications by either party to the attorney are not necessarily privileged in subsequent controversy between the two parties; this is particularly the case where insured and his insurer initially have common interest in defending action against former, and there is possibility that those communications might play role in subsequent action between insured and his insurer. Goldberg v. American Home Assur. Co., 80 A.D.2d 409, 439 N.Y.S.2d 2 (1st Dept. 1981). An insurer cannot assert attorney-client privilege against its insured under New York law, in insurer's lawsuit against insured seeking declaratory judgment as to whether it had duty to defend, with respect to its communications with attorney it appointed to represent insured in underlying tort case. Woodson, 80 A.D.2d at 328; Zurich, 137 A.D.2d at 402.

Where it is alleged that the insurer has breached a duty to its insured, the insurer may not use the attorney-client or work-product privilege to shield from disclosure material relevant to the insured's bad faith action. Diamond, supra; Woodson, supra; Zurich, supra.

2. Advice of counsel

Communications between insurer and its coverage counsel, that related to provision of legal advice, are privileged and do not have to be disclosed to insured under New York law in insurer's lawsuit against insured seeking
declaratory judgment as to whether it had duty to defend. Tudor Insurance Co. v. McKenna Associates, 2003 WL 21488058 (S.D.N.Y. June 23, 2003). Cf., Evanston Ins. Co. v. Dea, Inc., 2006 WL 1192737, at *4 (S.D.N.Y. May 4, 2006). ("Investigation conducted prior to decision to deny coverage cannot be considered ‘in anticipation of litigation’ because no litigation could be anticipated until a determination was made not to pay ... claim").

VII. Defenses In Actions Against Insurers

A. Misrepresentations/Omissions During Underwriting or During Claim

Misrepresentation, as a grounds for rescission, is governed by §3105 of New York's Insurance Law, which states:

(a) A representation is a statement as to past or present fact, made to the insurer by, or by the authority of, the applicant for insurance or the prospective insured, at or before the making of the insurance contract as an inducement to the making thereof. A misrepresentation is a false representation, and the facts misrepresented are those facts which make the representation false.

(b) No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless such misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such contract.

(c) In determining the question of materiality, evidence of the practice of the insurer which made such contract with respect to the acceptance or rejection of similar risks shall be admissible.

In order for an insurer to establish its right to rescind an insurance policy, it must establish that there were misrepresentations in the application and that they were material to the risk it was being asked to insure. See Republic Ins. Co. v. Masters, Mates and Pilots Pension Plan, 77 F.3d 48 (2nd Cir. 1996). The right to rescind must be exercised promptly after the insurer learns of the misrepresentation. See New York State Ins. Fund v. Mount Vernon Fire Ins. Co., 2010 WL 1292305 (2nd Cir. 2010).

policies in force at time of application was material since insurer would not have issued policy if it had known of applicant’s other insurance).


As long as it is stated in the insurance contract, an insurance company may reserve the right to cancel a policy for whatever reason, or no reason, at its discretion. See International Life Ins. & Trust Co. v. Franklin Fire Ins. & Trust Co., 66 N.Y. 119 (1876). Therefore, misrepresentations made in the presentation of a claim, which violate the standard insurance policy conditions prohibiting fraud and misrepresentation, may void the policy. This rule has been extended to situations involving misconduct by an insurer’s agent. See Cutrone, supra.

Where an insurance policy contains a provision stating that the “entire policy shall be void if any insured has intentionally concealed or misrepresented any material fact or circumstance relating to this insurance” and the issue is whether the stated language encompasses allegation of fraudulent claims for loss, it has been held that, since the provision fails to include the words “whether before or after loss” or “in case of any fraud or false swearing by the insured relating thereto,” the said provision is “ambiguous and should be construed to favor the insured.” Fiore v. State Farm Fire & Cas. Co., 135 A.D.2d 602, 603, 522 N.Y.S.2d 180 (2nd Dept. 1987).
B. Failure to Comply with Conditions

1. Assistance and cooperation

General liability policies contain a requirement that the insured cooperate with the insurance company in its investigation, defense or settlement of claims against the insured.


The New York Court of Appeals has recognized that disclaiming coverage for non-cooperation can be a difficult, fact-intensive task. See Continental Cas. Co. v. Stradford, 11 N.Y.3d 443, 871 N.Y.S.2d 607 (2008) (“Fixing the time from which an insurer’s obligation to disclaim runs is difficult. That period begins when an insurer first becomes aware of the ground for its disclaimer. But unlike cases involving late notice of claims or other clearly applicable coverage exclusions, an insured’s non-cooperative attitude is often not readily apparent. Indeed, as here, such a position can be obscured by repeated pledges to cooperate and actual cooperation.”) (citations omitted). Where the statute applies, a carrier’s disclaimer for failure to cooperate must comply with the timely disclaimer requirements of Insurance Law 3420(d). See Continental Cas. Co., supra (“Even if an insurer possesses a valid basis to disclaim for non-cooperation, it must still issue its disclaimer within a reasonable time”). See also County-Wide Ins. Co. v. Preferred Trucking Services Corp., 22 N.Y.3d 571, 983 N.Y.S.2d 460 (2014).

The insurer bears the burden of proof of proving the insured’s failure or refusal to cooperate. See Matter of Arbitration between Empire Mut. Ins. Co. and Shroud, 36 N.Y.2d 719, 367 N.Y.S.2d 972 (1975). The test is whether “the attitude of the insured, after his cooperation was sought, was one of willful and avowed obstruction.” See Commercial Union Ins. Co. v. Burr, 226 A.D.2d 416, 641 N.Y.S.2d 69 (2nd Dept. 1996); Baghaloo-White v. Allstate Ins. Co., 270 A.D.2d 296, 704 N.Y.S.2d 131 (2nd Dept. 2000). This is deemed to be a “very heavy burden.” Id. Substantial compliance by the insured will suffice in satisfying the obligations under the policy. See Baerga v. Transtate Ins. Co., 213 A.D.2d 217, 623 N.Y.S.2d 587 (1st Dept. 1995).

2. Late notice

By statute, New York amended its law with respect to late notice. Under the prior standard, which still applies to policies issued before January 17, 2009, an insured must notify the carrier “as soon as practicable” of an occurrence and of a claim or suit. Notice to an insurer operates as a condition precedent and the insurer need not show prejudice to rely on the

In interpreting what constitutes timely notice, courts have held that relatively short periods of unexcused delay are unreasonable as a matter of law. Power Auth. of the State of New York v. Westinghouse Elec. Corp., 117 A.D.2d 336, 502 N.Y.S.2d 420 (1st Dept. 1986) (53 day delay unreasonable as a matter of law); Herold v. East Coast Scaffolding, Inc., 208 A.D.2d 592, 616 N.Y.S.2d 97 (2nd Dept. 1994) (failure to notify insurer until three and a half months after accident was untimely); Zadrima v. PSM Ins. Co., 208 A.D.2d 529 (2nd Dept. 1994), 616 N.Y.S.2d 817 (4-month delay unreasonable as a matter of law).

In 2008, New York amended Insurance Law § 3420 to include a prejudice standard for late notice. The new prejudice provision is not retroactive and applies to policies issued on or after January 17, 2009. See Briggs Avenue LLC v. Ins. Corp. of Hannover, 11 N.Y.3d 377, 870 N.Y.S.2d 841 (2008). For policies covered by the new statute, the “failure to give any notice required by the policy … shall not invalidate any claim … unless the failure to provide timely notice has prejudiced the insurer.” See §3420(a)(5). “The 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.” See §3420(C)(2)(c). The statute applies “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.” See §3420(C)(2)(b). The irrebuttable presumption does not apply where a default judgment against the insured was vacated. See Castillo v. Prince Plaza, LLC, 43 Misc 3d 335, 981 N.Y.S.2d 906 (Sup. Ct. Kings Cty 2014).

As a result of the new statute, New York courts will probably create a high hurdle for insurers to deny coverage based on late notice (except for circumstances governed by the “irrebuttable presumption of prejudice”) because of the statutory reference to “materially impairs” the ability to investigate or defend the action, and the legislative intent to avoid disclaimers based on “technicalities.” If the insured has settled prior to notice, that should fit within the “irrebuttable presumption.” It remains to be seen whether a trial verdict or grant of partial summary judgment on liability to the plaintiff will qualify (or must an insurer take an appeal)? Also, if there is a default judgment against the insured is this a liability determination within the irrebuttable presumption, and again, must the insurer move to vacate the default? The cases around the country are split on the issue of whether a default judgment is prejudice by itself, or must the default be final.

As to prejudice, apart from the irrebuttable presumption, this is a fact-sensitive inquiry. As a practical matter, an insurer will rarely be able to prove material prejudice. The burden to prove the absence of prejudice shifts to the insured if the notice is more than two years late.
In Atlantic Cas. Ins. Co. v. Value Waterproofing, Inc., 918 F.Supp.2d 243 (S.D.N.Y. 2013), aff’d 548 Fed. Appx. 716 (2d Cir. 2013) the court found that an insurer was prejudiced under the new statute by the insured’s 6-month delay in providing notice to the insurer of an occurrence involving the collapse of a roof (where the injured had been working). The Court reasoned that the delay prevented the insurer from being able to investigate and ascertain the potential causes of roof collapse, where the property had been demolished during the delay. See also Wausau Underwriters Ins. Co. v. Old Republic Gen. Ins. Co., 122 F.Supp.3d 44 (S.D.N.Y. 2015) (conclusory allegations of prejudice insufficient).

Other jurisdictions have considered the following circumstances: (1) admissions of liability by the insured; (2) a significant change in the condition of the accident site; (3) the loss of key documents; (4) the death or unavailability of important witness(es); (5) the actual loss of an opportunity to settle; (6) the failure to hire experts or to conduct an independent medical examination (if the time has passed); or (7) the failure to conduct an investigation. See, generally, 1 Windt, Insurance Claims and Disputes, §1:4; 13 Couch on Insurance (3rd ed.) §193:69. The stage of the litigation when notice was given (i.e., after the discovery deadline or immediately prior to or during the trial) can be a factor in the prejudice determination. New York courts may consider cases from other jurisdictions in making determinations about prejudice.

C. **Challenging Stipulated Judgments: Consent and/or No-Action Clause**

An unauthorized settlement by the insured may vitiate liability without any discussion of prejudice. See Royal Zenith Corp. v. New York Marine Managers, Inc., 192 A.D.2d 390, 596 N.Y.S.2d 65 (1st Dept. 1993); State Farm Auto Ins. Co. v. Blanco, 208 A.D.2d 933, 617 N.Y.S.2d 898 (2nd Dept. 1994). In Royal Zenith Corp. v. New York Marine Managers, Inc., supra, the Court found that the insurers were not liable under the policy of insurance “where the insured...had violated the policy terms and conditions by voluntarily assuming liability by stipulation of settlement without the defendant insurer’s written consent.” One New York court has ruled that a plaintiff insurer was “not required to demonstrate prejudice to assert a defense of non-compliance” where the policy required that consent be obtained prior to settlement. See New York Central Mut. Fire Ins. Co. v. Danaher, 290 A.D.2d 783, 785, 736 N.Y.S.2d 195, 197 (3rd Dept. 2002).

Under New York law, where an insurance policy requires the insurer’s consent prior to a settlement, the insured must obtain such consent before settling a dispute, and the “failure of the insured to obtain such prior consent from the insurer constitutes a breach of a condition of the insurance contract and disqualifies the insured from availing himself of the pertinent benefits of the policy.” In re New York Cent. Mut’l Fire Ins. Co. v. Cavanagh, 265 A.D.2d 787, 788, 697 N.Y.S.2d 193 (3rd Dept. 1999); see also Vigilant Ins. Co. v. Bear Stearns Cas., Inc., 10 N.Y.3d 170, 855 N.Y.S.2d 45 (2008) (insured breached consent provision of policy by entering into consent decree with SEC without insurer’s consent); Cont’l Cas. Co. v. Ace Arm. Ins. Co., 2009 WL 857594 (S.D.N.Y. 2009) (“consent-to-settle provisions are a condition precedent to coverage”).

The limitation to this rule is as follows: "[W]here an insurer unjustifiably refuses to defend a suit, the insured may make a reasonable settlement or compromise of the injured party's claim, and is then entitled

the insurer's obligation to act in good faith for the insured's interests may be breached in other ways than by refusing or neglecting to defend a suit. It may be breached by neglect and failure to act protectively when the insured is compelled to make settlement at his peril; and unreasonable delay by the insurer, in dealing with a claim, may be one form of refusal to perform which could justify settlement by the insured.

Id. at 347.

D. Statute of limitations


VIII. Trigger And Allocation Issues For Long-Tail Coverage

A. Trigger of Coverage

In Continental Cas. Co. v. Rapid-American Corp., 80 N.Y.2d 640, 593 N.Y.S.2d 966 (1993), the Court of Appeals adopted an “injury-in-fact” test, identified as “onset of disease, whether discovered or not.” Similarly, in American Home Products Corp. v. Liberty Mut. Ins. Co., 748 F.2d 760 (2nd Cir. 1984), the Second Circuit discussed the injury-in-fact test -- “a real but undiscovered injury, proved in retrospect to have existed at the relevant time, would establish coverage, irrespective of the time the injury became diagnosable.” The Court added that in progressive injury cases, the New York Courts should look to whether there is measurable injury or damage, although unobserved, during the policy period. See Stonewall Ins. Co. v. Asbestos Claims Management Corp., 73 F. 3d 1178 (2nd Cir. 1995) (policies will be triggered throughout the period between exposure and date of claim or death in which the evidence persuades the trier of fact that successive injuries are recurring); U.S. Fidelity & Guaranty Co. v. Treadwell Corp., 58 F. Supp.2d 77 (S.D.N.Y. 1999) (bodily injury claimants “injured at all points in time from initial exposure through the date his claim is filed or he died”); Continental Cas. Co. v. Employers Ins. Co. of Wausau, 60 A.D.3d 128, 871 N.Y.S.2d 48 (1st Dept. 2008) (asbestos exposure triggered by injury-in-fact occurring during policy period); Cortland Pump & Equipment, Inc. v. Firemen's

B. Allocation Among Insurers


IX. Contribution Claims Between Insurers

New York law recognizes a cause of action for equitable contribution when a co-insurer pays more than its fair share for a loss covered by multiple insurers. See National Union Fire Ins. Co. of Pittsburgh, PA v. Hartford Ins. Co. of Midwest, 248 A.D.2d 78, 677 N.Y.S.2d 105 (1st Dept. 1998), aff’d 93 N.Y.2d 983, 695 N.Y.S.2d 740 (1999) (“where two or more insurers bind themselves to the same risk and one pays the whole loss, the paying insurer has a right of action against his coinsurers for a ratable portion of the amount paid”); International Multifoods Corp. v. Commercial Union Ins. Co., 309 F3d 76 (2d Cir. 2002) (“an insurer has a right in equity to collect a ratable contribution from any other insurer who is also liable for the same loss”). Two policies are considered to be co-insurers, if the two policies are both required to pay for defense and/or indemnity at the same level of coverage (i.e., primary or excess) with respect to the same underlying lawsuit. See National Cas. Co. v. Vigilant Ins. Co., 466 F. Supp.2d 533 (S.D.N.Y. 2006); see also U.S. Fire Ins. Co. v. American Home Assur. Co., 19 A.D.3d 191, 796 N.Y.S.2d 603 (1st Dept. 2005); Tops Markets Inc. v. Maryland Cas., 267 A.D.2d 999, 700 N.Y.S.2d 325 (4th Dept. 1999). Coinsurers may involve concurrent insurance both covering an accident with a fixed single date of loss, or successive insurers where the damage implicates multiple policy periods. See Arch Ins. Co. v. Harleyville Worcester Ins. Co., 2014 WL 3377124 (S.D.N.Y. 2014). The equitable basis for contribution among coinsurers is whether one insurer is unjustly enriched at the expense of another. See Maryland Cas. Co., v. W.R. Grace and Co., 218 F.3d 204 (2d Cir. 2000).

X. Duty to Settle

Under New York Law, insurance carriers owe a duty to their insureds to act in good faith when deciding whether to settle a claim and may be held liable for breach of that duty. Pavia v. State Farm Mut. Auto. Ins. Co., 82 N.Y.2d 445, 605 N.Y.S.2d 208 (1993); New England Ins. Co. v. Healthcare Underwriters Mut. Ins. Co., 295 F. 3d 232 (2nd Cir. 2002); Pinto v. Allstate Ins. Co., 221 F. 3d 394 (2nd Cir. 2000). A primary insurer discharges its duty by giving as much consideration to its insured’s interests as it does its own. The primary carrier also has a direct duty to the excess insurer,

The United States Court of Appeals for the Second Circuit has ruled that bad faith can be established even if the settlement demand exceeds the primary limits -- “plaintiffs’ willingness to settle for the policy limits is one way, but not the only way to show that an actual opportunity to settle existed.” New England Ins. Co. v. Healthcare Underwriters Mut. Ins. Co., 295 F. 3d 232, 247 (2nd Cir. 2002); see also Borchstein v. Nationwide Mut. Ins. Co., 448 F. 2d 987 (2nd Cir. 1971). According to the New York Pattern Jury Instruction, “the duty to act in good faith applies even though claimant’s settlement offer is in excess of the policy limit, if the insured is willing to contribute the excess.” NY PJI 4:67. Under established precedent, ordinary negligence should not expose an insurer to a claim for a bad faith refusal to settle. See Pavia, supra, 82 N.Y.2d at 453, 605 N.Y.S.2d at 211; see also In re Axis Reinsurance Co. v. REFCO Related Ins. Litigation, 2010 WL 1375712 (S.D.N.Y. 2010) (no breach by an insurer’s mistake in judgment).

To establish a liability insurer’s bad faith in failing to settle a claim, the insured must show 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,” or, in other words, the plaintiff must establish that the insurer engaged in “a pattern of behavior evincing conscious or knowing indifference to the probability that the insured would be held personally accountable for a large judgment if a settlement offer within the policy limits were not accepted.” Pavia, 82 N.Y.2d at 453, 605 N.Y.S.2d at 211-12; see also Vecchione v. Amica Mut. Ins. Co., 274 A.D.2d 576, 711 N.Y.S.2d 186 (2nd Dept. 2000). To prevail, a plaintiff must establish that the insured “lost an actual opportunity to settle … at a time when all serious doubts about [the insured’s] liability were removed”; Kumar v. American Transit Ins. Co., 57 A.D.3d 1449, 869 N.Y.S.2d 715 (4th Dept. 2008). The primary insurer could not be held liable to the excess insurer for bad-faith failure to accept a settlement offer within policy limits absent a showing that it had recklessly or consciously disregarded the excess insurer’s rights. Indemnity Ins. Co. of North America v. Transcontinental Ins. Co., 24 A.D.3d 121, 804 N.Y.S.2d 737 (1st Dept. 2005).

An insurer should, in good faith, communicate all settlement demands and offers to the insured, since the insured (or excess carrier) may be willing to make up the difference. See Smith v. General Acc. Ins. Co., 91 N.Y.2d 648, 674 N.Y.S.2d 267 (1998).