NEW YORK LAW INSURANCE LAW 3420 (2013)

§ 3420. Liability insurance; standard provisions; right of injured person

(a) No policy or contract insuring against liability for injury to person, except as provided in subsection (g) of this section, or against liability for injury to, or destruction of, property shall be issued or delivered in this state, unless it contains in substance the following provisions or provisions that are equally or more favorable to the insured and to judgment creditors so far as such provisions relate to judgment creditors:

(1) A provision that the insolvency or bankruptcy of the person insured, or the insolvency of the insured’s estate, shall not release the insurer from the payment of damages for injury sustained or loss occasioned during the life of and within the coverage of such policy or contract.

(2) A provision that in case judgment against the insured or the insured’s personal representative in an action brought to recover damages for injury sustained or loss or damage occasioned during the life of the policy or contract shall remain unsatisfied at the expiration of thirty days from the serving of notice of entry of judgment upon the attorney for the insured, or upon the insured, and upon the insurer, then an action may, except during a stay or limited stay of execution against the insured on such judgment, be maintained against the insurer under the terms of the policy or contract for the amount of such judgment not exceeding the amount of the applicable limit of coverage under such policy or contract.

(3) A provision 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 this state, with particulars sufficient to identify the insured, shall be deemed notice to the insurer.

(4) A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, an injured person or any other claimant if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as was reasonably possible thereafter.

(5) A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, injured person or any other claimant, unless the failure to provide timely notice has prejudiced the insurer, except as provided in paragraph four of this subsection. With respect to a claims-made policy, however, the policy may provide that the claim shall be made during the policy period, any renewal thereof, or any extended reporting period, except as provided in paragraph four of this subsection. As used in this paragraph, the terms “claims-made policy” and “extended reporting period” shall have their respective meanings as provided in a regulation promulgated by the superintendent.

(6) A provision that, with respect to a claim arising out of death or personal injury of any person, if the insurer disclaims liability or denies coverage based upon the failure to provide timely notice, then the injured person or other claimant may maintain an action directly against such insurer, in which the sole question is the insurer’s disclaimer or denial based on the failure to provide timely notice, unless within sixty days following such disclaimer or denial, the insured or the insurer: (A) initiates an action to declare the rights of the parties under the insurance policy; and (B) names the injured person or other claimant as a party to the action.

(b) Subject to the limitations and conditions of paragraph two of subsection (a) of this section, an action may be maintained by the following persons against the insurer upon any policy or contract of liability insurance that is governed by such paragraph, to recover the amount of a judgment against the insured or his personal
representative:

(1) any person who, or the personal representative of any person who, has obtained a judgment against the insured or the insured’s personal representative, for damages for injury sustained or loss or damage occasioned during the life of the policy or contract;

(2) any person who, or the personal representative of any person who, has obtained a judgment against the insured or the insured’s personal representative to enforce a right of contribution or indemnity, or any person subrogated to the judgment creditor’s rights under such judgment; and

(3) any assignee of a judgment obtained as specified in paragraph one or paragraph two of this subsection, subject further to the limitation contained in section 13-103 of the general obligations law.

(c)

(1) If an action is maintained against an insurer under the provisions of paragraph two of subsection (a) of this section and the insurer alleges in defense that the insured failed or refused to cooperate with the insurer in violation of any provision in the policy or contract requiring such cooperation, then the burden shall be upon the insurer to prove such alleged failure or refusal to cooperate.

(2)

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

(B) Notwithstanding subparagraph (A) of this paragraph, an irrebuttable presumption of prejudice shall apply 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.

(C) 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.

(d)

(1) (A) This paragraph applies with respect to a liability policy that provides coverage with respect to a claim arising out of the death or bodily injury of any person, where the policy is: (i) subject to section three thousand four hundred twenty-five of this article, other than an excess liability or umbrella policy; or (ii) used to satisfy a financial responsibility requirement imposed by law or regulation.

(B) Upon an insurer’s receipt of a written request by an injured person who has filed a claim or by another claimant, an insurer shall, within sixty days of receipt of the written request: (i) confirm to the injured person or other claimant in writing whether the insured had a liability insurance policy of the type specified in subparagraph (A) of this paragraph in effect with the insurer on the date of the alleged occurrence; and (ii) specify the liability insurance limits of the coverage provided under the policy.

(C) If the injured person or other claimant fails to provide sufficient identifying information to allow the insurer, in the exercise of reasonable diligence, to identify a liability insurance policy that may be relevant to the claim, the insurer shall within forty-five days of receipt of the written request, so advise the injured person or other claimant in writing and identify for the injured person or other claimant the additional information needed. Within forty-five days of receipt of the additional information, the insurer shall provide the information required under subparagraph (B) of this paragraph.
(2) If under a liability policy issued or delivered 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.

(e) No policy or contract of personal injury liability insurance or of property damage liability insurance, covering liability arising from the ownership, maintenance or operation of any motor vehicle or of any vehicle as defined in section three hundred eighty-eight of the vehicle and traffic law, or an aircraft, or any vessel as defined in section forty-eight of the navigation law, shall be issued or delivered in this state to the owner thereof, or shall be issued or delivered by any authorized insurer upon any such vehicle or aircraft or vessel then principally garaged or principally used in this state, unless it contains a provision insuring the named insured against liability for death or injury sustained, or loss or damage occasioned within the coverage of the policy or contract, as a result of negligence in the operation or use of such vehicle, aircraft or vessel, as the case may be, by any person operating or using the same with the permission, express or implied, of the named insured.

(f) (1) No policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any natural person arising out of the ownership, maintenance and use of a motor vehicle by the insured shall be issued or delivered by any authorized insurer upon any motor vehicle then principally garaged or principally used in this state unless it contains a provision whereby the insurer agrees that it will pay to the insured, as defined in such provision, subject to the terms and conditions set forth therein to be prescribed by the board of directors of the Motor Vehicle Accident Indemnification Corporation and approved by the superintendent, all sums, not exceeding a maximum amount or limit of twenty-five thousand dollars exclusive of interest and costs, on account of injury to and all sums, not exceeding a maximum amount or limit of fifty thousand dollars exclusive of interest and costs, on account of death of one person, in any one accident, and the maximum amount or limit, subject to such limit for any one person so injured of fifty thousand dollars or so killed of one hundred thousand dollars, exclusive of interest and costs, on account of injury to, or death of, more than one person in any one accident, which the insured or his legal representative shall be entitled to recover as damages from an owner or operator of an uninsured motor vehicle, unidentified motor vehicle which leaves the scene of an accident, a motor vehicle registered in this state as to which at the time of the accident there was not in effect a policy of liability insurance, a stolen vehicle, a motor vehicle operated without permission of the owner, an insured motor vehicle where the insurer disclaims liability or denies coverage or an unregistered vehicle because of bodily injury, sickness or disease, including death resulting therefrom, sustained by the insured, caused by accident occurring in this state and arising out of the ownership, maintenance or use of such motor vehicle. No payment for non-economic loss shall be made under such policy provision to a covered person unless such person has incurred a serious injury, as such terms are defined in section five thousand one hundred two of this chapter. Such policy shall not duplicate any element of basic economic loss provided for under article fifty-one of this chapter. No payments of first party benefits for basic economic loss made pursuant to such article shall diminish the obligations of the insurer under this policy provision for the payment of non-economic loss and economic loss in excess of basic economic loss. Notwithstanding any inconsistent provisions of section three thousand four hundred twenty-five of this article, any such policy which does not contain the aforesaid provisions shall be construed as if such provisions were embodied therein.

(2) (A) Any such policy shall, at the option of the insured, also provide supplementary uninsured/underinsured motorists insurance for bodily injury, in an amount up to the bodily injury liability insurance limits of coverage provided under such policy, subject to a maximum of two hundred fifty thousand dollars because of bodily injury to or death of one person in any one accident and, subject to such limit for one person, up to five hundred thousand dollars because of bodily injury to or death of two or more persons in any one accident, or a combined single limit policy of five hundred thousand dollars because of bodily injury to or death of one or more persons in any one accident. Provided however, an insurer issuing such policy, in lieu of offering to the insured the coverages stated above, may provide supplementary uninsured/underinsured motorists insurance for bodily injury, in an amount up to the bodily injury liability insurance limits of coverage provided under such policy, subject to a maximum of one hundred thousand dollars because of bodily injury to or death of one person in any one accident and, subject to such limit for one person, up to three hundred thousand dollars because of bodily injury to or death of two or more persons in any one accident, or a combined single limit policy of three hundred thousand dollars because of bodily injury to or death of one or more persons in any one accident, if such insurer also makes available a personal
umbrella policy with liability coverage limits up to at least five hundred thousand dollars which also provides coverage for supplementary uninsured/underinsured motorists claims. Supplementary uninsured/underinsured motorists insurance shall provide coverage, in any state or Canadian province, if the limits of liability under all bodily injury liability bonds and insurance policies of another motor vehicle liable for damages are in a lesser amount than the bodily injury liability insurance limits of coverage provided by such policy. Upon written request by any insured covered by supplemental uninsured/underinsured motorists insurance or his duly authorized representative and upon disclosure by the insured of the insured's bodily injury and supplemental uninsured/underinsured motorists insurance coverage limits, the insurer of any other owner or operator of another motor vehicle against which a claim has been made for damages to the insured shall disclose, within forty-five days of the request, the bodily injury liability insurance limits of its coverage provided under the policy or all bodily injury liability bonds. The time of the insured to make any supplementary uninsured/underinsured motorist claim, shall be tolled during the period the insurer of any other owner or operator of another motor vehicle that may be liable for damages to the insured, fails to so disclose its coverage. As a condition precedent to the obligation of the insurer to pay under the supplementary uninsured/underinsured motorists insurance coverage, the limits of liability of all bodily injury liability bonds or insurance policies applicable at the time of the accident shall be exhausted by payment of judgments or settlements.

(B) In addition to the notice provided, upon issuance of a policy of motor vehicle liability insurance pursuant to regulations promulgated by the superintendent, insurers shall notify insureds, in writing, of the availability of supplementary uninsured/underinsured motorists coverage. Such notification shall contain an explanation of supplementary uninsured/underinsured motorists coverage and the amounts in which it can be purchased. Subsequently, a notification of availability shall be provided at least once a year and may be simplified pursuant to regulations promulgated by the superintendent, but must include a concise statement that supplementary uninsured/underinsured motorists coverage is available, an explanation of such coverage, and the coverage limits that can be purchased from the insurer.

(3) The protection provided by this subsection shall not apply to any cause of action by an insured person arising out of a motor vehicle accident occurring in this state against a person whose identity is unascertainable, unless the bodily injury to the insured person arose out of physical contact of the motor vehicle causing the injury with the insured person or with a motor vehicle which the insured person was occupying (meaning in or upon or entering into or alighting from) at the time of the accident.

(4) An insurer shall give notice to the commissioner of motor vehicles of the entry of any judgment upon which a claim is made against such insurer under this subsection and of the payment or settlement of any claim by the insurer.

(5) This paragraph shall apply to a policy that provides supplementary uninsured/underinsured motorist insurance coverage for bodily injury and is a policy: (A) issued or delivered in this state that insures against liability arising out of the ownership, maintenance, and use of a fire vehicle, as defined in section one hundred fifteen-a of the vehicle and traffic law, where the fire vehicle is principally garaged or used in this state; or (B) as specified in paragraph one of this subsection. Every such policy that insures a fire department, fire company, as defined in section one hundred of the general municipal law, an ambulance service, or a voluntary ambulance service, as defined in section three thousand one of the public health law, shall provide such supplementary uninsured/underinsured motorist insurance coverage to an individual employed by or who is a member of the fire department, fire company, ambulance service, or voluntary ambulance service and who is injured by an uninsured or underinsured motor vehicle while acting in the scope of the individual’s duties for the fire department, fire company, ambulance service, or voluntary ambulance service covered under the policy, except with respect to the use or operation by such an individual of a motor vehicle not covered under the policy.

(g) No policy or contract shall be deemed to insure against any liability of an insured because of death of or injuries to his or her spouse or because of injury to, or destruction of property of his or her spouse unless express provision relating specifically thereto is included in the policy as provided in paragraphs one and two of this subsection. This exclusion shall apply only where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse.
(1) Upon written request of an insured, and upon payment of a reasonable premium established in accordance with article twenty-three of this chapter, an insurer issuing or delivering any policy that satisfies the requirements of article six of the vehicle and traffic law shall provide coverage against liability of an insured because of death of or injuries to his or her spouse up to the liability insurance limits provided under such policy even where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse. Such insurance coverage shall be known as "supplemental spousal liability insurance".

(2) Upon issuance of a motor vehicle liability policy that satisfies the requirements of article six of the vehicle and traffic law and that becomes effective on or after January first, two thousand three, pursuant to regulations promulgated by the superintendent, the insurer shall notify the insured, in writing, of the availability of supplemental spousal liability insurance. Such notification shall be contained on the front of the premium notice in boldface type and include a concise statement that supplementary spousal coverage is available, an explanation of such coverage, and the insurer's premium for such coverage. Subsequently, a notification of the availability of supplementary spousal liability coverage shall be provided at least once a year in motor vehicle liability policies issued pursuant to article six of the vehicle and traffic law, including those originally issued prior to January first, two thousand three. Such notice must include a concise statement that supplementary spousal coverage is available, an explanation of such coverage, and the insurer's premium for such coverage.

(h) In this section, the term "insurance upon any property or risk located in this state" includes insurance against legal liability arising out of the ownership, operation or maintenance of any vehicle which is principally garaged or principally used in this state, or arising out of the ownership, operation, use or maintenance of any property which is principally kept or principally used in this state, or arising out of any other activity which is principally carried on in this state.

(i) Except as provided in subsection (j) of this section, the provisions of this section shall not apply to any policy or contract of insurance in so far as it covers the liability of an employer for workers' compensation, if such contract is governed by the provisions of section fifty-four of the workers' compensation law, or by any similar law of another state, province or country, nor to the kinds of insurances set forth in paragraph three of subsection (b) of section two thousand one hundred seventeen of this chapter.

(j) (1) Notwithstanding any other provision of this chapter or any other law to the contrary, every policy providing comprehensive personal liability insurance on a one, two, three or four family owner-occupied dwelling, issued or delivered in this state on and after the first of March, nineteen eighty-four, shall provide for coverage against liability for the payment of any obligation, which the policyholder may incur pursuant to the provisions of the workers' compensation law, to an employee arising out of and in the course of employment of less than forty hours per week, in and about such residences of the policyholder in this state. Such coverage shall provide for the benefits in the standard workers' compensation policy issued in this state. No one who purchases a policy providing comprehensive personal liability insurance shall be deemed to have elected to cover under the workers' compensation law any employee who is not required, under the provisions of such law, to be covered.

(2) The term "policyholder" as used in this subsection shall be limited to an individual or individuals as defined by the terms of the policy, but shall not include corporate or other business entities or an individual who has or individuals who have in effect a workers' compensation policy which covers employees working in and about his or their residence.

(3) Every insurer who is licensed by the superintendent to issue homeowners or other policies providing comprehensive personal liability insurance in this state shall also be deemed to be licensed to transact workers' compensation insurance for the purpose of covering those persons specified in this subsection. NY CLS Ins § 3420 (2013)
INTRODUCTION

Knowledge of Insurance Law 3420 is crucial to handling of liability claims in New York. The Statute’s provisions impact a diverse array of liability policies and types of claims. The statute includes provisions as diverse as calling for certain minimum coverage for Auto Policies to creating workers compensation type of coverage in Homeowner’s policies for the insured’s household employees. The Statute also contains New York’s statutory notice prejudice rule, sets forth the timing for denials of coverage for certain policies and types of claims and creates the right of Plaintiffs to direct actions against Defendants’ Insurers. These latter provisions are the focus of today’s discussion, but it is advisable to know all of the Statute’s provisions.

DISCUSSION

POLICIES GOVERNED BY INSURANCE LAW 3420

(a) No policy or contract insuring against liability for injury to person, except as provided in subsection (g) of this section [spousal provisions], or against liability for injury to, or destruction of, property shall be issued or delivered in this state, unless it contains in substance the following provisions or provisions that are equally or more favorable to the insured and to judgment creditors so far as such provisions relate to judgment creditors:

The Statute only applies to liability policies issued or delivered in New York that provide coverage for bodily injury / death or property damage. This wording is an amendment from prior wording that called for the Statute to apply to policies delivered or issued for delivery in the State. The intended application is still similar and the new wording now clarifies that if the Insurer or its Agent issued the Policy in New York (from a New York office) or if the Policy was delivered to the Insured or its broker in New York (to a New York address) then the Statute applies. See for example, Preserver Ins. Co. v. Ryba, 10 N.Y.3d 635, 893 N.E.2d 97, 862 N.Y.S.2d 820 (2008), in which the New York Court of Appeals [the State’s highest Court] held that the requirements of Insurance Law 3420, [specifically for a timely denial by the Insurer] were inapplicable because the policy at issue, a standard form workers’ compensation and employers’ liability contract, was issued by a New Jersey Insurer and delivered in New Jersey to the New Jersey Insured Employer.

Certain provisions of the Statute restrict their application to only certain types of liability policies or to only certain types of claims. For example, the requirement for denials of coverage, discussed below, only applies to bodily injury or death claims from accidents occurring in New York. NY CLS Ins § 3420 (d) (2). In addition, the mandatory auto provisions only apply to motor vehicles principally garaged or principally used in the State. NY CLS Ins § 3420 ((f)(1). Therefore, it is imperative to read each provision carefully to determine if it applies to your policy or claim.

Excess Liability Policies are also governed by the Statute.

George Campbell Painting v National Union Fire Ins. Co. of Pittsburgh, PA, 92 A.D.3d 104
Whether the Statute applies to liability policies that do not specifically provide coverage for bodily injuries or property damages is unclear, albeit there are a few cases applying the Statute’s provisions to professional liability policies. See, e.g. In McCabe v. St. Paul Fire & Mar. Ins. Co., 25 Misc. 3d 726 (N.Y. Sup. Ct. 2009) the which Court noted:

Defendant's policy insuring plaintiffs' former attorney against liability for attorney malpractice was a policy insuring against liability "for injury to person" within the meaning of Insurance Law § 3420 (a), which gave plaintiffs the independent right to notify defendant of their claim upon the insured's failure to notify defendant. Although the policy excluded claims for "bodily injury," the basic coverage of the policy extended to claims for damages arising out "of error, omission, negligent act or 'personal injury', in the rendering of or failure to render 'legal services' for others by" the insured. The concepts of "personal injury" and "bodily injury" were mutually exclusive under the policy. Id.

NOTICE TO THE INSURER

Virtually every insurance policy has a provision requiring that the insurer be given notice of the loss or occurrence and for liability policies of the claim and suit as well. In occurrence based liability policies, the notice requirement is expressed as a condition precedent and generally requires the insured to provide immediate notice. (In claims made policies, such as professional liability policies, notice of a claim is the triggering event of coverage.) An occurrence based policy will require notice as soon as practicable of the occurrence, of the claim and of the suit. Even if the Policy does not include a specific notice provision, the Courts will read one into the Policy. Wabco Trade Co. v. Great American Ins. Co., 1983 U.S. Dist. LEXIS 13334 (S.D.N.Y. Sept. 28, 1983) (requiring prejudice to deny coverage for failure to give notice when policy contained no notice provision).

Each Insured Has Its Own Notice Obligation

Notice by one insured is not notice by any other insured. Thus, an additional insured has its own obligation separate from the named insured to provide notice. See, e.g., Delco Steel Fabricators v. American Home Assurance Company, 341 N.Y.S.2d 619. However, an Insured can give notice on behalf of other Insureds, including Additional Insureds, albeit the notice must specify it is on behalf of the other insureds.

Notice on behalf of one insured may also be deemed notice by another Insured, if the two Insureds are united in interest and have no adversity between them. See City of New York v Certain Underwriters at Lloyd’s of London, 294 AD2d 391 (2d Dept. 2002). “Where two or more insureds are defendants in the same action, notice of the lawsuit provided by one insured will be deemed notice on behalf of both insureds only where the two parties are united in interest or where there is no adversity between them.” Id. Therefore, if an additional insured has a claim or potential claim against the named insured, such as for indemnification, then the additional insured and the named insured are adversarial and the named insured’s notice will not be
considered notice on behalf of the additional insured. See, e.g., New York Telephone Comp. v. Travelers Casualty & Surety Co., 2001 N.Y. App.Div. Lexis 908 (1st Dept. 2001), in which the Court found that the named insured’s notice of a summons and complaint that named only the additional insured, not the named insured, as a defendant, was not notice on behalf of the additional insured. Instead it was notice of a claim by the additional insured against the insured; see also National Union Fire Ins. Co. of Pittsburgh, Pa. v Ins. Co. of North America, 188 AD2d 259 (1st Dept. 1992) (insureds united in interest where one insured party was sued as employee of other insured party); cf. Delco Steel Fabricators, Inc. v American Home Assurance Company, 40 AD2d 647 (1st Dept. 1972), affd 31 NY2d 1014 (1973) (parties not united in interest, and second tender untimely, when one party had cross claimed against another). In 1700 Broadway, Co. v Greater New York Mutual Insurance Company, 2008 NY Slip Op 30414U, 10 (N.Y. Sup. Ct. Feb. 7, 2008), the court held that, because an insured and additional insured had cross claimed against each other, they were not united in interest. The court also held, “adversity cannot be established until cross claims are asserted, upon the service of an answer or answers.”

Independent Notice By A Claimant/Plaintiff

(a)(3) A provision 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 this state, with particulars sufficient to identify the insured, shall be deemed notice to the insurer.

New York Insurance Law §3420(a)(3) permits an injured claimant to provide direct notice of a claim to the tortfeasor’s carrier. As the New York Court of Appeals has explained: “...although it is the insured that is charged with the primary duty to issue notice to the insurer, the Legislature has given an injured party the statutory right to fulfill this policy obligation by allowing any necessary notification to be issued by the claimant.” Am. Transit Ins. Co. v. Sartor, 3 N.Y.3d 71, 76 (N.Y. 2004). The Court cited to an old decision in support of its position, Lauritano v. American Fidelity Fire Ins. Co., 3 A.D.2d 564 (1st Dept. 1957), affirmed, 4 N.Y.2d 1028, in which an earlier version of Insurance Law 3420 permitted a claimant an independent right to provide notice for injuries from an auto accident. The Court in Lauritano, id. explained: “when the insured has failed to give proper notice, the injured party, by giving notice himself, can preserve his rights to proceed directly against the insurer.” Id. at 569. Thus, the Plaintiff may give its own independent notice to the Insurer and this notice can vitiate any right of the Insurer to not make payment of the Plaintiff’s judgment for the Insured based upon the late notice of the Insured.

For a time, the New York Appellate Departments took the position that where the insured is the first to notify the carrier, even if that notice is untimely, any subsequent notice by the injured party is superfluous. Ringel v Blue Ridge Ins. 293 A.D.2d 460, 462 (2d Dept 2002); see also Massachusetts Bay Ins. Co. v Flood, 128 A.D.2d 683, (2d Dept. 1987). lv denied 70 N.Y.2d 612 (1987); Mount Vernon Fire Ins. Co. v. Harris, 193 F. Supp. 2d 674 (E.D.N.Y. 2002); Agway Ins. v. Alvarez, 684 N.Y.S.2d 635 (2d Dept. 1999); Steinberg v. Hermitage Ins. Co., 26 A.D.3d 426, 809 N.Y.S.2d 569 (2d Dep’t 2006). However, the New York Appellate Divisions have determined that since the claimant/plaintiff has an independent right to provide notice, if he or she acts diligently in providing notice, untimely notice of the Insured prior to the injured party’s notice will not bar the injured party’s rights to recover for a judgment. Put another way, “where

If the Claimant provides its own independent notice, this notice will only be valid and overcome any late notice by the Insured if given timely. What is timely notice from a Plaintiff/Claimant is not judged as strictly as what is timely notice from an Insured. In Lauritano, the Court explained:

…”the standards by which the notice given by the injured party must be judged differ from those governing notice given by the insured. The statute having granted the injured person an independent right to give notice and to recover thereafter, he is not to be charged vicariously with the insured’s delay...When the injured party has pursued his rights with as much diligence “as was reasonably possible” the statute shifts the risk of the insured’s delay to the compensated risk-taker who can initially accept or reject those for whom it will bear such risks.

The injured person’s rights must be judged by the prospects for giving notice that were afforded him, not by those available to the insured. What is reasonably possible for the insured may not be reasonably possible for the person he has injured. The passage of time does not of itself make delay unreasonable. Promptness is relative and measured by circumstance. Thus, in Solomon v. Continental Fire Ins. Co. (160 N. Y. 595) notice given a considerable time after the event insured against had occurred, but within three days after plaintiff, an assignee of the original insured, was able to ascertain the identity of the insurer, was held to be timely. In Greenwich Bank v. Hartford Fire Ins. Co. (250 N. Y. 116, 131) it was held, although the policies required immediate notice, that notice given by a receiver of an insured corporation, as soon as he learned of the existence of insurance policies and the names of the insurers, was given within a reasonable time. And in Bazar v. Great Amer. Ind. Co. (306 N. Y. 481, 489) it was observed that a notice given to a liability insurer over 20 months after an accident would not have been untimely in the absence of prior knowledge, had the notice been in writing. Notice can hardly be given until there is knowledge of the facts upon which notice can be predicated (Trippe v. Provident Fund Soc., 140 N. Y. 23).

In determining whether an injured plaintiff provided timely notice, the Court considers whether the plaintiffs pursued their rights under §3420(a)(3) by attempting to identify and provide notice to the appropriate insurer “with as much diligence as was reasonably possible.” Becker v. Colonial Coop. Ins. Co., 24 A.D.3d 702, 704 (2d Dept. 2005) (internal citations and quotes omitted). In NGM Ins. Co. v. SHB Construction, Inc., 2012 N.Y. Misc. LEXIS 837 (N.Y. 2012), the Court upheld an insurance carrier’s denial of coverage to its insured and to the plaintiff for both of their late notices. The Court pointed out that the Plaintiff did not take any concrete steps to ascertain the identity of the insurance carrier. The Plaintiff had waited 47 days after receiving a copy of the Insurer’s denial letter to the Insured (and about 2 years from the date of accident) before providing his own notice to the Insurer. The Court found that the Plaintiff’s own notice was untimely since the Plaintiff did not act diligently to provide his own notice. See also Golebiewski v National Union Fire Ins. Co. of Pittsburgh, PA, 32 Misc. 3d 1210A (N.Y. 2011); Spentrev Realty Corp. v. United Nat’l Specialty Ins. Co., 28 Misc. 3d 1211A (N.Y. 2010).

The sufficiency of notice by an injured party is governed not by mere passage of time but by the means available for such notice. “[T]he injured party’s reasonable time within which to give notice is measured from when he or she obtained sufficient information to enable him or her to
provide notice or from when, through the exercise of due diligence, the injured party should or could have obtained such information.” Mc-Cabe v. St. Paul Fire and Mar. Ins. Co., 25 Misc.3d 726, 737, 884 N.Y.S.2d 75 (Sup. Ct. Erie Co. 2009) (emphasis added). Put another way, “where the injured person proceeds diligently in ascertaining coverage and in giving notice, he [or she] is not vicariously charged with any delay by the assured.” Tower Ins. Co. of N.Y. v. Lin Hsin Long Co., 50 A.D.3d 305, 309-310, 855 N.Y.S.2d 75 (1st Dep't 2008). Further, the injured party bears the burden of demonstrating that it made reasonable efforts to identify the insurer and provide it with prompt notice. Nationwide Mut. Fire Ins. Co. v Maitland, 79 A.D.3d 1348, 1351, 915 N.Y.S.2d 180 (3d Dep't 2010).

Whether the plaintiff’s efforts to notify the insurer were reasonable under the circumstances often presents an issue of fact. See e.g., Allstate Ins. Co. v. Marcone, 29 A.D.3d 715, 717-718, 815 N.Y.S.2d 235 (2d Dep't 2006), in which the court could not determine as a matter of law whether “Iossa was required to undertake more aggressive means of locating Marcone, ascertaining his insurance coverage, and notifying his insurer of the hunting accident [even though] Iossa’s attorney attempted to obtain information about Marcone from the police, and expressly requested in two letters reasonably designed to reach Marcone that he provide the required notice to his insurer. See also Nationwide Mut. Fire Ins. Co. v Maitland, 79 A.D.3d 1348, 1351, 915 N.Y.S.2d 180 (3d Dep't 2010) (“Here, within a few weeks of being diagnosed with herniated disks and advised of the need for surgery, Turner retained an attorney. Her attorney promptly engaged the services of a private investigator, but the investigator was unable to locate or speak with Maitland. After ascertaining that Turner had a viable claim, Turner's attorney immediately requested in a May 1, 2007 letter, and again in an October 2007 letter, that Maitland provide notice to his insurer and to contact him if he was not insured. Under these circumstances, the reasonableness of Turner’s actions in attempting to provide notice to plaintiff presents a question of fact for the jury to resolve.”); U.S. Underwriters Ins. Co. v. Carson, 49 A.D.3d 1061, 1064, 853 N.Y.S.2d 700 (3d Dep't 2008) (“Here, the record reveals that after being retained by Check's estate, Reynolds undertook a thorough investigation to ascertain the circumstances of the accident and the potentially responsible parties. Once he concluded that Carson bore potential liability, he promptly sent Carson a letter on January 7, 2003 advising him of the same. In addition, Reynolds contacted various insurance companies with whom Carson had coverage before he determined on March 3, 2003 that plaintiff wrote the policy covering the claim. Only a few weeks later, on March 19, 2003, Reynolds sent plaintiff written notification of the claim. As with the notice provided by Carson, we find that the reasonableness of the actions of Check's estate in providing notice also present a question of fact.”)

However, Courts will grant summary judgment in favor of an insurer as a matter of law where the identity of the defendant’s insurer was easily discoverable and the plaintiff made no effort to discover it. See e.g., Serravillo v. Sterling Ins. Co., 261 A.D.2d 384, 385, 689 N.Y.S.2d 521 (2d Dep't 1999) (“At bar, the nine-month delay in giving notice of the accident and the five-month delay in giving notice of the underlying action, in the absence of excuse or mitigating factors, and in light of the close family relationship between the injured plaintiff and the insureds, was unreasonable as a matter of law”); Rodriguez v. Liberty Mut. Ins. Co., 214 A.D.2d 366, 625 N.Y.S.2d 489, 490 (1st Dep't 1995) (“Plaintiff failed to give defendant notice of his claim "as soon as was reasonably possible" (Insurance Law § 3420 [a] [4]), given that the policy was listed
on the multiple dwelling registration form filed by the insured in 1982 with the Department of Housing Preservation and Development, the injury was sustained in June 1985, the underlying action was commenced in June 1988, plaintiff's default judgment in the underlying action was entered in August 1991, and plaintiff's attorney first advised defendant [insurer] of the claim when he informed it of the default judgment in October 1991.

In addition, Courts will grant summary judgment in favor of an insurer where Plaintiff’s efforts are directed toward locating the defendants or requesting that the defendant notify its insurer, rather than efforts to notify the insurer itself. See e.g., Spentrev Realty Corp. v. Untied Natl. Specialty Ins. Co., 28 Misc. 3d 1211(A), 911 N.Y.S.2d 696 (Sup. Ct. Kings Co. 2010), aff’d, 90 A.D.3d 636, 933 N.Y.S.2d 725 (2d Dept. 2011) (“In the case at bar, Martinez [the injured party] did not make any attempt to independently ascertain the identity of the insurer. In fact, Martinez’s pre-action letter to Spentrev only requested that Spentrev notify it insurer. It did not request Spentrev to notify Martinez of the identity of the insurer.”). In addition, in Tower Ins. Co. of N.Y. v. Lin Hsin Long Co., 50 A.D.3d 305, 309-310, 855 N.Y.S.2d 75 (1st Dep’t 2008), the Appellate Division, First Department reversed a decision of the lower court that had held there was an issue of fact as to whether the notice provided by the injured plaintiff the timely. The Appellate Court explained:

With regard to the issue of reasonable diligence, shortly after the accident, Theodoratos' counsel made inquiries with both the Westchester County Department of Health and the SLA, seeking “the name and address of the licensee” of the premises where the accident occurred; no request for information regarding the insurer of the licensee was requested from these agencies or anyone else. The plain language of the requests shows that Theodoratos' counsel was seeking to ascertain the identity of the licensee of the premises, not the licensee's insurer, and thus these requests do not evince reasonable diligence by Theodoratos' counsel in seeking to identify plaintiff. For the same reasons, the mere request for a copy of the police report regarding the accident generated by the New Rochelle Police Department does not evince reasonable diligence.

Even more importantly, however, Theodoratos' counsel's letter to the insured simply "suggest[ed]" that the insured forward the letter to its insurance carrier. Counsel's subsequent letter stated only that "a prompt response from [the insured's] insurance company would be appreciated." Neither letter is sufficient to raise a triable issue of fact regarding whether Theodoratos exercised reasonable diligence. Indeed, the undisputed fact that Theodoratos' counsel never even requested from the insured the name of its insurance carrier (nor undertook additional efforts to identify the carrier) compels the conclusion that Theodoratos did not exercise reasonable diligence.

More recently, in Castlepoint Ins. Co. v. Anlovi Corp., 2013 N.Y. Misc. LEXIS 1621 (Sup. Ct. N.Y. Co. 2013), the court, relying on Tower and Spentrev, held that the injured party did not act diligently in notifying the insurer of its claim where its January 27, 2009 letter simply asked the insured to notify its insurer, but did not ask for the identity of the insurer and its April 7, April 17 and June 9 letters to the insured also failed to request the identity of the insurer. According to the court, while “these letters, over a five-month period, demonstrate that [the plaintiff] hoped that insurance existed … they do not demonstrate any independent effort at all to demonstrate the insurer’s identity.”

On the other hand, in Golebiewski v National Union Fire Ins. Co. of Pittsburgh, P.A., 101 A.D.3d 1074, 1076-1077, 958 N.Y.S.2d 161 (2d Dep't 2012), notice was timely as a matter of
law where the insured failed to disclose the existence of its excess policy during discovery in the underlying action and plaintiff notified the excess carrier just prior to trial on the same day that they learned of the existence of the excess policy.

**Notice To An Agent or Broker**

(a) (3) A provision 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 this state, with particulars sufficient to identify the insured, shall be deemed notice to the insurer.

Notice to a licensed agent of an Insurer under Insurance Law 3420 is notice to the Insurer. Therefore, providing notice to an Insurer’s Underwriting Agent is notice to an Insurer, but notice to the Insured’s own Broker or to a Wholesale Broker with no agency/authority for the Insurer is not notice to the Insurer. As one Court has explained: “The insured failed to demonstrate a valid excuse for its delay in notifying plaintiff of the occurrence. Notice to a broker cannot be treated as notice to the insurer since the broker is deemed to be the agent of the insured and not the carrier.” *Tower Ins. Co. of N. Y. v. Mike’s Pipe Yard & Bldg. Supply Corp.*, 2006 NY Slip Op 9518, 1-2 (1st Dept. 2006). In *Gershow Recycling Corp. v. Transcontinental Ins. Co.*, 22 A.D3d 460, 462, 801 N.Y.S.2d 832 (2d Dept. 2005), the Appellate Division, Second Department, held that “it is well settled that notice to a broker cannot be treated as notice to the insurer since the broker is deemed to be the agent of the insured and not the carrier.” Commenting on the common practice of an insured only notifying its broker, as opposed to notifying its carrier, the Court observed:

“We recognize that it is common practice for insureds to notify their brokers, rather than their carrier, in the event of a claim or lawsuit. However, we emphasize that insureds do so at their peril since the law is clear: the policy requirement that notice must be provided to the carrier trumps any informal agreement or practice engaged in between insureds and their brokers.” *Id.* at 462.

**LATE NOTICE**

**The Time Period for an Insured to Provide Notice**

Some notice provisions, statutes or regulations specify a certain amount of time for notice to be given, such as the New York PIP regulations, which require notice within thirty (30) days. If the time to give notice is not specified, the amount of time is a factual issue determined by a reasonable standard; specifically, when would a reasonable insured give notice under the same circumstances.

The time to give notice incepts from when the insured has the requisite knowledge of the occurrence, claim or suit. Even though New York does not have a “bright line” test as to what is late notice, there are decisions in which the Courts have held that notice given just a week or two late is a breach of the notice conditions. For example, the Court of Appeals has held that notice provided as little as ten to fifty one days is late. *Deso v. London & Lancashire Indem. Co.*, 3 N.Y.2d 127 (1957), see also *Haas Tobacco Co. v. American Fidelity*
Co., 226 N.Y. 343 (N.Y. 1919). Since the timing of notice is an issue or reasonableness, the issue is often a question of fact, particularly if the delay in providing notice is only a few weeks to a few months late. However, if the notice is several months late, the Courts may find there was a breach of the notice conditions as a matter of law. See, e.g., People v. Helsinki, 203 A.D.2d 672, (3d Dept. 1994), (15 month delay was a breach of the notice condition); Holmes v. Morgan Guaranty & Trust Co. of New York, 636 N.Y.S.2d 778 (1st Dept. 1996), (ten month delay in forwarding litigation papers was unreasonable as a matter of law); Town Board v. Town of Poughkeepsie v. Continental Ins. Co., 213 A.D.2d 475 (2d Dept. 1995), (13 month delay in giving notice was a breach of the policy condition.)

If the Policy requires that notice is to be written, then oral notice will not satisfy the notice condition. Shaw Temple A.M.E. Zion Church v. Mt. Vernon Fire Ins. Co., 199 A.D.2d 37, (2d Dept. 1993) (nine month delay in providing written notice was a breach, despite the fact it was claimed prompt oral notice was given to the broker, who allegedly told the insured the insurer would be notified).

**When the Insured Breaches Its Notice Obligations**

**Statutory Prejudice Rule Created By Insurance Law 3420**

(a) No policy or contract insuring against liability for injury to person, except as provided in subsection (g) of this section, or against liability for injury to, or destruction of, property shall be issued or delivered in this state, unless it contains in substance the following provisions or provisions that are equally or more favorable to the insured and to judgment creditors so far as such provisions relate to judgment creditors:

***

(4) A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, an injured person or any other claimant if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as was reasonably possible thereafter.

(5) A provision that failure to provide timely notice has prejudiced the insurer, except as provided in paragraph four of this subsection. With respect to a claims-made policy, however, the policy may provide that the claim shall be made during the policy period, any renewal thereof, or any extended reporting period, except as provided in paragraph four of this subsection. As used in this paragraph, the terms "claims-made policy" and "extended reporting period" shall have their respective meanings as provided in a regulation promulgated by the superintendent.

***

(c)

***

(2)

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

(C) 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.

Policies and Claims to Which the Rule is Applicable

Insurance Law 3420 creates a Statutory Prejudice Rule that permits an Insurer to deny coverage only for late notice only if it was prejudiced. This rule only applies to Claims for bodily injuries, death or property damages and only applies to Policies issued on or after January 17, 2009.

The Proof of Prejudice Required

The Insurer must prove it was materially prejudiced in its ability to investigate or defend the claim. Moreover, the burden of proving the material prejudice depends upon the length of the delay in notice. If the notice is less than two years late, the Insurer must prove it was materially prejudiced. If the notice is more than two years late, the burden shifts to the insured, injured person or claimant to prove that the insurer was not prejudiced by the late notice. Further, if a Court of competent jurisdiction or a binding arbitration has determined the Insured’s liability, or if the insured has settled or reached another compromise of the claim or suit, then there is an irrebuttable presumption of prejudice.

There is little guidance as to what constitutes the material prejudice that an Insurer must prove when the notice is less than two years late. The Statute specifies that an 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. Since the enactment of Insurance Law 3420, there are no reported decisions considering what rises to the necessary impairment of the investigation or defense to be material prejudice. Is it the death of a witness or will the fact that a witness moved out of State suffice to be material prejudice? Is it the loss of an opportunity to view the accident scene or is it the absence of any evidence, such as photos, of an accident scene?

Other States that require material prejudice apply a very restrictive interpretation and tend to find materiality only when there are significant losses of the insurer’s rights, such as a complete loss of relevant testimony or the right to defend the insured against a claim. For example, in Merrimack Mut. Fire Ins. Co. v. Selby, 2009 Conn. Super. LEXIS 3202 (Conn. Super. Ct. Dec. 8, 2009), the court found a question of fact as to whether the carrier had suffered material prejudice where the home owner did not report the fall by the claimant on a stairwell in her home for two years. The evidence indicated that the insured likely knew of the fall at the time it occurred, since the claimant was removed from the premises via ambulance, but did not report the matter until a default had been entered against her. In addition, the insured had sold the home and the new owners had removed and replaced the stairwell at issue. Notwithstanding, the court opined that where there had been testimony from the listing agent that described the stairwell, it could not be certain that the insurer had suffered material prejudice. Further, since the plaintiff was
willing to set aside the default and allow the insured to defend itself, the carrier could not sufficiently demonstrate prejudice.

Material prejudice to defend against a claim for many States requires the complete loss of any right to defend the Insured, such as when there is a default judgment entered that is subject to no further appeals. Thus, by way of example, in Connecticut, an Insured will not be able to disprove material prejudice to an insurer when the insured has provided notice after the Court has entered a default judgment against it. Wagner v. General Accident Ins. Co. of Am., 1997 Conn. Super. LEXIS 184 (Conn. Super. Ct. Jan. 27, 1997). However, the New York legislature must have intended something less than a default judgment to be material prejudice since under the Statute if there is a default judgment, there is an irrebuttable presumption of prejudice.

Therefore, what constitutes material prejudice to an Insurer for the investigation or defense of a claim remains for decision by the New York Courts.

Other issues raised by the new statutory prejudice law remain for decision by the Courts. For example, what is a liability determination for there to be an irrebuttable presumption of prejudice? If notice is after the default motion, but prior to the entry of a default order, it would appear that the irrebuttable presumption does not arise since there is no court determination yet of liability. Indeed, in American Tr. Ins. Co. v. Hashim, 68 A.D.3d 618 (1st Dep’t 2009), leave for appeal denied, 14 N.Y.3d 708 (2010), the court considered the issue of prejudice under the common law rule, which requires an Insurer prove prejudice, if it has received late notice of a suit after having timely notice of the occurrence and claim. The court found that: “Plaintiff has not demonstrated prejudice by reason of the late notice of the underlying action. Plaintiff was notified of the legal action after the motion for a default judgment was made, but before the July 28, 2006 order scheduling an inquest. It could have appeared, opposed the motion, and filed for leave to file a late answer, but pursued none of those options.” Id. at 619. However, what if there is an order of default, but the order remains subject to a possible appeal and/or remains subject to an inquest before a judgment is imposed? Is this a determination of liability for the presumption to arise?

Thus, the application of the new statutory prejudice rule and its shifts in the burdens of proof remain for court decision. However, Insurers do need to be cautious in their approach and remember that a jury will determine any issue of fact regarding whether the Insurer has been materially prejudice and a jury is unlikely to be sympathetic to an insurer attempting to avoid coverage for a procedural issues such as late notice. Therefore, it is advisable to only deny for late notice given prior to two years or prior to a judgment on liability if there is clear and strong evidence of information, documents, witnesses or defenses that are no longer available.

New York’s Common Law No-Prejudice Rule

If a liability policy was issued prior to January 17, 2009, if the Policy at issue is not a liability policy or if the claim is not for bodily injuries, death or property damages, then the Statutory Prejudice Rule created by Insurance Law 3420 is inapplicable. Instead, New York’s “Common Law No Prejudice” Rule applies. The New York Court of Appeals, the state’s highest court, established the “No Prejudice Rule” in the case Security Mut. Ins. Co. v Acker-Fitzsimons Corp.,
31 NY2d 436, 440 (1972). Under this Rule, if the insured fails to give timely advice of an occurrence, claim or suit, no coverage is owed, regardless of actual proof of prejudice. Security Mutual Ins., Id. The Court explained the rationale for this rule as follows:

“the requirement of prompt notice of any occurrence that ‘may result in a claim’ should not be interpreted in a way that the insurer is compelled to relinquish its right to prompt notice and all the benefits that accrue therefrom—a timely investigation and the opportunity, if appropriate, to dispose of the claim in its early stages, an opportunity that might be irretrievably lost in the case of delayed notice—by placing undue emphasis on the “liability assessment of one not trained or even knowledgeable in such matters.” Id. at 240.

In Security Mutual, the notice provision of the policy issued to the insured required notice “as soon as practicable” after an accident or occurrence. After a major fire occurred at the insured premises during the policy period, and the insured learned that three firemen had suffered injuries, he notified his insurance broker. The broker failed to notify the insurer because he believed that until there was more concrete evidence that a claim against the insured would be filed, the insured was under no duty to notify the insurer. It was not until nineteen months later, when the firemen actually commenced personal injury actions against the insured, that the insured finally notified Security Mutual. According to the Court of Appeals, the insured’s knowledge of the firemen’s injuries was sufficient to apprise the insured of a potential occurrence, and the delay in notifying the insurer could not be excused or explained on the basis of “lack of knowledge” or “belief of nonliability.”

The Exceptions To The Common Law “No-Prejudice” Rule

If there has been timely notice of an occurrence or claim and only untimely notice of suit, the Insurer must then prove prejudice. In 2002, the New York Court of Appeals affirmed a decision that held that where there has been timely notice of the occurrence and claim, and only untimely notice of an SUM suit, the untimely notice of the suit is not a breach of the policy conditions that precludes coverage, unless the insurer was prejudiced by the late notice. Brandon v. Nationwide Mut. Ins. Co. 284 A.D.2d 886 (3d Dept. 2001) affirmed, 2002 NY Lexis 977 (N.Y. 2002). The Courts have expanded Brandon to apply to any late notice of suit following timely notice of an occurrence and claim. See, City of New York v. Cont’l Cas. Co., 2005 NY Slip Op 9469 (1st Dept. 2005); American Tr. Ins. Co. v. B.O. Astra Mgt. Corp., 2006 NY Slip Op 26169 (Supreme Ct., N.Y. County 2006).

Reasonable Excuse For Late Notice of an Occurrence

If an insured has a reasonable excuse for its untimely notice of an occurrence, it may avoid the loss of coverage for the breach of the policy notice conditions. “Absent a valid excuse, the failure to comply with the notice requirement vitiates the policy, and an insurer need not demonstrate prejudice before it asserts the defense of noncompliance.” Quality Investors, Ltd. v. Lloyd’s London, Eng., 11 A.D.3d 443 (2d Dept. 2004).

This reasonable excuse exception results in part from the Notice Condition provision that notice of an occurrence is to be provided when the Insured has reason to expect a claim to result. What the New York Courts consider to be a reasonable excuse was thoroughly reviewed by a trial level
The obligation to give notice as soon as practicable of an occurrence that may result in a claim is measured by the yardstick of reasonableness and it has generally been held that a failure to give notice may be excused when an insured, acting as a reasonable and prudent person, believes that he is not liable for the accident. The duty to give notice arises when, from the information available relative to the accident, an insured could glean a reasonable possibility of the policy’s involvement. It also bears noting that the insured bears the burden of proving, under all the circumstances, the reasonableness of any delay in the giving of notice.


As is evident by the above review by the court, New York Courts have held that the Insured has a reasonable excuse when there are facts indicating that there was no serious injury or damages or no indication that a claim would result, but not when the Insured’s only excuse is that it did not believe it would be liable. For example, in Argentina v. Otsego Mutual Fire Insurance Company, 631 N.Y.S. 2d 125 (N.Y. 1995) the New York Court of Appeals found that the Insured had a reasonable excuse for late notice because although the claimant was seen in the emergency room, the Insured had no reason to believe that permanent ongoing injury had occurred, even after making inquiries following the accident. Further, there was a close familial relationship between the claimant and the insured, which led the insured to believe that the claimant would have apprised them had he intended to bring a lawsuit.

The Courts will usually not permit an Insured to avoid the loss of coverage for late notice of a claim or suit. Indeed, the Courts will not permit an Insured to excuse a late notice of suit due to a failure to receive the suit after it had been served on the Secretary of State. Courts have said that because the Insured has the obligation to maintain a current address with the Secretary of State and because the Secretary of State is the agent for notice, once the Secretary of State has received the suit, the Insured is deemed to have the knowledge requisite to giving notice. See Briggs Ave. LLC v. Insurance Corp. of Hannover, 2008 N.Y. Slip. Op. 9004, 1 (N.Y. 2008), in which New York Court of Appeals, in answer to a certified question posed by the Federal Second Circuit Court of Appeals, held that the fact that the Insured did not receive actual...
knowledge of the suit because of its failure to maintain a current address with the Secretary of State was not an excuse for late notice to an insurer. The Court further explained that:

[The Insured] argument is essentially that its mistake was understandable [failure to keep its address current with the Secretary of State]; that it caused no prejudice to the insurer; and that the loss of insurance coverage is a harsh result. All this may be true, but it is irrelevant. We have long held, and recently reaffirmed, that an insurer that does not receive timely notice in accordance with a policy provision may disclaim coverage, whether it is prejudiced by the delay or not …While this rule produces harsh results in some cases, it also, by encouraging prompt notice, enables insurers to investigate claims promptly and thus to deter or detect claims that are ill-founded or fraudulent. The Legislature, weighing the competing interests at stake, has recently enacted legislation that strikes a different balance, more favorable to the insured (see L 2008, ch 388, §§ 2, 4 [amending Insurance Law § 3420, applicable to policies issued after January 17, 2009]), but that legislation has not yet become effective. The common law no-prejudice rule applies to this case. Id. citing (Argo Corp. v. Greater N.Y. Mut. Ins. Co., 4 NY3d 332, 339, 827 N.E.2d 762, 794 N.Y.S.2d 704 [2005];

An insured’s provision of a bordereaux or loss run (a listing of claims) is not fulfillment of the notice condition and will not provide the Insured with an acceptable/reasonable excuse for failing to give timely notice. In Steadfast Insur. Comp. v. Sentinel Real Estate Corp., 727 N.Y.S. 2d 393 (1st Dept. 2001) the Court held that periodic loss runs sent in conformance with a “Self-Insured Retention” reporting obligation did not satisfy the notice condition.

An Insured’s broker’s failure to timely provide notice after receiving timely notice from the Insurer is also not a reasonable excuse. Too often a broker receives timely notice from its client, the Insured, but fails to pass this notice on to the Insurer. The Courts have held that this failure is not a reasonable excuse for late notice. See Martini v. Lafayette Studios Corp., 177 Misc.2d 383, 676 N.Y.S.2d 808 (N.Y. 1998) (delay caused by the insured’s broker error did not relieve the insured of its obligation to timely notify the insurer of the claim). The only situation where a broker’s error will excuse an insured from providing timely notice is if the broker had a good faith belief that there was no coverage under the policy, and the insured relied upon such relief. See, e.g., Sparacino v. Pawtucket Mut. Ins., 50 F.3d 141 (2d Cir. 1994), in which the insured union relied upon its broker’s statement that the insurer did not owe coverage for the claim at issue, a rock throwing incident. The Court explained that: “Although the broker was apparently mistaken in his interpretation of the scope of the insurance contract, it was reasonable for the Union to rely on the statement and to believe that the policy did not cover any aspect of the rock-throwing incident. We conclude that the Union’s belief in noncoverage was reasonable under the circumstances presented here.” Id.

In addition, the Courts have repeatedly held that notice to the wrong insurer is not a reasonable excuse for an Insured’s breach of the notice conditions. As one Federal Court has stated in citing to New York law, “Negligence in notifying the wrong insurer does not excuse failure to give notice to the proper one.” Gardner-Denver Co. v. Dic-Underhill Constr. Co., 416 F. Supp. 934 (S.D.N.Y. 1976). In Gardner-Denver, the Court explained that: “the law in New York seems to be that timely notification to another insurer does not excuse failure to notify the insurer being sued as soon as practicable.” See also, Big Lift Shipping Co., (N.A.), Inc. v. Bellefonte Ins. Co., 594 F. Supp. 701 (S.D.N.Y. 1984), in which the insured had two insurers, each of which provided coverage for different property damaged in the loss. One insurer covered the cargo and
the other the damaged vessel. The Court held that notification to the wrong insurer did not excuse a 20-month delay in notice to the correct insurer.

Although the Courts have examined the reasonable excuse issue under Policies governed by the New York Common Law “No Prejudice Rule”, there is no reason to assume the Courts will not permit the same excuse and apply the same analysis for an Insurer’s late notice governed by the Statutory Prejudice Rule.

**REQUIREMENTS FOR DENIALS OF COVERAGE**

*(d) (2) If under a liability policy issued or delivered 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.*

Insurance Law 3420 only governs denials for Liability Policies which are for:

1. **Claims for bodily injuries or death.**


2. **For accidents that occur in New York.**

   The timely denial requirement only applies to bodily injury or death claims from an accident that occurred in New York. See, *Brennan v. Liberty Mut. Fire Ins. Co.*, 204 A.D.2d 675 (2d Dept. 1994), holding that: “Since the accident in this case occurred in Florida, Insurance Law 3420(d) is inapplicable.” *Id.*

3. **Policies issued or delivered in New York.**

   See, *First City Acceptance Corp. v. Gulf Ins. Co.*, 245 A.D.2d 649 (3d Dept. 1997) holding that because the policy at issue was issued and delivered in Massachusetts, the statute did not apply. However, when the Insured has locations in many States, the Courts will liberally find that the Policy was issued or delivered in the State. For example, in *American Ref-Fuel Co. v. Employers Ins. Co.*, 265 A.D.2d 49 (2d Dept. 2000) the court rejected the Insurer’s argument that the statute did not apply because: “the policies listed, as a named insured, the plaintiff, which is a New York corporation located in and performing work in New York. The fact that the policies also covered other corporations operating in other States and the happenstance that the policies were countersigned and actually delivered in another State is not determinative. Rather, the location of the insured and the risk to be insured are determinative. We further note that the claim was for bodily injury resulting from an accident occurring within this State.” Also see, *Columbia Casualty Comp. v. National Emergency Services, Inc.* 723 NYS2d
20

473 (1st Dept. 2001), in which the court held that the Statute applied when the Insured and certain risks were in New York, even though the corporate headquarters and the issuance of the Policy were outside New York.

**Time To Deny**

If Insurance Law § 3420 applies, then according to the Courts, the Insurer has as little as thirty days from when it has knowledge of the grounds for coverage to deny coverage. See, First Financial Ins. Co. v. Jetco Contracting Corp., 1 N.Y.3d 64 (N.Y. 2003) (48 days is unreasonable as a matter of law); West 16th St. Tenants Corp. v. Public Serv. Mut. Ins. Co., 290 A.D.2d 278 (1st Dept. 2002) (30 days is untimely where there is no other basis for the denial); Dryden v. Greasor, 702 N.Y.S.2d 479 (4th Dept. 2000) (27 day delay is timely as a matter of law).

Courts will permit additional time, if the Insurer has a reasonable basis to conduct an investigation and conducts it with due diligence. Central Mutual Fire Insur. v. Majid, 773 NYS2d 429 (2d Dept. 2004); Banner Casualty Company v. Nationwide Insur. Comp. 454 NYS2d 264 (Kings County, 1982).

If the information received suffices to raise a coverage defense, then the Courts will not permit additional time for an investigation, even if the investigation is to be able to deny on other grounds. For example, the Courts have held that if the Insured’s breach of the notice condition (its late notice) is apparent from the inception, then there is no need to investigate and the failure to timely deny will waive the insurer’s rights to deny coverage. Nova Casualty Comp. v. Charbonneau Roofing, Inc. 585 NYS2d 876 (3d Dept. 1992). Indeed, when late notice is apparent, a reservation of rights is insufficient and an insurer must deny or lose its rights to do so if it reserves its rights, rather than immediately deny coverage. See, Mohowk Minden Insur. Comp. v. Ferry 674 NYS2d 512 (3d Dept.1998); Aetna Life & Casualty Company 652 NYS2d 73 (2d Dept. 1997). One Court has explained:

we begin with the statutory language, which, on its face, requires the insurer to disclaim "as soon as is reasonably possible." This plain language cannot be reconciled with allowing the insurer to delay disclaiming on a ground fully known to it until it has completed its investigation (however diligently conducted) into different, independent grounds for rejecting the claim. If the insurer knows of one ground for disclaiming liability, the issuance of a disclaimer on that ground without further delay is not placed beyond the scope of the "reasonably possible" by the insurer's ongoing investigation of the possibility that the insured may have breached other policy provisions, that the claim may fall within a policy exclusion, or (as here) that the person making the claim is not covered at all. Stated otherwise, the statute mandates that the disclaimer be issued, not "as soon as is reasonable," but "soon as is reasonably possible" (emphasis added). George Campbell Painting v National Union Fire Ins. Co. of Pittsburgh, PA, 92 A.D.3d 104, 111 (N.Y. App. Div. 1st Dep't 2012)

The difficulty is that a denial should raise all grounds for a denial of coverage and the defenses for which an investigation is needed are not raised, then the right to deny upon those defenses may be lost. A reservation of rights may not suffice to protect those defenses. Therefore, it is advisable to either conduct the investigation and get out the denial upon all grounds within the thirty days of the original notice or couch the denial to be upon all grounds. For example, if the
denial is for late notice and another exclusion may also apply, such as the Employer’s Liability Exclusion, but the facts are not yet known, explain that the denial of coverage is for breach of the notice conditions. In addition, the Insurer denies coverage pursuant to the Employer’s Liability Exclusion, if the Plaintiff was an employee of the Insured.

**Who Must Be Advised Of The Denial**

The denial must be issued to each tendering insured, including additional insureds. Thus, if coverage is denied to the insured, it is necessary to advise the additional insureds who may be claimants against the Insured for indemnification or contribution. If coverage is being denied to an additional insured, then you must advise the additional insured timely and directly. *Consolidated Edison Company v. USF&G* 693 NYS2d 31 (1st Dept. 1999).

Moreover, any coverage denial subject to Insurance Law § 3420 must be advised to all Plaintiffs or Claimants. Failure to timely advice a Claimant/Plaintiff can result in the loss of the right to deny coverage for any judgment that the Claimant/Plaintiff may have against the Insured.1 See, *Garay v. Nat’l Grange Mut. Ins. Co.*, 2004 U.S. App. LEXIS 24086 (2d Cir. 2004.)

If the denial of coverage to the Insured is for late notice and the Plaintiff provides its own notice of the occurrence, claim or suit, an Insurer will only be permitted to deny payment of an unpaid judgment to the Plaintiff/Claimant if it has timely denied coverage to the Plaintiff for the Plaintiff’s own untimely notice. *Colon v. N.Y. Mut. Fire Ins. Co.*, 2005 NY Slip Op 50782U (2d Dept. 2005.) Thus, once a Plaintiff/Claimant has provided its own independent notice, the insurer may only deny any obligations to provide payment of any judgment to the Plaintiff/Claimant if the Plaintiff/Claimant has failed to diligently provide his or her own notice and if the insurer timely denies any such obligations to the Plaintiff/Claimant. *Vacca v. State Farm Insurance Co.* 15 A.D.3d 473 (2d Dept. 2005).

**Denial Of Coverage To Another Insurer**

The Courts have held that section 3420 (d) is not applicable to a request for contribution between co-insurers. See *Tops Mkts. v Maryland Cas.*, 267 AD2d 999, 1000, (4th Dept. 1999). Thus, an untimely denial will not cause an Insurer to lose the right to raise coverage defenses against an Insurer looking for shared coverage. However, if the Insurer is tendering for coverage to an Insurer on behalf of an Insured, then it appears an untimely denial is subject to preclusion under 3420(d). *JT Magen v. Hartford Fire Ins. Co.*, 2009 NY Slip Op 3851 (1st Dep’t 2009); *Bovis Lend Lease LMB, Inc. v. Royal Surplus Lines Ins. Co.*, 27 A.D.3d 84, 92-93 (1st Dep’t 2005). There is little case law on this issue, however, and there is no bright line to determine whether an insurer is tendering for co-insurance or on behalf of its insured.

---

1 Insurance Law 3420 permits Plaintiffs to bring direct actions against an Insurer for collection on an unpaid judgment against an Insured.
The Policy Provisions Subject To Insurance Law 3420 Denial Rules

There is no provision in the Statute limiting the requirements for denials to certain of the Policy provisions. However, the Courts have indicated that if an Insurer fails to comply with the Insurance Law 3420 requirements, the Insurer is precluded from relying on Exclusions or Conditions for the denial of coverage. The Insurer is not, however, precluded from raising the Insuring Agreement, such as Coverage A or Who is an Insured. This issue is discussed more thoroughly below. Therefore, if the denial is based upon an exclusion or condition, the requirements of Insurance Law 3420 apply. If the denial is based upon the Insuring Agreement or other Coverage provisions, there is no requirement need to comply, but it is recommended to assure that no issues arise.

The Contents Of The Denial Letter

The letter must be in writing. Further, the coverage position must be clear and properly explain the basis for the disclaimer, with citations to the applicable policy provisions. See, e.g. Zurich Insur. Comp. v. Lumbermen’s Casualty Company, 649 NYS2d 660 (1st Dept. 1996). All reasons for a denial must be raised or they will be lost. There are no decisions as to whether the letter to the Insured must be copied to the Injured Party or claimant. If there are no facts in the letter that can impact the Insured’s defenses or interests, then a copy of the letter can simply be sent to the Injured Party and other Claimants (or their Counsel.). If there are facts that may be detrimental to the Insured’s defense or interests, then it is best to send a separate letter to the Injured Party and other Claimants advising of the denial with recitation of the policy provisions under which coverage is being denied, but without any reference to the potentially harmful facts. Further, it is important that the letter explain the denial is for coverage to the Insured and for any payment of a judgment against the Insured. If, however, the Injured Party or other Claimant has given its own independent notice, then the letter must be addressed directly to them advising of the denial of any obligations to provide payment of any judgment that they may obtain against the Insured. The letter should spell out the reasons for this denial of payment, including the coverage defenses against the Insured and if relevant, the untimely notice by the Injured Party or Claimant.

The following is a good outline for a denial (and for reservation of rights) letter:

“CHECK”

Cite to Policy Wording
Have Correct Wording
Explain in Plain English
Clearly Explain Position
Keep Simple and Short
LOSS OF THE RIGHT TO DENY COVERAGE

The New York Courts tightly restrict the Insurer’s loss of rights under the Insuring Agreement, less tightly restrict the Insurer’s loss of rights under an Exclusion and fairly liberally allow for the Insurer’s loss of rights under a Condition, in particular the Notice Condition. There are three means by which an Insurer may lose its rights to raise policy provisions as a defense against coverage estoppel, waiver and statutory preclusion created pursuant to Insurance Law 3420.

ESTOPPEL

The loss of rights by estoppel is the most expansive and includes a possible loss of rights under the insuring agreement, exclusions and conditions. Estoppel “arises where an insurer acts in a manner inconsistent with a lack of coverage, and the insured reasonably relies on those actions to its detriment.” Chicago Ins. Co. v. Kreitzer & Vogelman, 265 F. Supp. 2d 335 (S.D.N.Y. 2004). The typical example of estoppel is when an insurer, though not in fact obligated to provide coverage, defends a case without asserting any policy defenses and as a consequence, the insured suffers the detriment of losing control over its defense. Therefore, estoppel arises where an insurer acts in a manner that is inconsistent with a lack of coverage, and the insured reasonably relies on those actions to his or her detriment. Burt Rigid Box v. Travelers Property Casualty Corp., 302 F.3d 83 (2d Cir. 2002). Moreover, for an Insurer to be estopped from raising coverage defenses, the Insured must be prejudiced. Hartford Ins. Group v. Mello, 81 A.D.2d 577 (2d Dept. 1981).

Thus, if an Insurer has been defending a claim for a period of time without any reservation of rights, it may be estopped from raising any coverage defenses under the Policy Insuring Agreement, any Policy Exclusions or Conditions. Burt Rigid Box v. Travelers Property Casualty Corp., 302 F.3d 83 (2d Cir. 2002). See also, Mount Vernon Fire Ins. v. Riccobono, 1999 U.S. Dist. LEXIS 15355 (S.D.N.Y. 1999)(“the doctrine applies when an insurer undertakes a defense ‘without asserting policy defenses or reserving the privilege to do so . . . For estoppel to apply only where the insurer unqualifiedly assumes a defense is logical, given that an insured must show reliance in order to invoke estoppel.’”).

WAIVER

In New York, waiver is a “voluntary and intentional relinquishment of a known right” and only permits a loss of rights under a Policy Condition, not an Insuring Agreement or Exclusion. Albert J. Schiff Associates, Inc. v. Flack, 435 N.Y.S.2d 972 (1980); State of New York v. Amro Realty, 936 F.2d 1420. (2d Cir. 1991). In Schiff, the Court of Appeals explained that: “where the issue is the existence or nonexistence of coverage (e.g., the insuring clause and exclusions), the doctrine of waiver is simply inapplicable.” Schiff at 975.

In a 2013 decision, K2 Inv. Group, LLC v. American Guar. & Liab. Ins. Co., 2013 N.Y. LEXIS 1461 (N.Y. June 11, 2013) the New York Court of Appeals held that due to a wrongful failure to defend the insured, the Insurer could not deny indemnity coverage upon exclusions. In some ways, the decision merely reaffirms the broad duty to defend but it appears to expand the
application of common law waiver to Exclusions, not just conditions. The Court of Appeals has agreed to hear rearguments on the decision and several Insurance Claims Organizations are submitting briefs on the issues. A decision should be forthcoming within the next few months.

**STATUTORY PRECLUSION**

Insurance Law 3420 requires an insurer to deny coverage as soon as reasonably possible. As discussed above, the requirement only applies to liability policies issued or delivered in NY and for claims for bodily injuries or death for accidents occurring in NY. If these factors exist, then the Courts hold that the failure to timely deny coverage will preclude an Insurer from raising an Exclusion or Condition as a defense against coverage. It will not preclude an Insurer from raising the Insuring Agreement as a coverage defense. In *Worcester Ins. Co. v. Bettenhauser*, 95 N.Y.2d 185 (N.Y. 2000), the Court of Appeals stated:

“Disclaimer pursuant to section 3420 (d) is unnecessary when a claim falls outside the scope of the policy’s coverage portion. Under those circumstances, the insurance policy does not contemplate coverage in the first instance, and requiring payment of a claim upon failure to timely disclaim would create coverage where it never existed. By contrast, disclaimer pursuant to section 3420 (d) is necessary when denial of coverage is based on a policy exclusion without which the claim would be covered…” Id at 189.

Thus, if the Insurer does not owe coverage because there are no “property damages” or “bodily injuries” caused by an “occurrence”, as required for most Coverage A Insuring Agreements, or because the injuries or damages did not occur during the Policy Period or because the defendant is not an Insured on the Policy, the Insurer is not constrained to deny coverage within the time requirements set forth in Insurance Law 3420 and will not be precluded from raising these coverage defenses. Accordingly, when an Insurer denies coverage to a party because that party does not qualify as an additional insured, the Insurer is not constrained to deny coverage within the time requirements set forth in Insurance Law 3420. *Nat’l Union Fire Ins. Co. v. Utica First Ins. Co.*, 775 N.Y.S.2d 175 (2d Dept. 2004). Similarly, the Insurer is not constrained by the time requirements to timely deny coverage due to cancellation of the policy. *See, Montefiore Med. Ctr. v. Liberty Mut. Ins. Co.*, 2006 NY Slip Op 5925 (2d Dept. 2006) (holding that untimely denial of PIP claim was not waived as policy was cancelled).

**PLAINTIFF’S REQUESTS FOR POLICY INFORMATION**

(d) (1) (A) This paragraph applies with respect to a liability policy that provides coverage with respect to a claim arising out of the death or bodily injury of any person, where the policy is: (i) subject to section three thousand four hundred twenty-five of this article, other than an excess liability or umbrella policy; or (ii) used to satisfy a financial responsibility requirement imposed by law or regulation.

(B) Upon an insurer’s receipt of a written request by an injured person who has filed a claim or by another claimant, an insurer shall, within sixty days of receipt of the written request: (i) confirm to the injured person or other claimant in writing whether the insured had a liability insurance policy of the type specified in subparagraph (A) of this paragraph in effect with the insurer on the date of the alleged occurrence; and (ii) specify the liability insurance limits of the coverage provided under the policy.
(C) If the injured person or other claimant fails to provide sufficient identifying information to allow the insurer, in the exercise of reasonable diligence, to identify a liability insurance policy that may be relevant to the claim, the insurer shall within forty-five days of receipt of the written request, so advise the injured person or other claimant in writing and identify for the injured person or other claimant the additional information needed. Within forty-five days of receipt of the additional information, the insurer shall provide the information required under subparagraph (B) of this paragraph.

For an Auto or Personal Lines Policy, a Plaintiff or Claimant is entitled to request and an insurer must provide within sixty days confirmation of the policy and that it was in effect on the date of
the accident, as well as the limits. There is no obligation to provide the complete policy. Although the Statute does not call for the provision of this information for commercial lines and does not call for the production of the complete policy, the insurance information and the policy are subject to disclosure in the underlying action or any coverage litigation that may be filed.

**DIRECT ACTIONS AGAINST THE INSURER**

(a) No policy or contract insuring against liability for injury to person, except as provided in subsection (g) of this section, or against liability for injury to, or destruction of, property shall be issued or delivered in this state, unless it contains in substance the following provisions or provisions that are equally or more favorable to the insured and to judgment creditors so far as such provisions relate to judgment creditors:

(2) A provision that in case judgment against the insured or the insured's personal representative in an action brought to recover damages for injury sustained or loss or damage occasioned during the life of the policy or contract shall remain unsatisfied at the expiration of thirty days from the serving of notice of entry of judgment upon the attorney for the insured, or upon the insured, and upon the insurer, then an action may, except during a stay or limited stay of execution against the insured on such judgment, be maintained against the insurer under the terms of the policy or contract for the amount of such judgment not exceeding the amount of the applicable limit of coverage under such policy or contract.

(6) A provision that, with respect to a claim arising out of death or personal injury of any person, if the insurer disclaims liability or denies coverage based upon the failure to provide timely notice, then the injured person or other claimant may maintain an action directly against such insurer, in which the sole question is the insurer's disclaimer or denial based on the failure to provide timely notice, unless within sixty days following such disclaimer or denial, the insured or the insurer: (A) initiates an action to declare the rights of the parties under the insurance policy; and (B) names the injured person or other claimant as a party to the action.

(b) Subject to the limitations and conditions of paragraph two of subsection (a) of this section, an action may be maintained by the following persons against the insurer upon any policy or contract of liability insurance that is governed by such paragraph, to recover the amount of a judgment against the insured or his personal representative:

(1) any person who, or the personal representative of any person who, has obtained a judgment against the insured or the insured's personal representative, for damages for injury sustained or loss or damage occasioned during the life of the policy or contract;

(2) any person who, or the personal representative of any person who, has obtained a judgment against the insured or the insured's personal representative to enforce a right of contribution or indemnity, or any person subrogated to the judgment creditor's rights under such judgment; and

(3) any assignee of a judgment obtained as specified in paragraph one or paragraph two of this subsection, subject further to the limitation contained in section 13-103 of the general obligations law.

**Prejudgment Direct Action**

Insurance Law 3420 permits a Plaintiff/Claimant to bring a direct action against a Defendant’s insurer prior to judgment in only one situation, when the Insurer has denied coverage for late notice. This provision applies only to policies issued after January 17, 2009 and only to claims for bodily injuries or death. The Plaintiff cannot bring the DJ, however, until at least 60 days
after the Insurer has filed the denial and then only if the Insured or Insurer have not filed a
coverage action and/or if filed, have not named the claimant in the action.

**Post-judgment Direct Action**

Insurance Law 3420 permits a Plaintiff or Defendant (or their representative or assignee) to bring
a direct action against an Insurer on any coverage issue if a judgment against the Insured
Defendant is not satisfied within thirty days following judgment. The damages must, however,
be for injuries sustained during the policy period or for contribution or indemnification for these
damages. The Statute lays out a procedure to be followed prior to filing the suit. Specifically,
the Plaintiff/Defendant must serve the Insured and Insurer with notice of entry of the judgment,
wait thirty days and then if the judgment remains unpaid and if there is no stay of execution, the
action may be filed against the Insurer.

**Defenses**

If first notice of the suit is the judgment, the Insurer can raise the Insured’s defenses as well its
own coverage defenses in the direct action. If there was earlier notice, then the Insurer can
only raise its own coverage defenses, not the Insured’s defenses. Further, in a new Court of
Appeals decision, *K2 Investment Group, LLC v American Guarantee & Liability Insurance
Company* 2013 NY LEXIS 1461 (NY, 2013) the Court determined that due to a wrongful
failure to defend the insured, the Insurer could not deny indemnity coverage upon exclusions.
Therefore, if the defense has improperly denied defense coverage despite covered allegations
or claims, it may be precluded from relying upon an exclusion or condition as a coverage
defense for indemnity coverage obligation, even if the facts show no such indemnity
obligation.
SUMMARY OF RELEVANT 3420 PROVISIONS

APPLICATION:
LIABILITY POLICIES FOR BI OR PD
ISSUED OR DELIVERED FOR ISSUANCE IN NY

NOTICE
---BY INSURED, EACH INSURED WITH OWN OBLIGATION, ONE CAN GIVE NOTICE ON BEHALF OF OTHER, MUST BE SPECIFIC OR MUST NOT BE ADVERSARIAL AND MUST BE UNITED IN INTEREST
---BY INJURED PERSON OR CLAIMANT OR THEIR REPRESENTATIVE OR ASSIGNEES
---TO INSURER OR ITS AGENT, NOT BROKER OF INSURED
---REASONABLE PERIOD OF TIME, ISSUE OF FACT UNLESS SIGNIFICANT DELAY-
COURTS MORE LIBERAL WITH INJURED PERSON OR CLAIMANT, BUT MUST PROVE DUE DILIGENCE/EFFORTS TO IDENTIFY INSURER TO GIVE NOTICE
---REASONABLE EXCUSE - IF INJURED PERSON OR CLAIMANT CAN SHOW NOT REASONABLY POSSIBLE TO GIVE NOTICE WITHIN PRESCRIBED TIME AND NOTICE GIVEN AS SOON AS POSSIBLE THEREAFTER

DENY LATE NOTICE POST 1/17/09
PREJUDICE BURDEN:
IF NOTICE LESS THAN 2 YEARS LATE-
INSURER MUST PROVE PREJUDICE
IF NOTICE MORE THAN 2 YEARS LATE-
INSURED, INJURED PERSON OR CLAIMANT MUST PROVE INSURER NOT PREJUDICED
IF INSURED’S LIABILITY HAS BEEN DETERMINED BY COURT OR BY BINDING ARBITRATION, OR
IF THE INSURED RESOLVED CLAIM BY SETTLEMENT OR OTHER COMPROMISE:
IRREBUTTABLE PRESUMPTION OF PREJUDICE
PREJUDICE = MATERIAL IMPAIRMENT TO ABILITY TO INVESTIGATE OR DEFEND

DISCLAIMER OF LIABILITY OR DENIAL OF COVERAGE
APPLICATION:
MOTOR VEHICLE OR ACCIDENT IN NY
LIABILITY POLICY – includes Excess/Umbrella, unclear if Coverage B or if PL/other
ISSUED OR ISSUED FOR DELIVERY IN NY
BI OR DEATH CLAIM

REQUIREMENTS:
IN WRITING
TO INSURED, INJURED PERSON OR OTHER CLAIMANT
AS SOON AS REASONABLY POSSIBLE, INTERPRETED BY COURTS TO BE 30 DAYS OR LESS FROM KNOWLEDGE
“CHECK”

FAILURE TO COMPLY:
PRECLUDE RELIANCE BY INSURER ON EXCLUSION OR CONDITION,
DOES NOT PRECLUDE RELIANCE ON INSURING AGREEMENT

DIRECT ACTIONS AGAINST INSURER:
PREJUDGMENT FOR NOTICE ISSUE ONLY IF NO DJ WITHIN 60 DAYS BY INSURER OR INSURED OR IF DJ NOT NAMED CLAIMANT
POSTJUDGMENT FOR ALL ISSUES THIRTY DAYS AFTER SERVE NOTICE OF ENTRY OF JUDGMENT ON INSURED AND INSURER AND REMAINS UNPAID, UNLESS STAY OF EXECUTION
DEFENSES
---IF HAD NOTICE BEFORE JUDGMENT AND AN OPPORTUNITY TO DEFEND, CAN ONLY RAISE COVERAGE ISSUES
---IF HAD NO NOTICE UNTIL AFTER JUDGMENT, CAN RAISE INSURED’S DEFENSES AND COVERAGE ISSUES