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SCAN

SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. ROY S. MAHON

Justice

AMY B. BRZOZOWSKI and PAUL BRZOZOWSKI,

Plaintiff(s),

- against -

ELIZABETH TORTORA and LOUIS B. TORTORA,

Defendant(s).

TRIAL/IAS PART 7

INDEX NO. 19573/2008

MOTION SEQUENCE NO. 1

MOTION SUBMISSION DATE: July 28, 2010

The following papers read on this motion:

Notice of Motion	**X**
Affirmation in Opposition	**X**
Reply Affirmation	**X**

Upon the foregoing papers, the motion by defendants for an Order pursuant to CPLR §3212 granting summary judgment dismissing plaintiffs' Verified Complaint on the ground that the injuries alleged by plaintiffs do not meet the "serious injury" threshold as set forth in §5102(d) of the Insurance Law of the State of New York, is determined as hereinafter provided:

This personal injury action arises out of a motor vehicle accident that occurred on July 31, 2007 at approximately 1:30 pm on Route 25 at its intersection with Underhill Boulevard, Syosset, New York.

The plaintiffs in the plaintiffs' Verified Bill of Particulars set forth:

> "As a result of the accident, plaintiff Amy B. Brzozowski's vehicle was rear-ended by the vehicle owned and operated by the defendants. The impact caused the plaintiff to be jolted forward causing injuries to her neck and back. She went to the emergency room of Syosset Hospital, complained of her back tightening up with greater pain over the mid-thoracic area, radiating to both scapulae. Plaintiff was examined and diagnosed with back contusion/sprain. She was prescribed medication for symptoms of Federbush. Following discharge from the emergency room, neck and back pain and stiffness increased and intensified.
>
> Plaintiff was examined by Dr. Federbush and referred to orthopaedist, Dr.

Ralph Parisi. She was first seen on August 15, 2007. She described experiencing severe, constant pain and difficulty with most physical activities. Her neck pain was radiating into her fingers. Dr. Parisi's examination found trapezial spasm, limited range of motion in the cervical spine and pain with motion in the lumbar spine. Dr. Parisi diagnosed cervical lumbar sprain and prescribed medication to relieve pain. She followed up with Dr. Parisi on September 11, 2007, noting that symptoms of pain had worsened and she was experiencing increased limitations of physical activities. Standing or sitting for any extended period of time was more difficult. Paravetebral spasm, diminished forward flexion and positive bi-lateral straight leg raising at 60 degrees was noted. Medrol dosepak was prescribed and an MRI was recommended as was physical therapy.

Plaintiff began physical therapy on August 21, 2007 at Precision Sports Therapy with the goal of reducing pain and restoring full use to the injured areas using a variety of active and passive modalities. Plaintiff attended physical therapy three times a week through January 2008.

A Lumbar MRI taken at the Central Orthopaedic Group on September 25, 2007 found a disc bulge at L4-5, asymmetric to the right.

Plaintiff began acupuncture treatments with Dr. James Y. Z. Wu at LI Complementary & Family Medical Care, PC in January 2008. Dr. Wu found muscle spasm in the neck and lower back with restrict cervical and lumbar range of motion and shoulder. Plaintiff continued with acupuncture through May 2008, receiving treatment approximately three times a week. She experienced intermittent relief, particularly of cervical symptoms, but it was not long lasting.

Cervical MRI taken on May 25, 2008 at North Shore Open MRI found central disc herniation at T2-3 with midline flattening of the subarachnoid space.

Referred to neurologist Dr. Itzhak Haimovic with pain, numbness and weakness in the left arm and hand. EMGs of May 28, 2008 performed by Dr. Haimovic found evidence of acute denervation in the right C7 nerve root consistent with symptoms of pain, weakness and numbness in the left arm and hand. EMGs of May 28, 2008 performed by Dr. Haimovic found evidence of acute denervation in the right C7 nerve root consistent with symptoms of pain, weakness and numbness in the left arm and hand. Lumbar EMGs were unremarkable.

At the end of May 2008, plaintiff's lumbar symptomatology noticeably worsened with pain radiating bilaterally in to the buttocks and thigh.

A Lumbar MRI of April 24, 2008 taken at Manetto Hill MRI Associates found broad disc bulges at L2-3, L3-4 and L4-5.

The plaintiff was then referred to Dr. Peter Kechejian beginning on June 5, 2008. At that time her lower back symptoms was bothering her more than her neck and upper back. Examination found compression pain over her upper

thoracic area and palpable pain in her bilateral paraspinal lumbar muscles around the L5 level. Dr. Kechijian found the plaintiff to be suffering from thoracic and lumbar radiculopathy and recommended lumbar epidural steroid injection therapy. Plaintiff proceeded to have these injections on June 7 and June 14 at North Shore Hospital in Syosset. Any relief from lumbar symptomology was not permanent.

Plaintiff began a course of treatment with chiropractor, Dr. Barry Goldstein, on June 20, 2008. Dr. Goldstein found bilateral cervical, thoracic and lumbar tenderness, bilateral spasm of cervical, thoracic and lumbar paraspinal muscles, bilateral trapezii, bilateral gluteus medius musculature and bilateral piriformis musculature. He diagnosed shoulder derangement, displacement of lumbar intervertebral displacement of thoracic intervertebral disc and pelvic sublaxation/non-allopathic lesions of the pelvic region. Plaintiff saw Dr. Goldstein through August 21, 2008. Relief was intermittent and not long lasting.

Plaintiff began treatment with Dr. Bill Akpinar, an alternative pain management specialist beginning in August 2008 and continuing through October 2008. As with other treatment sought, relief from symptoms was intermittent and brief.

Pelvic MRI and ultra sound on December 8, 2008 was not remarkable with regard to plaintiff's lower back, hip and buttock symptoms.

A Thoracic MRI of February 14, 2009 at Nassau Radiologic Group found left paracentral disc protrusion at T2-3 impinging on the left hemicord and central disc protrusion at T4-5 minimally impinging on the ventral aspect of the spinal cord.

Due to persistent symptomatology and seeking to augument prior diagnosis, plaintiff underwent a full body bone scan was prescribed on of January 26, 2009 at Nassau Radiologic Group. The scan was not unremarkable.

Most recently, the plaintiff has consulted orthopaedists, Dr. Erik Parker and Dr. Charles B. Goodwin, to see if some type of surgical intervention might be appropriate to address her condition but after examination and review of records and diagnostic testing, no such remedy can be recommended.

Plaintiff's symptoms have been persistent since the date of the accident and she has continued to seek out treatment. She has never returned to her pre-accident physical condition and subsequently has never been able to fully resume the usual activities of her daily life and those in which she does engage precipitate, without exception, the onset of greater gain and stiffness."

The defendants in support of the defendants' application submit three affirmed letter reports all dated September 18, 2009 of Comprehensive Radiology Review, PLLC by A. Robert Tantleff, MD, a radiologist of a review of MRIs of the plaintiff's lumbar spine; cervical spine and thoracic spine' an affirmed letter report dated February 11, 2010 of John C. Killian, MD, an orthopedist of an orthopedic examination of the plaintiff conducted on February 8, 2010 and an affirmed letter report dated March 9, 2010 of Island Neurological

Associates, PC by Erik J. Entin, MD, a neurologist of a neurological examination of the plaintiff conducted on March 9, 2010.

The rule in motions for summary judgment has been succinctly re-stated by the Appellate Division, Second Dept., in **Stewart Title Insurance Company, Inc. v. Equitable Land Services, Inc., 207 AD2d 880, 616 NYS2d 650, 651 (Second Dept., 1994):**

> "It is well established that a party moving for summary judgment must make a prima facie showing of entitlement as a matter of law, offering sufficient evidence to demonstrate the absence of any material issues of fact (*Winegrad v. New York Univ. Med. Center*, 64 N.Y.2d 851, 853, 487 N.Y.S.2d 316, 476 N.E.2d 642; *Zuckerman v. City of New York*, 49 N.Y.2d 557, 562, 427 N.Y.S.2d 595, 404 N.E.2d 718). Of course, summary judgment is a drastic remedy and should not be granted where there is any doubt as to the existence of a triable issue (*State Bank of Albany v. McAuliffe*, 97 A.D.2d 607, 467 N.Y.S.2d 944), but once a prima facie showing has been made, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish material issues of fact which require a trial of the action (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324, 508 N.Y.S.2d 923, 501 N.E.2d 572; *Zuckerman v. City of New York, supra*, 49 N.Y.2d at 562, 427 N.Y.S.2d 595, 404 N.E.2d 718)."

It is noted that the question of whether the plaintiff has made a prima facie showing of a serious injury should be decided by the Court in the first instance as a matter of law **(see Licaro v. Elliot, 57 NY2d 230, 455 NYS2d 570, 441 NE2d 1088; Palmer v. Amaker, 141 AD2d 622, 529 NYS2d 536, Second Dept., 1988; Tipping-Cestari v. Kilhenny, 174 AD2d 663, 571 NS2d 525, Second Dept., 1991)**.

In making such a determination, summary judgment is an appropriate vehicle for determining whether a plaintiff can establish prima facie a serious injury within the meaning of Insurance Law Section 5102(d) **(see, Zoldas v. Louise Cab Corp., 108 AD2d 378, 381, 489 NYS2d 468, First Dept., 1985; Wright v. Melendez, 140 AD2d 337, 528 NYS2d 84, Second Dept., 1988)**.

Serious injury is defined, in Section 5102(d) of the Insurance Law, wherein it is stated as follows:

> "(d) 'Serious injury' means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, ember, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment."

In pertinent part, the report of Dr. Killian sets forth:

"PHYSICAL EXAMINATION:

The claimant was a well developed, thin female, who was in no acute distress.

SPINAL COLUMN

On inspection the normal cervical lordosis, thoracic kyphosis and lumbar lordosis were maintained without evidence of atrophy, asymmetry, deformity or muscle spasm. Her head was held in a normal attitude, her shoulders and pelvis were level and there was no evidence of scoliosis. On palpation she did not complain of tenderness in the midline in the cervical spine but she did complain of upper trapezial tenderness on both sides. She did not complain of thoracic tenderness. She did complain of midline tenderness at the thoracolumbar junction and she complained of tenderness over the buttocks on both sides. There was no palpable muscle spasm or deformity in the cervical, thoracic or lumbar regions. The spinal motions were tested (by visual observation) and it was found that cervical flexion and extension were full at 45 degrees (normal 45 degrees); right and left rotation were full at 90 degrees (normal 90 degrees) and right and left lateral flexion were full at 45 degrees (normal 45 degrees). She complained of a feeling of stiffness with full right rotation of her neck but she did not complain of pain with any of the cervical motions and there was no muscle spasm. Thoracolumbar extension was full at 40 degrees (normal 40 degrees), right and left rotation were full at 30 degrees (normal 30 degrees), right and left lateral flexion were full at 35 degrees (normal 35 degrees) with a complaint of a feeling of stiffness with those motions but without muscle spasm or complaints of pain. She bent forward to reach her lower shins (normal ankles) with a normal reversal of the lumbar lordosis, a complaint of pain and a refusal to bend further. Straight leg raising was negative bilaterally in the sitting position. In the supine position she complained of a feeling of stiffness with straight leg raising on both sides at 70 degrees but she did not complain of pain.

NEUROLOGICAL EXAMINATION

The upper and lower extremity neurological examination was done and it was found that the reflexes including the biceps, triceps, brachoiradialis, knee jerks and ankle jerks were intact and symmetrical. All major muscle groups in both upper extremities and both lower extremities were 5 out of 5 in strength and symmetrical. Sensation was intact and symmetrical to pin and light touch over both upper extremities and both lower extremities. The circumferential muscle masses of her upper and lower extremities were measured and found to be symmetrical with the biceps measuring 9", the forearms 8 ½", the thighs 14" and the calves 12". Her gait was observed and she was noted to ambulate without evidence of a limp. She was able to toe walk and heel walk satisfactorily and symmetrically.

OPINION

Based on the history obtained from this claimant I would conclude that she was treated for complaints related to her neck, mid back and lower back during the period after the 7/31/07 accident. She did have extensive MRIs done which showed age related degeneration in the cervical spine, thoracic

spine and lumbar spine but did not show evidence of any acute injuries caused by this accident. She reports that she had electroddiagnostic studies done of her arms and legs which showed no damage. She indicates that she went to numerous doctors and chiropractors but she has now stopped going for treatment. She still complains of fairly generalized pain in the neck, upper back and lower back with extension into the legs but not into the arms.

The physical examination fo her spinal column was remarkable for subjective complaints of tenderness and subjective complaints of a feeling of stiffness at the extremes of motion which were unaccompanied by objective findings including restricted motion or muscle spasm. Her complaints of tightness with straight leg raising in the supine position were contradicted by negative straight leg raising in the sitting position. The neurological examination was normal.

There were no positive objective physical findings in this examination to confirm Ms. Brzozowski's subjective complaints. Based on this examination I would conclude that she has recovered fully from the problems with her spine for which she was treated after this accident. There was no objective evidence of any impairment or disability from injuries from this accident. She is capable of working at her normal capacity and performing all of her usual activities of daily living without limitations due to injuries caused by the 7/31/07 accident."

Dr. Entin states in said physician's report of neurological examination:

"PHYSICAL EXAMINATION

Physical examination revealed an alert female, in n acute distress.

The head was normocephalic and atraumatic.

Examination of the low back revealed no dorsal or lumbosacral paraspinal muscle spasm. Double straight leg raising was negative to 90 degrees bilaterally while the claimant was sitting.

MENTAL STATUS

Mental status examination revealed the following: The claimant was alert and oriented x3. Recent memory was intact. Language function was intact, without evidence of aphasia. Speech was of normal quality.

CRANIAL NERVE EXAMINATION

Visual fields were full to confrontation. Funduscopic examination was unremarkable. Pupils were equal, round and reactive to light and accommodation. There was no ptosis and the extraocular muscles were intact. There was no facial paresis. Hearing was grossly normal. There was no nystagmus. Palatal movements were intact bilaterally. The sternomastoid muscles were intact bilaterally. Tongue movements were full, and there was

no atrophy of the tongue.

MOTOR EXAMINATION

Gait was normal. There was no Romberg sign. Examination of strength was normal. Muscle tone was normal. There was no muscle atrophy. There were no abnormal involuntary movements. Coordination examination revealed normal finger-to-nose, heel-to-shin, rapid alternating movements and tandem walking. Deep tendon reflexes were symmetrical throughout. Plantar responses were flexor bilaterally. There were no Hoffman reflexes.

SENSORY EXAMINATION

All primary and cortical sensory modalities were intact.

IMPRESSION

Ms. Brzozowski has an entirely normal neurological examination, with no evidence, historically or on examination, of neurological deficit or neurological disability referable to the accident of 7/31/07.

The above-captioned claimant was examined in accordance with the restrictive rules concerning an independent medical examination. It is therefore understood that no doctor-patient relationship exists or is implied by this examination.

The claimant was examined with reference to the specific complaints emanating from the original injury. Any other medical conditions which are either unreported or are felt to be unrelated to the original injury are considered beyond the purview of this examination."

The respective reports of Dr. Tantleff provides:

"As per your request, I performed an independent radiology review of MRI of the THORACIC SPINE. My findings are as follows:

MEDICAL RECORDS SUBMITTED: Radiology report f MRI of the Thoracic Spine.

FINDINGS DESCRIBED IN REPORT: left paracentral disc protrusion at T2-3 impinging on the left final hemicord; central disc protrusion at T4-5 minimally impinging on the ventral aspect of the spinal cord.

(The following statements are noted in the body of the report, but not in the Impression: the thoracic discs have diminished height and signal intensity).

REVIEW OF FILMS: Four sheets of images are submitted from UNSPECIFIED FACILITY. The report is from NASSAU RADIOLOGIC GROUP, PC. The image quality and image detail is fair.

The examination reveals degeneration and desiccation of the visualized intervertebral discs variably throughout the lower cervical and thoracic region.

There is discovertebral endplate spurring of the opposing discovertebral endplates variably through the lower cervical and thoracic region consistent with spondylosis and longstanding chronic degenerative discogenic disc disease.

There is regional costovertebral junction arthropathy and facet arthropathy without definable evidence of degenerative neuroforaminal stenosis.

There is no MRI evidence of asymmetry of the paraspinal musculature. There is no evidence of spasm or contusion. There is no evidence of edema, and specifically, there is no evidence of swelling or enlargement of the prevertebral soft tissue space. There is no evidence of abnormal or asymmetric contractions. Therefore, there is no evidence of muscle spasm of the deep muscles adjacent to the thoracic spine.

At T2-3, there is a focal degenerative disc protrusion which approaches but does not compress, deviates or displace the cervical cord; compromise the lateral recess or obtrude the exit zone of the neural foramen. At T4-5, there is a more minimal disc protrusion of no consequence. The posterior CSF space is maintained at all levels. The cervical alignment is maintained as are the regional soft tissues.

Additionally, in association with the findings is disc degeneration, desiccation and discovertebral endplate spurring, which further confirms the chronicity of the findings.

There is no significant narrowing of either the transverse or sagittal diameter of the canal to indicate a spinal stenosis condition. The thoracic spinal cord is intrinsically normal. There is no paraspinal mass demonstrated. No fracture or subluxation is present. There is no evidence of thecal sac, cord or exiting nerve root impingement. The nerve roots in the thecal sac as well as existing nerve roots are normally distributed."

"As per your request, I performed an independent radiology review of MRI of the CERVICAL SPINE. My findings are as follows:

MEDICAL RECORDS SUBMITTED: Radiology report not available.

REVIEW OF FILMS: Two sheets of images are submitted from NORTH SHORE OPEN MRI. Sagittal images only are submitted. There are no axial views. The image quality and image detail is fair.

The examination reveals degeneration and desiccation of the visualized intervertebral discs variably throughout the upper thoracic and cervical region.

There is discovertebral endplate spurring of the opposing discovertebral endplates variably through the upper thoracic and cervical region consistent

with spondylosis and longstanding chronic degenerative discogenic disc disease.

The neural foramen are not well demonstrated on the current examination. As minimally visualized, they appear to be open and patient without abnormality.

There is no MRI evidence of asymmetry of the paraspinal musculature. There is no evidence of spasm or contusion. There is no evidence of edema, and specifically, there is no evidence of swelling or enlargement of the prevertebral soft tissue space. There is no evidence of abnormal or asymmetric contractions. Therefore, there is no evidence of muscle spasm of the deep muscles adjacent to the cervical spine.

The cervical cord, existing nerves and nerve roots reveal no evidence of compression, deviation, or displacement as a result of discal abnormality nor is there evidence of disc bulge, protrusion or herniation. There is no evidence of central canal, lateral recess or neural foraminal stenosis at any level. Nor is there evidence of mass effect on the cervical cord, thecal sac or existing nerve roots. The posterior CSF space is maintained at all levels.

There is no significant narrowing of either the transverse or sagittal diameter of the canal to indicate a spinal stenosis condition. No lytic or blastic lesions, fractures or subluxations are noted. There is no significant compromise of the neural foramina. The nerve roots in the thecal sac as well as existing nerve roots are normally distributed. No abnormal signal changes are present within the canal indicative of disc herniation or mass. Prevertebral soft tissues and posterior spinal muscles outline normally. There is no intrinsic abnormality of the cervical spinal cord."

"As per your request, I performed an independent radiology review of MRI of the LUMBAR SPINE. My findings are as follows:

MEDICAL RECORDS SUBMITTED: Radiology report of MRI of the Lumbar Spine.

FINDINGS DESCRIBED IN REPORT: broad bulge at L2-3, L3-4 and L4-5 with no encroachment of foramina and no mass effect on the cord; there is no stenosis.

There is discovertebral endplate spurring of the opposing discovertebral endplates variably throughout the lower thoracic and lumbar region consistent with spondylosis and longstanding chronic degenerative discogenic disc disease.

There is a mild regional facet arthropathy identified. The neural foramina are open, patent and adequate.

There is no MRI evidence of asymmetry of the paraspinal musculature. There is no evidence of spasm or contusion. There is no evidence of edema. There

> is no evidence of abnormal or asymmetric contractions. Therefore, there is no evidence of muscle spasm of the deep muscles adjacent to the lumbar spine.
>
> There is no evidence of central canal, lateral recess or neural foraminal stenosis at any level. Nor is there evidence of mass effect on the thecal sac or existing nerve roots.
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> The lumbar lordosis is maintained as are the regional soft tissues.
>
> There is no significant narrowing of either the transverse or sagittal diameter of the canal to indicate a spinal stenosis condition. No lytic or blastic lesions, fractures or subluxations are noted. There is no significant compromise of the neural foramina. The nerve roots in the thecal sac as well as existing nerve roots are normally distributed. No abnormal signal changes are present within the canal indicative of disc herniation or mass. There is no evidence of spondylolysis or spondylolisthesis. Psoas and posterior spinal muscles outline normally."

The Court finds that the defendants have submitted evidence in admissible form to make a "prima facie showing of entitlement to judgment as a matter of law" **(Winegrad v. New York University Medical Center, 64 NY2d 851, 853; Pagano v. Kingsbury, supra at 694)** and is sufficient to establish that the plaintiff did not sustain a serious injury. Accordingly, the burden has shifted to the plaintiff to establish such an injury and a triable issue of fact **(see Gaddy v. Eyler, 79 NY2d 955, 582 NYS2d 990, 591 NE2d 1176; Jean-Meku v. Berbec, 215 AD2d 440, 626 NYS2d 274, Second Dept., 1995; Horan v. Mirando, 221 AD2d 506, 633 NYS2d 402, Second Dept., 1995).**

In opposition to the defendants' requested relief, the plaintiffs, amongst other things, submits an affidavit of the plaintiff Amy B. Brzozowski; certain unsworn reports and prescriptions of the Central Orthopedic Group; certain unsworn reports and records of Precision Sports; certain unsworn reports of LI Complementary & Family Medical Care, PC; an unsworn report of North Shore Open MRI; an unsworn report of Neurological Specialties of Long Island, PLLC by Itzhak C. Halmovic with attachments; an unsworn report of Manetto Hill MRI Associates, LLP; certain unsworn reports of North American Partners in Pain Management, LLP; certain unsworn reports of Dr. Barry S. Goldstein; certain unsworn reports of North Shore Craniofacial Care, PC; certain unsworn reports of Nassau Radiologic Group, PC. The plaintiffs do not set forth a rationale for the submission of the respective unsworn reports.

In examining the issue of the submission of unsworn reports, the Court in **Grasso v Angerami**, 79 NY2d 813, 580 NYS2d 178, 588 NE2d 76 stated:

> "APPEAL, by permission of the Court of Appeals, from so much of an order of the Appellate Division of the Supreme Court in the Third Judicial Department, entered May 29, 1991, as affirmed an order of the Supreme Court (Robert F. Doran, J.), entered in Schenectady County, granting a motion by defendant for summary judgment dismissing the complaint.
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> In October 1983, plaintiff's motor vehicle was struck from behind triggering the instant personal injury action. Defendant moved for summary judgment contending that plaintiff had not sustained a serious injury as defined by

> Insurance Law §5102(d). Finding plaintiff's proof in opposition, an unsworn letter report from his doctor, to be legally insufficient, Supreme Court dismissed the complaint.
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> . . .
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> Memorandum.
> The order of the Appellate Division should be affirmed, with costs.
> In opposition to the defendant's motion for summary judgment pursuant to Insurance Law §5102(d), plaintiff tendered proof of "serious injury" in inadmissible form, namely an unsworn doctor's report. Inasmuch as plaintiff did not offer any excuse for his failure to provide the medical report in proper form, we need not consider whether proof of serious injury in inadmissible form is sufficient to defeat a motion for summary judgment pursuant to Insurance Law §5102(d), if an acceptable excuse for the deficiency is offered."
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> **Grasso v Angerami, supra at 814-815**

The Court further notes that the plaintiff Amy B. Brzozowski's affidavit fails to offer any medical evidence in admissible form as to any objective test to substantiate the plaintiff's contentions as to the plaintiff's alleged injuries.

Based upon all of the foregoing, the defendants' application for an Order pursuant to CPLR §3212 granting summary judgment dismissing plaintiffs' Verified Complaint on the ground that the injuries alleged by plaintiffs do not meet the "serious injury" threshold as set forth in §5102(d) of the Insurance Law of the State of New York, is **granted**.

SO ORDERED.

DATED: 9/29/2010

Ray S. Mallon
J.S.C.