

WMOP, LLC v Scottsdale Ins. Co.
2020 NY Slip Op 30968(U)
April 13, 2020
Supreme Court, New York County
Docket Number: 655953/2018
Judge: Melissa A. Crane
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: I.A.S. PART 15

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WMOP, LLC, and WMOP, LLC D/B/A ACHIEVE REHAB
AND NURSING FACILITY,

DECISION AND ORDER

Index No. 655953/2018

Plaintiff,

- against -

SCOTTSDALE INSURANCE COMPANY and MT. HAWLEY
INSURANCE COMPANY,

Defendants.

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MELISSA A. CRANE, J.:

Motion sequence nos. 001 and 002 are consolidated for disposition.

This insurance coverage dispute arises out of two successive policies defendants
Scottsdale Insurance Company (Scottsdale) and Mt. Hawley Insurance Company (Mt. Hawley)
issued to plaintiff WMOP, LLC. In motion sequence no. 001, Scottsdale moves, pursuant to
CPLR 3211 (a) (7), for dismissal of the complaint against it. In motion sequence no. 002, Mt.
Hawley moves, pursuant to CPLR (a) (1) and (7), for dismissal of the complaint against it.

BACKGROUND

Plaintiff operates Achieve Rehabilitation and Nursing Facility (Achieve) located at 170
Lake Street, Liberty, New York (NY St Cts Elec Filing [NYSCEF] Doc No. 2 [complaint], ¶ 3).

A. The Scottsdale Policy

Scottsdale issued Long Term Care Facilities Liability Policy no. KBS0000050 (the
Scottsdale Policy) to plaintiff in effect from June 1, 2016 to June 1, 2017, with a \$1 million limit
of liability per claim and a \$3 million aggregate limit of liability, retroactive to December 1,
2008 (NYSCEF Doc No. 6, Cheryl Dommer [Dommer] aff, exhibit A at 4). The Scottsdale
Policy is a “CLAIMS MADE AND REPORTED POLICY” (*id.*). As such, coverage is “limited

to liability for covered acts committed subsequent to the retroactive date ... for which claims are first made against you while the policy is in force and which are reported to us in accordance with the terms of the policy” (*id.* [capitalization removed]).

Section I of the Long Term Care Facilities Liability Professional Liability Coverage form states, in relevant part:

“We will pay on behalf of the ‘insured,’ those sums that the ‘insured’ becomes legally obligated to pay as ‘damages’ and ‘claim expenses’ because of a ‘claim’ made against the ‘insured’ during the ‘policy period’ or any applicable ‘extended reporting period,’ provided such ‘claim’ is reported to us in accordance with the provisions of Section VI”

(*id.* at 32). The Scottsdale Policy defines a “claim” as “an oral or written demand, including a lawsuit and the allegations contained therein, received by any ‘insured’ for monetary damages arising out of an ‘incident’ and a ‘claim’ includes any ‘related incidents,’ ‘related claims’ and/or occurrences.’ A ‘claim’ shall be deemed made when received by any ‘insured’ or us” (*id.* at 33 [Section III (C) (G)]). “Damages” is defined as “judgments, awards and settlements that an ‘insured’ is legally obligated to pay on account of a covered ‘claim’” (*id.* at 34 [Section III (C) (K)]). An “incident” means “any ‘offense,’ any ‘medical incident,’ or any act, error or omission in the course of rendering ‘professional services’ that arises out of the ‘insureds’ operations at an ‘insured location’” (*id.* at 35 [Section III (C) (T)]).

Section VI details plaintiff’s obligations for reporting claims and incidents. Section VI (A) partially states, in relevant part, that “[a]s a condition precedent to their rights under this policy, you shall give us written notice of any ‘claim’ made against the ‘insureds’ as soon as practicable after a ‘notice manager’ first learns of such ‘claim’” (*id.* at 44). Section VI (B) provides:

“If during the ‘policy period,’ you become aware of an ‘incident’ that is expected to be the basis of a ‘claim’ against you, you must give written notice to us as soon as reasonably possible during the ‘policy period.’ Notice of an ‘incident’ does not constitute notice of a ‘claim.’ If, however, such notice is given, then any such ‘claim’ that is subsequently made against you, and reported to us, shall be deemed to have been made at the time such written notice was first provided to us.

Such notice must state the reasons for anticipating a ‘claim,’ with full particulars, including, but not limited to:

1. How, when and where the ‘incident’ took place;
2. The names and addresses of any injured persons and witnesses;
3. The nature and location of any injury or damage arising out of the ‘incident’; and
4. The circumstances by which you first became aware of the possible ‘claim.’”

(*id.* at 44-45).

B. The Mt. Hawley Policy

Mt. Hawley issued Healthcare Organization Professional General Liability Policy no. MHP0000059 (the Mt. Hawley Policy) to plaintiff in effect from June 1, 2017 to June 1, 2018, with a \$1 million per claim limit of liability and a \$3 million aggregate limit of liability retroactive to June 1, 2008 (NYSCEF Doc No. 24, Cherlye Taylor [Taylor] aff, exhibit E at 2-3). As with the Scottsdale Policy, the Mt. Hawley Policy “provides some coverages on a claims made basis such coverages only cover claims first made against the insureds during the policy period” (*id.* at 2 [capitalization removed]).

Section I of the Healthcare Organization Professional and General Liability Insurance Policy form contains the insuring agreements for professional liability and commercial general liability coverage. The professional liability section reads in part:

“The **Company** will pay on behalf of the **Insured** ... which the **Insured** becomes legally obligated to pay as a result of a **Claim** alleging a **Medical Incident**, provided always that:

1. such **Claim** is first made against the **Insured** during the **Policy Period** or any applicable Extended Reporting Period; and
2. notice of such **Claim** is given to the **Company** in accordance with Section VI Conditions B. of this Policy; and
3. the **Insured** had no actual knowledge of such **Medical Incident** prior to the **Policy Period**; and
4. such **Claim** arises from a **Medical Incident** that took place on or after the **Retroactive Date** specified in the Declarations and prior to the expiration of the **Policy Period**”

(*id.* at 6 [Section I (A)]). The Mt. Hawley Policy defines a “claim” as “a written demand seeking monetary damages that is received by an **Insured**, including a **Suit**” (*id.* at 6 [Section II (D)]). A “medical incident” is:

- “1. an actual or alleged act, error or omission by an **Insured** in the rendering of or a failure to render **Medical Professional Services**;
...

All related acts, errors or omissions in the rendering of or failure to render **Medical Professional Services** to any one person shall be considered one **Medical Incident**. If a **Medical Incident** arises from a series of related **Medical Professional Services**, such **Medical Incident** will be deemed to have happened at the time of the first act, error or omission, as a result of which the Insured may be legally obligated to pay a **Loss** ...”

(*id.* at 10 [Section II (Q)]. An “occurrence” means:

- “1. An accident, including continuous or repeated exposure to substantially the same general harmful conditions, that results in **Bodily Injury** or **Property Damage** neither expected nor intended from the standpoint of the **Insured**;
 2. An offense, arising out of the **Named Insured’s** business or in the course of advertising the **Named Insured’s Medical Professional Services** including continuous or repeated exposure to the same general harmful condition, the results in Personal or Advertising Injury.
- All **Loss** that arises from the same or related injurious arterial or act shall be considered one **Occurrence**”

(NYSCEF Doc No. 24 at 11-12 [Section II (U)]).

The Mt. Hawley Policy contains a number of exclusions, two of which are relevant on this motion. Section III (A) (5) excludes from professional liability coverage “PRIOR ACTS,” specifically “any **Medical Incident**, act, error or omission of which an **Insured** had knowledge prior to the inception date of the **Policy Period**” (*id.* at 13). Section III (C) (2) also states:

“[T]he **Company** shall not pay any **Loss** or **Defense Expenses** and this Policy shall not apply to any **Claim** based on, arising out of, directly or resulting from, in consequence of, or in any way involving

...

2 PRIOR CLAIMS OR OCCURRENCE

any acts, errors, omissions, **Medical Incidents**, **Occurrences**, facts, matters, events, **Suits** or demands that were notified or reported to, or should have been reported to, or in accordance with, any policy of insurance or policy ... in effect prior to the effective date as stated in Item 2 (a) of the Declarations”

(*id.* at 17-18).

C. The Underlying Action and the Disclaimers of Coverage

Decedent Melvin Eisner (Eisner) was a resident at Achieve from April 30, 2015 to August 17, 2016 (NYSCEF Doc No. 13, affirmation of Courtney E. Scott, exhibit B, ¶ 10). Eisner allegedly sustained multiple injuries while under plaintiff’s care (*id.*, ¶ 100). Eisner passed away on August 25, 2016 (*id.*, ¶ 3).

By letter dated May 19, 2017 (the May Letter), Finkelstein & Partners (Finkelstein), representing Eisner’s estate, requested that Scottsdale furnish it with a complete copy of Eisner’s nursing home records (NYSCEF Doc No. 7, Dommer aff, exhibit B at 9). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorization form (the Authorization) submitted with the May Letter identified the purpose of the request as “Other: Legal Proceeding” and stated the authorization would expire at the “Conclusion of case or trial” (*id.* at 11). Plaintiff’s broker, Cornell Insurance Services (Cornell), submitted an ACORD General

Liability Notice of Occurrence/Claim form dated May 30, 2017 (the May Notice), along with the May Letter and Authorization, to Scottsdale. The May Notice described the occurrence as “Melvin Eisner – Attorney Record Request – Notice of Intent – Allegation Unknown,” and listed plaintiff’s in-house counsel, as the primary contact (*id.* at 3).

Nationwide E&S Claim (Nationwide), acting for Scottsdale, responded to plaintiff on June 5, 2017 (NYSCEF Doc No. 8, Dommer aff, exhibit C at 1). Although it acknowledged receipt of the May Letter, Nationwide wrote the May Letter did not meet the definition of a claim and did not meet the requirements for reporting an incident under the terms of the Scottsdale Policy (*id.* at 2-3). Nationwide offered to review any additional information plaintiff wished to provide, but plaintiff did not respond to Nationwide’s offer.

On December 14, 2017, Cornell forwarded a letter dated November 28, 2017 (the November Letter) plaintiff received from Finkelstein, in which Finkelstein stated that the Eisner estate had retained it “related to personal injuries [Eisner] sustained while under the care of your facility” and advised plaintiff to contact its insurance carrier (NYSCEF Doc No. 9, Dommer aff, exhibit D at 1-2). Nationwide replied to plaintiff on December 14, 2017, writing that Scottsdale would neither defend nor indemnify plaintiff on the Eisner matter (NYSCEF Doc No. 10, Dommer aff, exhibit E at 1). Scottsdale predicated its disclaimer on the ground that neither a claim nor an incident had been reported within the policy period (*id.* at 2-4).

On December 5, 2017, Cornell submitted an ACORD General Liability Notice of Occurrence/Claim form together with a copy of the November Letter to Mt. Hawley (NYSCEF Doc No. 21, Taylor aff, exhibit B at 1). In its January 11, 2018 response, Mt. Hawley disclaimed coverage, citing three policy exclusions discussing “prior acts” and a disclosure obligation printed on its insurance application as bases for the disclaimer (*id.* at 4-5).

Mt. Hawley wrote that its investigation revealed that Eisner had died from aspiration pneumonia shortly after transferring to a hospital from Achieve and that he had been diagnosed with pressure ulcers, sepsis and malnutrition (*id.* at 3-4). These factors, coupled with the transmission of the May Letter to Scottsdale, indicated that plaintiff was aware of the Eisner matter prior to the inception date of the Mt. Hawley Policy. Thus, none of the insuring agreements were triggered (*id.* at 4). Mt. Hawley repeated its coverage position in a February 23, 2018 letter to plaintiff's in-house counsel, writing that plaintiff was aware of the Eisner matter before the policy period (NYSCEF Doc No. 22, Taylor aff, exhibit C at 3-4).

On August 21, 2018, Eisner's estate commenced an action asserting claims for negligence and wrongful death against plaintiff entitled *Eisner v Achieve Rehabilitation and Nursing Facility*, Sup Ct, Sullivan County, index No. 1680/2018 (the *Eisner* Action) (NYSCEF Doc No. 13 at 2). Plaintiff subsequently forwarded the summons and complaint in the *Eisner* Action to Mt. Hawley. In a letter to plaintiff dated September 27, 2018, Mt. Hawley adhered to its earlier position that there was no coverage (NYSCEF Doc No. 26, Taylor aff, exhibit G at 1). On this occasion, Mt. Hawley referred to a related claims provision in its policy, and stated that the complaint in the *Eisner* Action and the November 28 Letter constituted a single claim for purposes of the professional liability insuring agreement, and disclaimed coverage for the same reasons set forth in its January 11, 2018 and February 23, 2018 letters (*id.* at 2-3).

Plaintiff commenced this action by filing a summons and complaint on November 30, 2018. The complaint pleads causes of action for breach of contract against Scottsdale and Mt. Hawley and for a judgment. In lieu of serving answers, defendants move separately for dismissal.

DISCUSSION

Dismissal under CPLR 3211 (a) (1) is warranted “only where the documentary evidence utterly refutes plaintiff’s factual allegations, conclusively establishing a defense as a matter of law” (*Goshen v Mutual Life Ins. Co. of N.Y.*, 98 NY2d 314, 326 [2002]). “To be considered ‘documentary’ under CPLR 3211 (a) (1), evidence must be unambiguous and of undisputed authenticity” (*Fontanetta v John Doe 1*, 73 AD3d 78, 86 [2d Dept 2010] [internal citation omitted]). In effect, “the paper’s content must be ‘essentially undeniable and . . . assuming the verity of [the paper] and the validity of its execution, will itself support the ground on which the motion is based” (*Amsterdam Hospitality Group, LLC v Marshall-Alan Assoc., Inc.*, 120 AD3d 431, 432 [1st Dept 2014] [internal citation omitted]).

On a motion to dismiss brought under CPLR 3211 (a) (7), the court must “accept the facts as alleged in the complaint as true, accord the plaintiff the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory” (*Leon v Martinez*, 84 NY2d 83, 87-88 [1994] [citations omitted]). Ambiguous allegations must be resolved in plaintiff’s favor (*see JF Capital Advisors, LLC v Lightstone Group, LLC*, 25 NY3d 759, 764 [2015]). The motion will be denied “if from its four corners factual allegations are discerned which taken together manifest any cause of action cognizable at law” (*Guggenheimer v Ginzburg*, 43 NY2d 268, 275 [1977]). However, “the court is not required to accept factual allegations that are plainly contradicted by the documentary evidence or legal conclusions that are unsupported based upon the undisputed facts” (*Robinson v Robinson*, 303 AD2d 234, 235 [1st Dept 2003]). “When evidentiary material is considered, the criterion is whether the proponent of the pleading has a cause of action, not whether he has stated one” (*Guggenheimer*, 43 NY2d at 275).

A. Motion Sequence No. 001

Scottsdale advances two arguments in support of its motion. Scottsdale first argues that a claims made policy, as is the case here, provides coverage for claims reported during the policy period. Scottsdale maintains that plaintiff cannot demonstrate it reported a claim because the May Letter did not seek monetary damages. Scottsdale next argues that the May Letter fails to meet the requirements for giving notice of an incident because it is not sufficiently specific.

Plaintiff counters that the May Letter and Authorization furnished Scottsdale with adequate notice of a claim or potential claim. Finkelstein is a well-known personal injury law firm specializing in nursing home negligence claims (NYSCEF Doc No. 32, plaintiff's memorandum of law at 14; NYSCEF Doc No. 34, affirmation of Howard S. Edinburgh [Edinburgh], exhibit A at 10-18). Thus, the fact that Finkelstein requested Eisner's records and the mentions of "Legal Proceeding" and "Conclusion of case or trial" in the Authorization should have made Scottsdale aware of a potential personal injury lawsuit against plaintiff. Plaintiff further contends that receipt of a HIPAA authorization imposes certain requirements upon the recipient related to the preservation of records, and subjects that recipient to penalties for noncompliance. For instance, plaintiff posits that, in the event it failed to preserve Eisner's records, the plaintiff in the *Eisner* Action could pursue sanctions for spoliation, which may lead to a stricken answer and an inquest on damages. Plaintiff also adds that Scottsdale treated the May Letter as a claim, because it appeared on a loss run report generated for Scottsdale's parent (NYSCEF Doc No. 39, Edinburgh affirmation, exhibit C at 2). Hence, the May Letter constitutes a claim within the meaning of the Scottsdale Policy. As an alternative, plaintiff posits

that the May Letter serves as a notice of a potential claim under Section VI (B) of the Scottsdale Policy.

1. The First Cause of Action for a Declaratory Judgment

The first cause of action seeks a judgment declaring that Scottsdale must defend, indemnify and hold plaintiff harmless in the *Eisner* Action.

“A motion to dismiss a declaratory judgment action prior to the service of an answer presents for consideration only the issue of whether a cause of action for declaratory relief is set forth, not the question of whether the plaintiff is entitled to a favorable declaration” (*Matter of Tilcon N.Y., Inc. v Town of Poughkeepsie*, 87 AD3d 1148, 1150 [2d Dept 2011] [internal quotation marks and citation omitted]; *Red Robin Stores, Inc. v Rose*, 274 App Div 462, 467 [1st Dept 1948] [same]). Thus, to sustain a cause of action for declaratory relief, the plaintiff must show that the “cause of action is sufficient to invoke the court’s power to ‘render a declaratory judgment ... as to the rights and other legal relations of the parties to a justiciable controversy’” (*Matter of Tilcon N.Y., Inc.*, 87 AD3d at 1150 quoting CPLR 3001]).

Here, the court finds that the complaint fails to state a cause of action for a declaratory judgment. As noted above, the Scottsdale Policy is a claims made policy. “[C]overage under a ‘claims made’ policy applies to claims made and reported during a given policy period” (*Executive Risk Indem., Inc. v Starwood Hotels & Resorts Worldwide, Inc.*, 98 AD3d 878, 880 [1st Dept 2012], *lv denied* 21 NY3d 851 [2013]), irrespective of when the acts giving rise to the claim took place (*see Senate Ins. Co. v Tamarack Am.*, 14 AD3d 922, 923 [3d Dept 2005]; *see also* 7 Steven Plitt et al., *Couch on Insurance* 3D § 102:22 [2019]). “A claims-made policy is designed to protect the policyholder during the life of the policy upon notice to the carrier within the policy period,” and therefore, this type of policy gives an insurer “certainty

that, when the policy period ends without a claim having been made, the insurer will be exposed to no further liability” (*American Guar. & Liab. Ins. Co. v Chicago Ins. Co.*, 105 AD3d 655, 656 [1st Dept 2013] [internal quotation marks and citation omitted]). A notice provision in an insurance policy constitutes a condition precedent to coverage, and an insured’s failure to comply with a condition precedent vitiates the insurance contract (*see Great Canal Realty Corp. v Seneca Ins. Co., Inc.*, 5 NY3d 742, 743 [2005]). Thus, whether coverage exists turns on the Scottsdale Policy’s definition of a “claim,” and whether plaintiff reported a “claim” within the policy period.

It is well settled that “[a]n insurance agreement is subject to principles of contract interpretation ... [and] ‘unambiguous provisions of an insurance contract must be given their plain and ordinary meaning’” (*Universal Am. Corp. v National Union Fire Ins. Co. of Pittsburgh, Pa.*, 25 NY3d 675, 680 [2015] [internal quotation marks and citation omitted]). That said,

“[a] contract of insurance is ambiguous if the language therein is susceptible of two or more reasonable interpretations ... whereas, in contrast, a contract is unambiguous if the language has ‘a definite and precise meaning, unattended by danger of misconception in the purport of the [agreement] itself, and concerning which there is no reasonable basis for a difference of opinion’”

(*Broad St., LLC v Gulf Ins. Co.*, 37 AD3d 126, 131 [1st Dept 2006] [internal quotation marks and citations omitted]). Any ambiguity in an insurance contract must be resolved in the insurer’s favor (*see Gilbane Bldg. Co./TDX Constr. Corp. v St. Paul Fire & Mar. Ins. Co.*, 143 AD3d 146, 151 [1st Dept 2016], *affd* 31 NY3d 131 [2018]).

A claim for purposes of the Scottsdale Policy means “an oral or written demand ... for monetary damages arising out of an ‘incident’” (NYSCEF Doc No. 6 at 33). This language is

clear, plain and unambiguous (*see e.g. Home Ins. Co. of Illinois (N.H.) v Spectrum Info. Tech., Inc.*, 930 F Supp 825, 846 [ED NY, 1996] [stating that “the term ‘claim’ as used in liability insurance policies is unambiguous and generally means a demand by a third party against the insured for money damages or other relief owed”]). A review of the May Letter reveals that plaintiff contacted it about the Eisner request within the Scottsdale Policy period. However, the letter does not assert a demand for monetary damages, and therefore, does not constitute a claim under the terms of the Scottsdale Policy.

“A claim requires ... a specific demand for relief” (*Seneca Ins. Co. v Kemper Ins. Co.*, 2004 WL 1145830, *5, 2004 US Dist LEXIS 9159, *13 [SD NY, May 21, 2004, No. 02-Civ-10088 (PKL)], *affd* 133 Fed Appx 770 [2d Cir 2005] [internal quotation marks and citation omitted]). “[A] claim must relate to an assertion of legally cognizable damage, and must be a type of demand that can be defended, settled and paid by the insurer” (*Evanston Ins. Co. v GAB Bus. Servs.*, 132 AD2d 180, 185 [1st Dept 1987]). “[A]n accusation that wrongdoing occurred is not by itself a claim; nor is a naked threat of a future lawsuit, or a request for information or an explanation” (*Seneca Ins. Co.*, 2004 WL 1145830, *5, 2004 US Dist LEXIS 9159, *13). Further, because a demand is can trigger certain rights and obligations, the court must look to purpose of the demand, because “a mere request ... carries no legal consequences” (*Gil Enterprises, Inc. v Delvy*, 79 F3d 241, 246 [2d Cir 1996]).

Here, the May Letter plainly fails to articulate a demand. The May Letter states plaintiff “must give access to medical records within 24 hours of request” (NYSCEF Doc No. 7 at 9), but a request for Eisner’s records does not equate to a demand for monetary damages. Importantly, the Scottsdale Policy defines “damages” as “judgments, awards and settlements” that plaintiff is legally obligated to pay (NYSCEF Doc No. 6 at 34). The letter does not explain whether Eisner

would pursue monetary damages if plaintiff ignored the request or even if monetary damages would be available. The letter references to two regulations, 42 CFR 483.10 (a) (2) (i) and (ii) (Resident rights) and 45 CFR 164.524 (c) (4) (i) (Access of individuals to protected health information), but these regulations do not grant Eisner the authority to seek redress for a violation. The Authorization referred to a “Legal proceeding,” but it does not state whether plaintiff had already initiated a suit for damages or whether a suit was imminent (*see Matter of Reliance Ins. Co.*, 55 AD3d 43, 47 [1st Dept 2008], *affd* 12 NY3d 725 [2009] [stating that counsel’s letter failed to express a present intent to initiate legal proceedings]; *Seneca Ins. Co. v Kemper Ins. Co.*, 2004 WL 1145830, *5, 2004 US Dist LEXIS 9159, *14 [concluding that a letter in which a claimant alleged it sustained actual damages from the insured’s actions, sought a “possible resolution” of the matter, and stated that the claimant would “proceed accordingly” if the matter did not settle constitutes a claim]). Consequently, plaintiff failed to report a claim in accordance with the unambiguous terms of the Scottsdale Policy (*see Penn Traffic Co. v National Union Fire Ins. Co. of Pittsburgh, PA*, 79 AD3d 1729, 1732 [4th Dept 2010] [granting summary judgment to the insurer where the insured failed to comply with the notice of claim requirement in a claims made policy]).

Plaintiff’s contention that it reported a potential claim to Scottsdale is unpersuasive. The phrase “potential claim” does not appear in the provisions discussing plaintiff’s reporting obligations (NYSCEF Doc No. 6 at 44 [Section VI (A)]). Further, even if the Scottsdale Policy required plaintiff to report a potential claim, nothing in the May Letter expresses an intent that a future demand was inevitable (*see Matter of Reliance Ins. Co.*, 55 AD3d at 47). As noted above, the Scottsdale Policy directs plaintiff to furnish it with “notice of an ‘incident’ that is expected to become the basis of a ‘claim’” (NYSCEF Doc No. 6 at 44-45). The notice must include how,

when and where an incident took place, the names and addresses of the injured person and witnesses, the nature and location of the injury, and the circumstances by which plaintiff first became aware of the potential claim (NYSCEF Doc No. 6 at 44-45). In effect, the notice must detail the specific facts that could give rise to a possible claim (*see Liberty Ins. Underwriters, Inc. v Perkins Eastman Architects, P.C.*, 101 AD3d 650, 650 [1st Dept 2012] [finding that the insured “timely advised” of a potential claim because it identified specific problems with a construction project and the names of potential claimants, informed the insurer about the positions of the owner and contractor, and advised that negotiations with the performance bond surety were progressing slowly]; *JPMorgan Chase & Co. v Travelers Indem. Co.*, 22 Misc 3d 1111[A], 2009 NY Slip Op 50087[U], *4 [Sup Ct, NY County 2009], *affd* 73 AD3d 9 [1st Dept 2010] [stating that the notice provided to the insurer contained all of the information the notice provision in the policy required that the plaintiff believed would likely lead to a claim]; *United Specialty Ins. v Columbia Cas. Co.*, 2017 WL 2734859, *7 [Sup Ct, Queens County, May 23, 2017, McDonald, J., index No. 703959/16] [stating that cursory information is insufficient]). Further, an “insured must adhere as closely as possible to the terms of the policy by providing a timely notice of the circumstances which the insured believes could lead to an action against them” (*JPMorgan Chase & Co. v Travelers Indem. Co.*, 2007 NY Slip Op 30285[U], *9 [Sup Ct, NY County 2007] [finding that a letter apprised the insurer of the underlying circumstances that could have rendered the plaintiffs liable]).

Here, plaintiff failed to satisfy the policy’s terms for reporting an incident, because the May Letter, Authorization and May Notice are devoid of the type of detail or reasons why plaintiff ought to anticipate a possible claim (*see 16449 CBB, LLC v Zurich Am. Ins. Co.*, 31 Misc 3d 1212[A], 2011 NY Slip Op 50654[U], *11 [Sup Ct, Queens County 2011] [concluding

that an incident report was “devoid of any details as to how, when and where the ‘occurrence’ took place ... was clearly insufficient to apprise the insurer of a potential claim”). The May Letter and the Authorization did not disclose Eisner’s intent to pursue a personal injury lawsuit against it. The May Notice identified Achieve as the location of an incident, but otherwise did not list the names of any witnesses other than Eisner. Significantly, the May Notice described the occurrence as “Allegation Unknown.” This language is too vague and ambiguous to describe an offense, medical incident, act, error or omission concerning plaintiff’s professional services.

Equally unconvincing is plaintiff’s reliance on an internal loss run report generated for Scottsdale’s parent company. The manner by which Scottsdale chose to list the matters it received on an internal report has no bearing on whether it treated the May Letter as a claim. Notably, the report does not ascribe an amount for the Eisner matter in the loss reserves or incurred loss categories. Nor does it give a description of the alleged loss. In any event, the inclusion of the Eisner matter on a loss run report does not satisfy the notice of claim requirement (*see Steadfast Ins. Co. v Sentinel Real Estate Corp.*, 283 AD2d 44, 53 [1st Dept 2001]).

The cases plaintiff cites are inapposite. The insurance contract at issue in *Weaver v Axis Surplus Ins. Co.* (2014 WL 5500667, *2, 2014 US Dist LEXIS 154746, *5 [ED NY, Oct. 30, 2014, No. 13-CV-7374 (SJF/ARL)], *affd* 639 Fed Appx 764 [2d Cir 2016]) defined a “claim” as a demand for monetary and non-monetary relief, whereas a claim under the Scottsdale Policy is a demand for only monetary damages. Additionally, the court determined that a letter the insured received from Maryland’s Attorney General qualified as a claim for non-monetary relief (2014 WL 5500667, *8, 2014 US Dist LEXIS 154746, *23). In connection with an inquiry into an alleged violation of the Maryland Business Opportunities Sales Act by the insured, the

Attorney General requested records from the insured, directed the insured to cease all offers of sales in the state pending the outcome of the inquiry, and advised that a failure to respond could result in formal legal action against the insured (2014 WL 5500667, *4, 2014 US Dist LEXIS 154746, *11-12). The court observed that the letter placed the insured on notice of specific, potential actions the Attorney General could take if it found violations, such as an assessment of civil or criminal penalties (2014 WL 5500667, *9, 2014 US Dist LEXIS 154746, *26-27). On appeal, the Second Circuit expanded on the District Court's reasoning, stating "the [Attorney General's] Letter made clear that it was not just a 'mere request for information'" (*Weaver*, 639 Fed Appx at 767, quoting *Gil Enterprises, Inc.*, 79 F3d at 246). Assuming the definition for a claim under the Scottsdale Policy included a demand for non-monetary relief, the May Letter lacks the type of detail about future actions similar to that expressed in the Attorney General's letter. *Weaver* is also distinguishable from the present matter because the insurer disclaimed coverage on the ground that the claim was "first made" prior to the inception of the policy (2014 WL 5500667, *14, 2014 US Dist LEXIS 154746, *43-44). Here, Scottsdale denied coverage on the ground that a claim had not been made at all.

Likewise, *Colony Ins. Co. v AIG Specialty Ins. Co.* (2018 WL 1478045, 2018 US Dist LEXIS 49580 [SD NY, Mar. 26, 2018, No. 15-CV-3896 (VSB)]) is factually dissimilar. There, the court concluded that a letter constituted a claim within the meaning of the insurance contract. The letter had requested that the plaintiff insurer pay its aggregate policy limit to settle a construction defect claim brought against its insured or else face a lawsuit to collect any excess judgment. The court reasoned that the letter "gave precise factual and legal justification" for a lawsuit against the insurer for its bad faith handling of the construction defect claim such that a lawsuit based upon "the actions described in the ... [d]emand [l]etter was not a remote

possibility, but a realistic possibility” (2018 WL 1478045, *9, 2018 US Dist LEXIS 49580, *23-24 [internal quotation marks and citation omitted]). In this action, the May Letter did not refer to a pending legal proceeding or describe the factual and legal justification for a possible future lawsuit against plaintiff.

The facts in *Chiera v Liberty Ins. Underwriters, Inc.*, 20 Misc 3d 1141[A], 2008 NY Slip Op 51817[U] [Sup Ct, Westchester County 2008]) do not aid plaintiff. The incident underlying that action involved an unfavorable determination made after a traverse hearing against the plaintiff’s client (2008 NY Slip Op 51817[U], * 5). The plaintiff insured informed the defendant insurer of the adverse decision in connection with a policy renewal (*id.*). After the plaintiff’s client brought suit, the defendant disclaimed coverage because the plaintiff had failed to timely notify it of a claim or potential claim as the policy required (*id.*, *6). The court observed that coverage on the claims made policy triggered by: (1) giving written notice of a claim or potential claim against it or (2) giving written notice when the insured “first become[s] aware during the policy period ... of a wrongful act for which coverage is otherwise provided” (*id.*, *12). Because the phrase “potential claim” appeared in the notice of claim provision, the court construed a “potential claim” to mean

“a demand for money ... which, though not actually yet asserted, as been impliedly articulated by a third party, such as by a letter ... indicating that a claim might be forthcoming, a letter expressing dissatisfaction with the insured’s performance, a letter inquiring as to ... insurance coverage, or other, similar circumstances”

(*id.*, *15). While the plaintiff “could reasonably have expected a claim *might* eventuate,” coverage under the notice of claim provision “was not triggered merely by awareness, or constructive awareness, on the part of ... [the insured of its] potential liability” (*id.*, *10). Therefore, notice of the decision involving plaintiff’s client could not be “construed as an

intention to make a claim, or even anything at all” (*id.*, *15). In this instance, counter to plaintiff’s assertion, the May Letter is deficient, because it did not apprise plaintiff of a potential lawsuit against it, express Eisner’s dissatisfaction with plaintiff’s services or inquire as to plaintiff’s insurance coverage. Because the May Letter is insufficient to trigger coverage, Scottsdale is entitled to dismissal of the first cause of action against it.

2. *The Third Cause of Action for Breach of Contract*

To sustain a cause of action for breach of contract, a plaintiff must prove the existence of a contract, plaintiff’s performance, the defendant’s breach, and damages (*see Harris v Seward Park Hous. Corp.*, 79 AD3d 425, 426 [1st Dept 2010]). Here, the breach of contract cause of action is merely a restatement of the declaratory judgment claim as it seeks to recoup the costs plaintiff incurred in the Eisner Action, and is dismissed against Scottsdale (*see United States Fire Ins. C. v American Home Assur. Co.*, 19 AD3d 191, 192 [1st Dept 2005]).

B. Motion Sequence No. 002

On its motion, Mt. Hawley submits that, as with the Scottsdale Policy, the Mt. Hawley Policy is a claims made policy. Mt. Hawley argues that plaintiff’s submission of the May Letter to Scottsdale is sufficient to trigger the “prior claims or occurrences” exclusion found in Section III (A) (5), which bars coverage for “any acts, errors, omissions, **Medical Incidents, Occurrences**, facts, matters, events, **Suits** or demands that were notified or reported to, or should have been reported to, or in accordance with, any policy of insurance or policy” (NYSCEF Doc No. 24 at 17). Mt. Hawley contends that the allegations in the *Eisner* Action’s complaint arise from the same facts and events plaintiff previously reported to Scottsdale. Mt. Hawley argues the May Letter is not a routine records request because it was made by a personal injury law firm acting for the estate of a deceased former resident, and threatened a legal

proceeding or trial “relating to the care that WMOP had provided to Mr. Eisner” (NYSCEF Doc No. 18, Mt. Hawley’s memorandum of law at 7).

Plaintiff, in opposition, argues that the November 28 Letter constitutes a claim as defined in the Mt. Hawley Policy. Further, plaintiff submits that the prior claims exclusion is inapplicable for two reasons. First, plaintiff submits that the May Letter does not qualify as a claim or demand under the terms of the Scottsdale Policy. Second, the May Letter is devoid of any statement identifying any act, error or omission, medical incident or occurrence pertaining to Eisner’s care at Achieve.

1. The Second Cause of Action for a Declaratory Judgment

The second cause of action seeks a judgment declaring that Mt. Hawley must defend, indemnify and hold plaintiff harmless in the *Eisner* Action.

Preliminarily, the court rejects Mt. Hawley’s argument that plaintiff is precluded from taking two contrary positions in this action with regards to the May Letter. Whether plaintiff is entitled to coverage involves separate determinations under the terms of Scottsdale and Mt. Hawley policies (*see University of Pittsburgh v Lexington Ins. Co.*, 2016 WL 7174667, *4, 2016 US Dist LEXIS 170285, *11-12 [SD NY, Dec. 8, 2016, No. 13-CV-335 (KBF)]).

Whereas it is incumbent upon an insured to prove its entitlement to coverage (*see Platek v Town of Hamburg*, 24 NY3d 688, 694 [2015]), an insurer seeking to invoke a policy exclusion as a bar to coverage must “demonstrate that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case” (*Lend Lease [US] Constr. LMB Inc. v Zurich Am. Ins. Co.*, 136 AD3d 52, 59 [1st Dept 2015], *affd* 28 NY3d 675 [2017] [internal quotation marks and citation omitted]). “[A]n ambiguity in an exclusionary clause must be construed ... against the insurer” (*DMP Contr.*

Corp. v Essex Ins. Co., 76 AD3d 844, 846 [1st Dept 2010] [internal quotation marks and citation omitted]).

Prior notice or prior claims exclusions in claims made policies are routinely enforced (*see Berkshire Hathaway Specialty Ins. Co. v H.I.G. Capital, LLC*, 172 AD3d 570, 571 [1st Dept 2019] [finding that the unambiguous language of a prior notice exclusion in an insurance policy established that “as a matter of law, that there is no possible factual or legal basis on which plaintiffs may eventually be held liable under the ... Policy”]; *Rosenbaum v Chicago Ins. Co.*, 306 AD2d 29, 30 [1st Dept 2003] [concluding there was no coverage for the plaintiff insured who had given its prior insurers notice of the alleged negligence that gave rise to the legal malpractice claim]; *Hunt v Galaxy Ins. Co.*, 223 AD2d 821, 822 [3d Dept 1996] [concluding that the plaintiff failed to take “the steps necessary to preserve ... coverage” by giving timely written notice of a potential claim]; *Zahler v Twin City Fire Ins. Co.*, 2006 WL 846352, *7, 2006 US Dist LEXIS 14263, *20 [SD NY, Mar. 31, 2006, No. 04-Civ-10299 (LAP)] [finding there was no coverage based on an unambiguous prior notice exclusion]).

Here, the documentary evidence Mt. Hawley proffered does not utterly refute the allegations in the complaint. The reported or “should have been reported” language in the Mt. Hawley Policy “requires a subjective determination of the insured’s knowledge of the relevant facts and an objective determination of whether a reasonable person in the insured’s position should have expected such facts to be the basis of a claim” (*Ulster County v CSI, Inc.*, 95 AD3d 1634, 1635 [3d Dept 2012]; *see also CPA Mut. Ins. Co. of Am. Risk Retention Group v Weiss & Co.*, 80 AD3d 431, 431 [1st Dept 2011] [stating that “it was unreasonable for defendants to have failed to foresee that these facts might form the basis of a claim against them” in view of the evidence establishing that they had subjective knowledge of the facts giving rise to a potential

claim]; *see also Executive Risk Indem. Inc. v Pepper Hamilton LLP*, 13 NY3d 313, 322 [2009], *rearg denied* 13 NY3d 927 [2010] [decided under Pennsylvania law]). At this juncture, it is unclear whether plaintiff could have reasonably foreseen a future claim against it. The May Letter did not identify a specific, objectionable act, error or omission with respect to plaintiff's services while Eisner was a resident (*see e.g. Chiera*, 2008 NY Slip Op 51817[U], *15). Similarly, the letter fails to describe a "medical incident" or "occurrence" as those terms are defined in the Mt. Hawley Policy. The Authorization did not refer to specific legal proceeding against plaintiff, and the May Letter offered no facts or details that Eisner's representative was contemplating a possible claim for damages against plaintiff. And while Mt. Hawley's disclaimer letters stated that its investigation had revealed Eisner suffered from pressure ulcers, sepsis and malnutrition, Mt. Hawley has not submitted the records cataloguing those conditions. Hence, the documentary evidence produced thus far is insufficient to establish plaintiff's subjective knowledge that a negligence claim was inevitable.

Further, there has been no discovery, and thus, it would be improper at this stage of the action to determine whether plaintiff reasonably believed Eisner would pursue a claim against it. The cases Mt. Hawley cites in support also involved decisions made on summary judgment motions. For instance, in *University of Pittsburgh v Lexington Ins. Co.*, the District Court concluded that the facts adduced during discovery would lead "any reasonable juror ... to conclude that a principal of [the insured] had a reasonable expectation of liability" (2016 WL 7174667, *4, 2016 US Dist LEXIS 170285, *12). The evidence included testimony from the insured's principal who believed that a claim was "'inevitable' and that there was a 'possibility' that this inevitable claim would be against [the insured]" (2016 WL 7174667, *4, 2016 US Dist LEXIS 170285, *13). Likewise, the trial court in *Rosenbaum*, another case Mt. Hawley cites,

issued the determination on a motion for summary judgment where the “plaintiff, by his own account, gave his prior insurers notice of the alleged negligence giving rise to the subject claim before the inception of his first policy from” the defendant insurer (306 AD2d at 30).

Consequently, that part of Mt. Hawley’s motion to dismiss the second cause of action is denied.

2. The Fourth Cause of Action for Breach of Contract

In view of the foregoing, that part of Mt. Hawley’s motion to dismiss the fourth cause of action is also denied.

Accordingly, it is hereby

ORDERED that the motion of defendant Scottsdale Insurance Company to dismiss the complaint against it (motion sequence no. 001) is granted and the complaint is dismissed in its entirety against said defendant, with costs and disbursements to said defendant as taxed by the Clerk of the Court, and the Clerk is directed to enter judgment accordingly in favor of said defendant; and it is further

ADJUDGED and DECLARED that defendant Scottsdale Insurance Company does not have a duty to defend or indemnify plaintiff in the underlying Eisner action; and it is further

ORDERED that the action is severed and continued against the remaining defendant; and it is further

ORDERED that counsel for defendant Scottsdale Insurance Company shall serve a copy of this order with notice of entry upon the County Clerk (Room 141B) and the Clerk of the Trial Support Office (Room 158); and it is further

ORDERED that such service upon the Clerk of the Court and the Clerk of the General Clerk’s office shall be made in accordance with the procedures set forth in the Protocol on Courthouse and County Clerk Procedures for Electronically Filed Cases (accessible at the “E-

Filing” page on the court’s website at the address www.nycourts.gov/supctmanh); and it is further

ORDERED that the motion of defendant Mt. Hawley Insurance Company to dismiss the complaint against it (motion sequence no. 002) is denied; and it is further

ORDERED that Mt. Hawley shall serve an answer to the complaint within 20 days after service of a copy of this order with written notice of entry; and it is further

ORDERED that counsel are directed to appear for a preliminary conference via telephone on May 18, 2020 at 11:00 AM. Plaintiff is directed to apprise defendant and the court (macrane@nycourts.gov) of a call in number by April 20, 2020.

Dated: April 13, 2020

ENTER:



J.S.C.